

Complaint Investigations of Minnesota Health Care Facilities

*Report to the Minnesota Legislature
explaining the investigative process and
summarizing investigations from July 1, 2002
to June 30, 2005 and Information on
Deficiencies Issued by OHFC from October 1,
2004 to September 30, 2005*

Minnesota Department of Health

March 2006



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Introduction

Minnesota Statutes, section 626.557, requires the Minnesota Department of Health (MDH) to annually report to the Legislature and the Governor information about alleged maltreatment in licensed health care entities.

Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), states:

Summary of reports. The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:

- (1) whether and where backlogs of cases result in a failure to conform with statutory time frames;
- (2) where adequate coverage requires additional appropriations and staffing; and
- (3) any other trends that affect the safety of vulnerable adults.

In order to provide an appropriate context for the information specified in the law, this report will also address the Department's complaint investigation responsibilities relating to health care facilities. This report will provide summary data relating to the number of complaints and facility reported incidents received during state FY 03 to state FY 05; will provide summary data as to the nature of the allegations contained within those complaints and reports; describe the Office of Health Facility Complaints (OHFC) process from the intake function to completion of the investigative process; and then address issues relating to the performance of its responsibilities. This latter category will include information on the ability to conform to statutory requirements, the effectiveness of current staffing, and any trends relating to the safety of vulnerable adults. Since the complaint investigation function is also a critical component of the federal certification process, information as to the federal requirements and performance evaluations will be included. Expanded information on OHFC's issuance of federal deficiencies related to nursing homes is included in Part 2 of this Report.

Part 1: State Fiscal Year Information

Background

There are over 2,000 licensed health care entities in the state. Licensed health care entities include nursing homes, hospitals, boarding care homes, supervised living facilities, home care agencies, hospice programs, hospice residences, and free standing outpatient surgical facilities. The licensure laws contained in Minnesota Statutes Chapters 144 and 144A detail the Department's responsibilities in this area. In addition, MDH is the survey agency for the purpose of certifying a health care facility's participation in the Medicare and Medicaid programs.

The purpose of licensing and federally certifying health care facilities is to protect the health, safety, rights and well being of those receiving services by requiring providers of services to meet minimum standards of care and physical environment. The licensure laws at the state level and the federal certification requirements provide for the development of regulations that establish those minimum standards. MDH rules, the Vulnerable Adults Act (VAA), the Patients Bill of Rights, and federal

Medicare and Medicaid certification regulations are the primary legal foundation for patient/resident protection efforts.

In addition to the development of the regulations, the licensure and certification laws also provide the structure for monitoring performance in two ways: the survey process and a distinct mechanism to respond to complaints about the quality of the care and services provided. This report will focus on the complaint investigation process.

The Office of Health Facility Complaints is a program within the Minnesota Department of Health's Division of Compliance Monitoring. OHFC is responsible for investigating complaints and facility reported incidents of maltreatment in licensed health care entities in Minnesota.¹

State and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC. State law also mandates that allegations of maltreatment against a vulnerable adult or a minor be reported by the licensed health care entity. Maltreatment is defined in Minnesota Statutes 626.557 (Vulnerable Adults Act) as cases of suspected abuse, neglect, financial exploitation, unexplained injuries, and errors as defined in Minnesota Statutes 626.557, subd. 17(c)(5).²

OHFC Responsibilities

OHFC is responsible for the receipt of all complaints and facility reported incidents; for gathering information that will assist in the appropriate review of this information; for evaluation and triage of this information and for selecting the level of investigative response. In addition, OHFC is required to notify complainants and reporters as to the outcome of the review and any subsequent investigation. These specific functions will be addressed later in the report.

A Director and an Assistant Director manage OHFC. There are 15 investigators assigned to the Office; 12 investigators are assigned to the St. Paul office and the remaining 3 are located in the MDH offices in Fergus Fall, Duluth and Rochester. There are 2 individuals responsible for the intake of complaints and facility reported incidents. There are 5 support staff assigned to the Office. In addition to the complaint related activities, OHFC is also responsible for the activities related to the processing of criminal background checks and set asides. Two additional staff are assigned to this activity.

¹ Statutory authority for OHFC is found in Minnesota Statutes 144A.51 to 144A.54. In addition to the requirements of state law, OHFC is also the entity responsible for reviewing and investigating complaints under the federal Medicare and Medicaid certification requirements.

OHFC is the "lead agency" for the purposes of reviewing and investigating facility reported incidents of maltreatment under the provisions of the Vulnerable Adult Abuse Act, Minnesota Statutes 626.557 and the Reporting of Maltreatment of Minors Act, Minnesota Statutes 626.556.

² While OHFC does conduct investigations relating to the maltreatment of minors in MDH licensed facilities, the information presented in this report will be based on complaints and facility reported incidents involving vulnerable adults. OHFC investigates very few cases involving a minor each year.

**TABLE 1
OHFC BUDGET AND STAFFING HISTORY**

Fed Fiscal Year	Investigators	Supervisor Managers	Intake Staff	Admin. Staff	Total Staff	OHFC Funding
FFY05	15	2	2	5	24	Total Oper. Budget: \$2,266,286 Medicare 38.60% Medicaid 29.20% State Licensure 32.30%
FFY04	13	2	2	5	22	Total Oper. Budget: \$1,910,796 Medicare 37.30% Medicaid 28.90% State Licensure 33.80%
FFY03	14	2	2	5	23	Total Oper. Budget: \$1,776,396 Medicare 37.10% Medicaid 30.70% State Licensure 32.30%

OHFC Funding sources are Medicare, Medicaid, and State Licensure Fees

How OHFC Receives Information

Concerns about issues or situations in licensed health care entities come to OHFC in one of two ways: **a complaint or a facility reported incident**. A **complaint** is an allegation relating to maltreatment or any other possible violation of state or federal law that is made by an individual who is not a designated reporter. A **facility reported incident** is received from a designated reporter in a facility and describes a suspected or alleged incident of maltreatment as defined in the Vulnerable Adults Act.

Table 2, below, includes the numbers of complaints and facility reported incidents received during the past three state fiscal years by facility type.

**Table 2: Complaints & Facility Reported Incidents by Facility Type
FY03, FY04, FY05**

Complaints Received	FY03	FY04	FY05
Nursing Home	835	838	866
Hospital	398	316	340
Home Health	294	324	362
Other Licensed Entities	104	124	105
* Total Complaints Received	1631	1602	1673
Facility Reported Incidents	FY03	FY04	FY05
Nursing Home	4613	3785	2849
Hospital	220	156	169
Home Health	311	303	318
Other Licensed Entities	107	92	112
** Total Facility Reported Incidents Received	5251	4336	3448
*** Grand Total	6882	5938	5121

As shown in Table 2, OHFC yearly receives several thousand complaints and facility reported incidents. **It is imperative to note that OHFC reviews every complaint and facility reported incident.** State and federal law require that these complaints and facility reported incidents be reviewed to make a determination as to what investigative process will be employed to resolve the allegation.

Types of Maltreatment Allegations and Other Concerns Received by OHFC

Each complaint or facility reported incident might contain more than one allegation, each of which must be reviewed for investigative purposes. For example, an allegation that a resident was neglected might state the nature of the specific concern but also indicate that inadequate staffing was also a concern. Complaints and facility reported incidents are coded to identify various categories of maltreatment and other violations of state and federal law. Table 3 illustrates the recording of all allegations for nursing homes for state FY03, FY04 and FY05; the maltreatment allegations and concerns identified by complainants and the maltreatment allegations and concerns contained in facility reported incidents. Tables 4, 5 and 6 on the following pages summarize all allegations for the other licensed health care entities.

Table 3: Nursing Home Allegations from Complaints and Facility Reported Incidents FY03, FY04, FY05

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	28	193	37	168	33	171
Physical Abuse	65	374	53	310	55	205
Sexual Abuse	20	137	15	92	14	106

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	18	86	9	62	10	67
Exploitation by other	5	112	4	76	4	90

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	344	441	316	351	352	276
Falls	50	1019	54	980	58	782
Medications	54	144	51	90	45	76
Decubiti	40	8	33	10	18	5
Dehydration	9	0	10	1	4	0
Nutrition	12	1	9	2	5	2
Neglect, Failure to notify MD	17	2	6	0	6	1
Neglect of Supervision	59	495	33	417	44	365

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
<i>Allegation : Unexplained Injury</i>	Comp	FRI	Comp	FRI	Comp	FRI
	35	1147	18	968	14	456

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	107	53	131	39	133	58
Nursing, Infection Control, Medications	100	8	136	10	120	2
Other	108	7	120	10	137	6

**Table 4: Hospital Allegations from Complaints / Facility Reported Incidents
FY03, FY04, FY05**

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	5	12	1	2	1	9
Physical Abuse	16	9	10	10	4	2
Sexual Abuse	16	41	10	24	0	0
Accident	0	0	0	0	0	3

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	1	1	1	1	0	6
Exploitation by other	2	2	0	0	0	0

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	101	21	34	1	29	4
Falls	4	13	4	5	4	7
Medications	25	8	9	4	5	2
Decubiti	12	2	9	2	7	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	3	0	0	0	0	0
Neglect of Supervision	15	85	6	78	3	10

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	4	8	5	8	1	4

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	133	16	119	18	158	13
Nursing, Infection Control, Medications	19	0	64	0	50	12
ER Services	11	0	11	0	5	0
Discharge Planning	19	2	15	1	5	0
EMTALA	17	0	20	0	19	0
Other	17	0	27	0	64	4

**Table 5: Home Health Care Allegations from Complaints / Facility Reported Incidents
FY03, FY04, FY05**

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	15	22	21	15	25	24
Physical Abuse	20	26	20	31	13	7
Sexual Abuse	8	10	9	11	17	36
Accident	0	26	0	4	0	11

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	37	66	24	75	29	48
Exploitation by other	4	25	6	20	6	16

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	88	31	92	32	119	28
Falls	10	23	14	40	13	51
Medications	22	16	39	12	30	17
Decubiti	5	0	9	0	6	0
Dehydration	1	0	2	0	0	0
Nutrition	0	0	3	0	0	0
Neglect, Failure to notify MD	3	0	3	0	1	0
Neglect of Supervision	14	43	31	33	14	14

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations:Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	6	36	5	34	1	4

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	52	8	65	9	76	12
Nursing,InfectionControl, Medications, Shortage Staff	37	2	31	2	59	1
Other	29	1	24	2	3	1

Table 6 : Other Licensed Entities Allegations from Complaints / Facility Reported Incidents

FY02, FY03, FY04

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	11	19	11	23	6	6
Physical Abuse	7	26	9	23	7	14
Sexual Abuse	6	14	4	8	1	3
Accident	0	3	0	3	0	1

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	3	5	6	7	5	2
Exploitation by other	1	10	0	7	1	1

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	25	29	22	17	16	13
Falls	2	14	2	24	2	12
Medications	5	16	8	11	8	20
Decubiti	1	1	1	0	3	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	1	0	0	0
Neglect, Failure to notify MD	1	0	0	0	0	0
Neglect of Supervision	13	39	17	54	3	25

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	3	16	4	17	6	9

	FY 2003	FY 2003	FY 2004	FY 2004	FY 2005	FY 2005
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	40	5	53	5	44	7
Nursing, Infection Control, Medications, Shortage Staff	17	2	19	1	6	2
Other	25	3	34	3	19	33

How OHFC Reviews Information – the Intake and Triage Processes

As described below, the OHFC review process consists of an intake process and triage process.

The need to set priorities or to triage the allegations is specifically recognized in both state and federal law. The VAA requires that each lead agency "...shall develop guidelines for prioritizing reports for investigation." Minn. Stat. 626.557, subd. 9b. In addition, the Centers for Medicare and Medicaid Services (CMS) also requires that the state survey agencies develop triage criteria to govern the review of complaints and facility reported incidents. CMS also specifies time frames for the initiation and completion of certain types of investigations.³ The federal performance review of Minnesota's complaint process for federal fiscal year '04 is noted later in this report.

Intake Process

Intake staff review each complaint or facility reported incident as it is received. Intake staff are trained to follow specific protocols and policies in assessing which investigative option the complaint or facility reported incident should be assigned. In many situations, intake staff will request that additional information be provided for review. For example, intake staff will often request that a facility submit medical records and its own investigative reports to be reviewed as the result of a submission of a facility reported incident. Intake staff may also request more information from complainants to assist in the OHFC review process, receiving and placing over 8500 telephone calls a year related to complaint and facility reported incident activity

In situations when it is apparent that a complaint does not allege a violation of state or federal law, intake staff will assist in identifying appropriate referrals to other agencies, such as the Office of the Ombudsman for Older Minnesotans or to a licensure board.

There are multiple ways to address concerns about the care and services provided in our health care facilities. OHFC encourages that residents, patients and families raise concerns directly with the facility. Facility staff are more available and accessible which hopefully will lead to a prompt resolution of the complaint or concern. Working with a family or resident council in a nursing home or other residential facility can provide a forum for raising issues and requesting that action be taken to address the concerns.

Minnesota also has a strong and effective ombudsman program that can work with residents, family members and others to advocate for changes within a facility outside of the regulatory process.

³ Chapter 5 of the State Operations Manual outlines the state survey agency responsibilities for the complaint review and investigation process. The State Operations Manual is published by CMS and is required to be used by the survey agencies in implementing the Medicare and Medicaid certification process for nursing homes. Online access to the SOM, publication 100-07, is available at the following website: <http://www.cms.hhs.gov/Manuals/10M/list.asp>

The complainant is informed that the allegation has been referred to another agency and that no further action will be taken by MDH.

Triage Process

Once the intake process is completed, the information will then be reviewed to determine the extent of any further investigative review by OHFC. This information is reviewed on a daily basis. Intake staff will automatically start the process for an onsite investigation if serious allegations, such as sexual or physical abuse are identified or allegations of potential immediate jeopardy concerns are noted.

OHFC has adopted a policy and procedure that outlines the factors that are considered to triage the complaints and facility reported incidents. This process will determine the extent of its investigative review. The policy and procedure is attached as Appendix A. OHFC also places a priority on those situations when action needs to be taken to determine whether an alleged perpetrator may be subject to disqualification or a referral to the Nursing Assistant Registry with a finding of abuse or neglect.

A number of investigative options are possible, ranging from taking no further action to the initiation of an onsite investigation. Intermediate steps are also considered, such as requesting additional information from a provider if not already requested by Intake staff; requiring facilities to review complaint allegations and submit documentation for a desk investigation, making referrals to other entities such as the Office of the Ombudsman for Older Minnesotans or the appropriate licensure boards; or providing information to the Licensing and Certification program to review at the next scheduled survey of the facility as an “area of concern.” The results of the triage process for state FY03, FY04 and FY05 are shown in Table 7.

The following investigative options are possible:

It could be determined that no further review or investigation will occur. This would happen when there is no alleged violation of rules or regulations, when sufficient information is not available or when requested medical and other records have been reviewed and no possible violations were identified. In addition, a review of information submitted by the facility may indicate that appropriate corrective action had been taken. The complainant or reporting entity is notified that OHFC has reviewed the information and no further investigative action will be taken. The complainant or the reporting entity is told to contact OHFC if there are questions regarding this decision.

The complaint could be handled as a desk investigation. In this situation, OHFC will contact the facility, indicate that a complaint has been filed, and require the facility to submit to OHFC information relating to the allegation and the steps taken to address those concerns. This information is reviewed and, if further action is required, an onsite investigation will be conducted. The complainant is notified that the OHFC has reviewed the complaint and, if the facility’s information is accepted, no determination as to whether the complaint is substantiated will be made. Generally, the desk investigation is used in situations when concerns about resident care have been raised, but a review of the records and information provided from the facility would be considered reliable and credible and an onsite investigation would not add to the investigative review. For example, if concerns were raised about the appropriateness of a

medication regimen or the failure to obtain medical or other treatments, a review of the records may provide sufficient information. Dirty rooms, cold food and medication errors not resulting in harm are also common allegations.

The complaint is referred to the Licensing and Certification Program as an “area of concern”. The allegation is shared with licensing and certification staff and will be reviewed during the next survey process. These “areas of concern” are usually of a general nature not involving an allegation of abuse or neglect. Examples of such complaints include neglect issues that do not result in actual harm or that are not recurring; verbal or mental abuse that does not result in a resident feeling frightened or threatened; patient rights issues; physical plant complaints that do not pose immediate threat to the safety of patient/residents; and dietary and housekeeping complaints that do not impact care.

The complaint or facility reported incident could be assigned for an onsite investigation. Complaints and facility reported incidents that are determined to require this level of investigation are typically the most egregious and serious in nature. Examples would include situations when a potential immediate jeopardy concern has been identified; or when serious neglect concerns are raised such as situations causing fractures, pressure ulcers, or significant weight loss. Other examples will be addressed in the section describing the time frames for the initiation of the investigation. When a complaint is assigned for an onsite investigation, a letter is sent to the complainant notifying that this is the investigative procedure that will be used and a case number and the name of the investigator assigned is in the letter. When the onsite investigation is completed, a copy of the final report is provided to the complainant.

**Table 7: Complaints and Facility Report Incidents Assigned for Further Review
FY03, FY04, FY05**

	FY03	FY04	FY05
Onsite	509	516	474
Desk	121	152	146
Refer to Survey	57	64	148

Onsite Investigations

After it has been determined that an onsite investigation of a complaint or facility reported incident is required, further prioritization is completed to assure a timely response based on the nature of the allegation. For example, an onsite investigation of a complaint or facility reported incident that alleges immediate jeopardy must be initiated within two working days of receipt of the allegation. Immediate jeopardy includes those situations, which are or have the potential to be life threatening or resulting in serious injury.

Complaints, which allege a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), often referred to as “patient dumping”, must be investigated within a two-day period.

Complaints and facility reported incidents that allege a higher level of actual harm will be investigated onsite within 10 working days of receipt of the complaint, and consist of situations that result in serious adverse consequences to patient/resident health and safety but do not constitute an immediate crisis and delaying an onsite investigation would not increase the risk of harm or injury. This would include situations when neglect has led to pressure sores or significant weight loss, when physical abuse has been alleged, unexplained or unexpected death which may have been the result of neglect or abuse; physical abuse of residents; mental or emotional abuse which threatens or intimidates residents; or failure to obtain medical intervention.

Complaints and reports assessed as not having a higher level of actual harm, but having the potential to do so, are assigned for onsite investigation within 45 days. These types of complaints and facility reported incidents include resident care issues, inadequate staffing which has a negative impact on resident health and safety, and patient rights issues.

Resolution of Onsite Investigative Reviews Conducted in State FY03, FY04, FY05

All onsite investigations are governed by the requirements defined in the federal laws and regulations governing the Medicare and Medicaid certifications programs and state laws. OHFC is responsible for forwarding all investigative reports to the facility and complainant when an investigation is completed. The VAA requires that investigations be completed within 60 days. If this is not possible, OHFC is required to provide an estimate as to when the investigation will be completed. Federal policy requires that immediate jeopardy investigations be completed within 2 working days after the onsite investigation and EMTALA investigations be completed within 10 working days after the onsite investigation.

When an onsite investigation is completed, the findings are either substantiated, unsubstantiated or inconclusive. **A substantiated finding means** a preponderance of the evidence shows that the allegation occurred. **An unsubstantiated finding means** a preponderance of the evidence shows that the allegation did not occur. **A finding of inconclusive means** that there is less than a preponderance of evidence to show that the allegation did or did not occur.

The results of the onsite investigative review conducted by OHFC is as follows:

Table 8: Results of Completed Onsite Investigations FY03, FY04, FY05

	FY03		FY04		FY05	
	Number	Percent	Number	Percent	Number	Percent
Substantiated	183	36.0	192	37.2	165	34.8
Inconclusive	203	39.9	165	32.0	172	36.2
Un-substantiated	123	24.1	159	30.8	137	29.0
Total	509	100	516	100	474	100

All VAA investigative reports are referred to the Medicaid Fraud Division of the Attorney General's Office and the long-term care ombudsman receives copies of all public reports. If maltreatment is substantiated, a copy of the report is provided to the MN Department of Human Services, MDH Licensing and Certification, the city and/or county attorney, the local police department, and any affected licensing board.

Public reports of all onsite investigations for the past two years are available on MDH's website: <http://www.health.state.mn.us/divs/frp/directory/surveyapp/provcompselect.cfm>

If OHFC makes a finding of maltreatment involving a nursing assistant working in a nursing home, those findings are reported to the Nursing Assistant Registry (NAR). The NAR is responsible for notifying the nursing assistant and informing the nursing assistant of the appeal rights. Once a finding is entered on the Registry, the individual is permanently prohibited from working in a nursing home. These individuals are also referred to the Minnesota Department of Human Services for disqualification, as are other individuals who have maltreated an individual, for whom disqualification is required.

Number of employees with substantiated maltreatment findings:

FY03	FY04	FY05
75	92	66

Number of hearings requested:

FY03	FY04	FY05
21	20	33

Number of people referred to the Nursing Assistant Registry with substantiated findings of abuse, neglect, or exploitation:

FY03	FY04	FY05
52	64	58

Investigations of Deaths

Not all deaths in nursing homes or other health care facilities are the result of abuse or neglect. However, if allegations are made that the death was the result of neglect or abuse, those deaths are carefully reviewed by OHFC.

During the past three state fiscal years, OHFC conducted 130 onsite investigations relating to deaths in health care facilities. Like all other concerns identified in a complaint or in a facility reported incident, deaths are reviewed by Intake staff and triaged according to the OHFC policy. The focus of this review is to determine whether there is sufficient information to support the allegation that abuse or neglect caused the death. If a facility reported incident related to a death alleged neglect or abuse, medical records would be requested and reviewed to determine any basis for the abuse or neglect allegation. A summary of the completed onsite investigations that involved a report of death indicates the following:

In FY 03, OHFC conducted 56 onsite investigations relating to deaths, 45 of which were the subject of a complaint, the remaining 11 were based on a facility reported incident. 20 of these investigations were substantiated, 20 were inconclusive and 16 were unsubstantiated. 29 of the investigations involved deaths in nursing homes.

In FY 04, OHFC conducted 47 onsite investigations relating to deaths, 36 of which were based on complaints, the remaining 11 were based on facility reported incidents. 16 of these investigations were substantiated, 12 were inconclusive and 19 were unsubstantiated. 37 of the investigations involved deaths in nursing homes.

In FY 05, OHFC conducted 27 onsite investigations relating to deaths, 21 of which were the subject of a complaint, the remaining 6 were based on a facility reported incident. 10 of those investigations were substantiated, 9 were inconclusive and 8 were unsubstantiated. 15 of the investigations involved deaths in nursing homes.

Evaluation of the OHFC Complaint Process

Case Backlog and Conformance to Statutory Time Frames

One of the areas required to be addressed in this report is whether or not there is a backlog of cases and whether or not OHFC investigative activities conform to statutory time lines.

Under the provisions of the VAA, OHFC as the “lead agency” has a number of specific time frames to meet. These include providing information on the initial disposition⁴ of a report within 5 business days from receipt; completing the final disposition within 60 days of its receipt; providing a copy of the investigative report within 10 days of the final disposition to parties identified in the VAA and responding to requests for reconsideration within 15 days of the request.

The most significant time frame relates to the completion of the final disposition within 60 days. As defined in the VAA, the final disposition is the determination as to whether or not the maltreatment report will be substantiated, inconclusive, etc. Conformance to this time frame will be discussed later in this section.

While no other specific time frames are contained in state law, the time frames imposed on OHFC by virtue of the federal certification program are significant. Each year, CMS conducts performance reviews of each state survey agency. One of the performance standards relates to the “conduct and reporting of complaint investigations...”. The standards focus on the following areas: whether the state agency follows appropriate guidelines for the prioritization of complaints; are various types of complaints - such as those alleging immediate jeopardy, a violation of EMTALA, or nursing home complaints alleging higher levels of “actual harm” - initiated and/or completed within designated time lines; and is the appropriate data entered into the federal system on a timely basis.

⁴ As defined in the VAA, the initial disposition is the lead agency’s determination as to whether the report will be assigned for further investigation.

The federal thresholds for being in conformance with these elements are high, 90% or higher. CMS review for FFY 04 did not identify any significant concerns with OHFC's triage process, how investigative priorities are set, and the general timeliness of our activities. A copy of the final review for that year is attached as Appendix C.

The federal review indicates that the policies and procedures used by OHFC are appropriate to identify the cases that require more intensive levels of investigation. While OHFC has generally met the time frames for the initiation of onsite investigative reviews, completion of the investigative reports does not meet the 60 day time limit in the VAA. The average completion days for reports, which would include VAA mandated reports, has been approximately 99 days each of the past 3 state fiscal years. To a large extent, delays in completion of reports are attributed to ongoing case assignment to the investigators and the need to meet the federally mandated time lines for the start of the federal process. For FY 03, 61% of the onsite investigations needed to be initiated within 10 days or less. This percentage increased to 64% in FY 04 and was 59% in FY 05. In order to meet the federal performance standards, pressure is placed on the investigators to initiate an increasing number of investigations. This delays the ability to complete already assigned investigations.

While concerned with this delay, steps have been taken to speed up the process in situations when the investigation will result in a substantiated finding, when correction orders or federal deficiencies will be issued, or when findings leading to the potential disqualification of an individual will be made. In these situations, actions are required by the facility to take steps to come into compliance with state or federal regulations, the process for disqualification of an individual needs to commence, or referrals of substantiated findings to law enforcement personnel or to appropriate licensure boards needs to be made.

Adequacy of Staffing

As noted previously, OHFC is beyond the final disposition time frame of 60 days mandated by the VAA. To a certain extent, additional staffing resources would assist to reduce the time frame by reducing the number of new assignments given to the current complement of investigators. However, the need for new staff and the attendant costs need to be weighed against the potential benefits to be achieved and how this would improve the safety of patients and residents. The federal budget authorized OHFC to hire two additional investigators in FFY05. This was done, however, calendar year 2005 was a year of investigator staff transition for OHFC. The full complement of investigators for calendar year 2005 averaged 13 because of staff departures and extended medical leave.

While additional staff will help, a more important variable relating to the adequacy of staffing is determining whether more investigative reviews, especially onsite investigations, will improve the safety of vulnerable adults. Several factors need to be taken into consideration, including the time for completion of onsite investigations and the types of issues that may not get reviewed as part of the complaint process.

Over the past few years, there has been an increase in the average number of hours for the completion of onsite investigations whether or not the investigation is subsequently substantiated.

The average hours for completing an investigation are as follows:

	FY03	FY04	FY05
Complaint substantiated	42.7 hrs	39.1 hrs	45.0 hrs
Complaint un-substantiated	25.6 hrs	23.8 hrs	29.2 hrs
Inconclusive	25.4 hrs	25.2 hrs	32.6 hrs

There needs to be further analysis of these numbers to determine whether or not the hours could be reduced. However, this does not seem to be a likely possibility. OHFC is devoting more time to serious allegations which will be more complicated to review. As discussed above, the appropriate triage and priority assignment for complaints is a major emphasis of CMS. OHFC is seeing a slight increase in the number of investigations that need to be assigned in less than 10 days. This means that cases involving higher levels of harm are increasing and it is reasonable to assume that these cases will be more clinically complicated. As hours for completion increase, this will reduce annual caseload for the investigators.

The current triage and priority setting process used by OHFC has been reviewed and accepted by CMS. MDH federal performance reviews indicate that CMS has accepted OHFC's performance as it relates to review and priority setting and time frames for complaint initiation. This means that the most serious investigations are getting the appropriate level of investigative review by OHFC.

Until recently, OHFC has had a fairly stable investigative work unit. In SFY05, 5 of the longer-term investigators transferred to another unit within the Department. The time devoted to hiring and training 5 replacement and 2 additional positions has had an impact on workload performance.

Part 2: The Authority and Responsibility of the Office of Health Facility Complaints Regarding Federally Certified Nursing Homes

The Office of Health Facility Complaints (OHFC) is responsible for the review of complaints and facility reported incidents from all licensed and federally certified health care facilities in the state. While not specifically required under the reporting provisions outlined in Minnesota Statutes §626.557, subdivision 12b, clause (e), the Department believes that it is appropriate to provide information relating to the activity and performance of OHFC under the federal certification requirements.

OHFC is a distinct program within the Department's Compliance Monitoring Division. OHFC has statewide jurisdiction and is responsible for complaint and facility reported incident investigations in all licensed and certified health care facilities in the state. These facilities include hospitals, nursing homes, boarding care homes, supervised living facilities (SLF) and home health care providers, including assisted living home care providers. Specific responsibilities mandated by the Centers for Medicare and Medicaid Services (CMS), which is the federal agency responsible for the certification of these facilities, include the investigation of alleged violations of the Emergency Medical Treatment and Labor Act (EMTALA) by hospitals; conducting complaint investigations authorized by the CMS Regional Office in accredited hospitals; investigating complaints against certified health care facilities

or providers; and investigating facility reported incidents submitted by certified facilities under federal law.⁵

During Federal Fiscal Year 2005⁶ (FFY05) OHFC conducted 407 on-site investigations, of which 278 were in nursing homes. Part 2 of this report addresses the activities and responsibilities of OHFC as they relate only to certified nursing homes.

While some OHFC staff are located outside of the Department's St. Paul location, the Office does not assign investigators to precise geographical districts such as those created by the Division's Licensing and Certification Program. All investigative findings are reviewed in the St. Paul office. Final reports, correction orders and federal deficiencies are issued from that office. The data provided in this report and in past reports are compiled on a statewide basis. Unlike the Licensing and Certification Program, the classification of data by geographic districts is not a relevant factor in reviewing OHFC operations.

Legal Authority

The authority for the OHFC to conduct investigations in nursing homes is found in Minnesota Statutes §§144A.51 -.54⁷; in Minnesota Statutes §626.557⁸ and in federal statutes and regulations⁹. As the "state survey agency" for federal certification purposes, the Minnesota Department of Health is responsible for performing the complaint related functions described in federal law. These functions have been assigned to the Compliance Monitoring Division and OHFC is the designated entity within the Division responsible for these activities.

OHFC is required to follow the provisions of federal law as well as the provisions contained in the State Operations Manual (SOM), which is published by CMS. The SOM details the duties and responsibilities of the state survey agency and is the document that includes the various interpretive guidelines for certified facilities. Chapter 5 of the SOM details the specific requirements that are to be followed while conducting complaint investigations.

In addition to the specific laws requiring the establishment of a complaint office, state and federal law outlines the authorities for issuing correction orders, federal certification deficiencies and imposing

⁵ Certified nursing homes and Intermediate Care Facilities for the Mentally Retarded are required under federal regulations to report to the appropriate state authority allegations of mistreatment, neglect and abuse. See 42 CFR 483.13(c) and 42 CFR 483.420(d).

⁶ FFY 05 runs from October 1, 2004 to September 30, 2005.

⁷ Minn. Stat. §§ 144A.51-.54 establishes the Office of Health Facility Complaints and outlines its responsibilities to investigate complaints against health care facilities and providers.

⁸ Minnesota Statutes §626.557, also known as the Vulnerable Adult Abuse Reporting Act, provides the authority and responsibility of a "lead agency," in this case, OHFC, to review and investigate allegations of maltreatment, i.e. abuse, neglect and financial exploitation reported by health care facilities.

⁹ Sections 1819 (g)(4) and 1919(g)(4) of the Social Security Act require that the State survey agency maintain procedures and staff to investigate complaints of violations by nursing homes; 42 CFR 488.332 is the regulatory provision addressing state agency responsibilities for nursing home complaint investigations; and 42 CFR 488.335 requires that the state survey agency investigate all allegations that an individual in a nursing home might have abused or neglected a resident or misappropriated the residents property. This section requires that substantiated findings of abuse and neglect be reported to the state's Nursing Assistant Registry or to the appropriate licensure boards.

finer or other remedies for facility noncompliance.¹⁰ Under these provisions, OHFC has the authority to make findings, issue deficiencies and state licensing correction orders, issue state penalty assessments; and recommend to the CMS Regional Office the imposition of remedies against certified facilities. OHFC also makes determinations of maltreatment against facilities and individuals under the state VAA law and under the provisions of federal regulations. Facility and individual requests for reconsideration or requests for administrative hearings on those findings are processed by OHFC. OHFC staff are also responsible for the review of set-aside requests for individuals that have been disqualified under the provisions of Minnesota Statutes, Chapter 245C. OHFC staff are involved in any hearings or judicial challenges related to those decisions.

Combination of State and Federal Provisions

Federal and state provisions authorizing investigations and detailing the requirements to be followed by health care facilities do not create significant conflict with each other. For that reason, OHFC combines its federal and state authorities and responsibilities when conducting investigations in nursing homes. Reasons that support and justify this combined approach include the following:

1. The licensure and certification regulations applicable to nursing homes are generally consistent. Thus, a finding of noncompliance under the federal certification program often supports a finding of noncompliance under state law. Appendix I of the Department's Annual Quality Improvement Report on the Nursing Home Survey Process, dated December 15, 2005 provides greater detail on the relationship between the state and federal regulations. A copy of this report can be found at the following web site: <http://www.health.state.mn.us/divs/fpc/aqirnhs2005.pdf>
2. Both the state VAA law and the federal regulations impose similar obligations on nursing homes relating to the internal investigation of abuse or neglect allegations. The federal provisions require that the nursing home report allegations consistent with state law, therefore, the submission of a report required by the VAA law meets this federal obligation.
3. The provisions of the VAA requiring that the lead agency make determinations as to the culpability of individuals for abuse or neglect and the federal requirements addressing abuse and neglect findings against nursing assistants and other individuals working in certified nursing homes are also consistent.

Specific Components of the Investigative Process for Nursing Homes

Intake and Triage

The intake and triage process used by OHFC to review complaints and facility reported incidents is included in Part 1 of this report.

¹⁰ Minnesota Statutes §144A.10 specifies the authority to issue correction orders and penalty assessments to nursing homes. Federal authority for the issuance of remedies can be found in 42 CFR Part 488. Chapter 7 of the SOM also addresses the specific duties of the state survey agency relating to nursing home enforcement.

Federal policy specifically assigns time lines to specific types of complaints. See §§ 5020 to 5030H in Chapter 5 of the SOM. There are no corresponding state timelines for the initiation of an onsite complaint investigation.¹¹

The OHFC triage policy incorporates the more precise federal requirements for determining the type of allegations and the timeline for the initiation of a complaint investigation. It is these provisions that mandate that investigations of allegations of immediate jeopardy are to be investigated within 2 days and that investigations of allegations of “high actual harm” are to be investigated within 10 days. 90% of the total number of onsite nursing home investigations (250 of the 278) conducted by OHFC fall within those two categories.

Table 9 identifies the number of investigations that needed to be initiated within 2 days and the number of investigations that needed to be initiated within 10 days. The compliance percentage is also included.

Table 9: FFY05 OHFC Onsite Nursing Home Complaint and Facility Reported Incident Investigations Required within 2 or 10 Days

Provider Type	Number of onsite investigations	Number of onsite investigations within required time	Percent within required time
Nursing home	278 total	246 of 250	98.4%
Nursing home required within 10 days	229	226	98.69%
Nursing home required within 2 days	21	20	95.24%

CMS evaluates, on a yearly basis, OHFC’s compliance with these triage requirements. Appendix C is the CMS evaluation of Standard 6 that addresses this issue for FFY 04. A final CMS determination of compliance with this standard for FFY 05 was received on February 28, 2006, too late for inclusion in this report.

Abbreviated Standard Surveys

Chapter 5 of the SOM outlines the protocols to be followed by the state survey agency for complaint investigations. Due to the similarities between the state and federal regulations for nursing homes, these federal protocols are utilized for nursing home investigations under both federal and state law.

¹¹ In accordance with Minn. Stat. §626.557, subd. 9c, OHFC is required to notify the reporter that the report has been received and provide information on the initial disposition of the report within 5 business days of the receipt of the report. As defined in section 626.5572, subd. 12, the “initial disposition” is the lead agency’s determination as to whether the report will be assigned for further investigation. The VAA requires that the lead agency complete its investigation within 60 calendar days of the receipt of the report or provide information as to the reason for the delay and the projected completion date. See section 626.557, subd. 9c (d).

Complaint investigations in certified nursing homes are referred to as abbreviated standard surveys. This term is defined in § 7001 of the SOM as follows:

Abbreviated Standard Survey means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change in ownership, management, or director of nursing; or other indicators of specific concern.

Section 7203 E of Chapter 7 of the SOM outlines the expectation for an abbreviated standard survey as follows:

This survey focuses on particular tasks that relate, for example, to complaints received, or a change of ownership, management, or Director of Nursing. It does not cover all the aspects covered in the standard survey, but rather concentrates on a particular area of concern(s). The survey team (or surveyor) may investigate any area of concern and make a compliance decision regarding any regulatory requirement, whether or not it is related to the original purpose of the survey complaint.

Sections 5400 to 5450 of the SOM contain specific requirements and outline specific tasks to be completed during the abbreviated standard survey. These tasks include the following:

- **Section 5410 - Offsite Survey Preparation:** This includes the review of the allegation as well as other information that may have been received during the intake/triage process. It is during this process that other information regarding the facility such as prior survey and complaint history and discussions with the ombudsman about similar complaints would occur.
- **Section 5420 - Entrance Conference/Onsite Preparatory Activities:** On site investigations must be unannounced and at the time of the entrance, the general purpose of the visit will be provided. The investigator needs to assure that the confidentiality of individuals identified as part of the complaint, such as the reporter or specific residents, be protected.
- **Section 5430 - Information Gathering:** In addition to determining whether the complaint is substantiated, the OHFC investigative process is also required to determine the degree of facility compliance with the regulations and to determine if other residents, not specifically identified in the allegation, are at risk. Since Section 5430 addresses this process it is provided in its entirety.

The order and manner in which information is gathered will depend on the type of complaint that is being investigated. Conduct comprehensive, focused, and/or closed record reviews as appropriate for the type of complaint. It is very important to remember that the determination of whether the complaint happened is not enough. The surveyor needs to determine noncompliant facility practices related to the complaint situation and which, if any, requirements are not met by the facility.

Perform information gathering in order of priorities, i.e., obtain the most critical information first. Based on this critical information about the incident, determine what other information to obtain in the investigation.

Observations, record review and interviews can be done in any order necessary. As information is obtained, use what has been learned to determine what needs to be clarified or verified as the investigation continues.

Observe the physical environment, situations, procedures, patterns of care, delivery of services to residents, and interactions related to the complaint. Also, if necessary, observe other residents with the same care need. After determining what occurred, i.e., what happened to the resident and the outcome, investigate what facility practice(s) or procedures affected the occurrence of the incident.

EXAMPLE

It was verified through the investigation that a resident developed a pressure sore/ulcer which progressed to a Stage IV, became infected and resulted in the resident requiring hospitalization for aggressive antibiotic therapy. Observe as appropriate: dressing changes, especially to any other residents with Stage III or IV pressure sores; infection control techniques such as hand washing, linen handling, and care of residents with infections; care given to prevent development of pressure sores (such as turning and repositioning, use of specialized bedding when appropriate, treatments done when ordered, keeping residents dry, and provision of adequate nutritional support for wound healing).

Record review: If a specific resident is involved, focus on the condition of the resident before and after the incident. If there are care issues, determine whether the appropriate assessments, care planning, implementation of care, and evaluations of the outcome of care have been done as specified by the regulatory requirements.

EXAMPLE

For a complaint of verbal and physical abuse, review the record to determine the resident's mood and demeanor before and after the alleged abuse. Determine if there are any other reasons for the change in the resident's demeanor and behavior. Determine whether an assessment has been done to determine the reason for the change in mood and behavior. Does the record document any unexplained bruises and/or complaints of pain, and whether they occurred in relation to the alleged incident?

Interviews: Interview the person who made the complaint. If the complainant is not at the facility at the time of the survey, he/she should be interviewed by telephone, if possible. Also, interview the person the complaint is about. Then, interview any other witnesses or staff involved. In order to maintain the confidentiality of witnesses, change the order of interviews if necessary. It may not always be desirable to interview the person who made the complaint first, as that may identify the person as the complainant to the facility. Interview residents with similar care needs at their convenience.

As interviews proceed, prepare outlines needed for other identified witnesses and revise outlines as new information is obtained.

It is important to note that OHFC has the authority to investigate the allegations that initiated the onsite investigation, and an obligation to expand that review to assure that similar concerns do not affect other residents in the facility. For this reason, OHFC will review records of a number of residents, make required observations in the areas identified as a concern, review incident reports to determine frequency of concerns or whether there is a possible pattern of noncompliance, and complete other tasks as necessary to determine whether the facility is in compliance with a regulation and the scope and severity of any noncompliance. If during the course of the investigation other unrelated findings of noncompliance are identified, OHFC investigators are required to issue appropriate deficiencies or state correction orders. All OHFC investigators are considered qualified surveyors and have passed the federally required SMQT tests.

- **Section 5440 – Information Analysis:** This is the step that determines whether the information obtained during the investigation will substantiate the complaint and determine if the nursing home has violated any regulatory provisions, and whether corrective action had been initiated by the facility. Information gathered by the investigator is reviewed by either the Director or Assistant Director of OHFC. Decisions are made as to whether the information supports the investigator’s recommended deficiencies or correction orders or whether additional information is needed.
- **Section 5450 – Exit Conference:** Once the information analysis has been completed, including the required supervisory reviews, the investigator will advise the facility administrator whether deficiencies or correction orders will be issued.

Differences Between the Investigative Process and the Survey Process

OHFC is required to follow the federal regulations and the policies and procedures developed by CMS. However, there are some key differences in the process for an investigation as compared to a survey of a nursing home. One key difference is that most of the information required to support compliance during a survey process are gathered while the team is onsite. Therefore, at the time of the exit conference, the nursing home is notified of these findings. The nursing home is provided information identifying the findings of the survey process and informed that the survey team’s supervisor will consult with Central Office staff, as appropriate, and make final decisions.

In contrast, OHFC investigations can rarely be concluded at the time of the onsite investigation, and for that reason, an exit conference is not conducted at the end of that onsite visit. The onsite investigation is in fact just one of the initial stages of the investigative process. It is the time when records are reviewed and obtained, when individuals needing to be interviewed will be identified and some of these interviews will be conducted.

Most of the investigative activity is based on the off-site review of records, determining if additional records might be required and completing interviews of the individuals identified as having information or potentially having information related to the allegations.

The supervisory review of the draft deficiencies or correction orders is similar to the supervisory review process used in the Licensing and Certification Program. The investigator follows the same process used to draft the deficiencies by the survey team. This includes necessary references to the interpretive guidelines for nursing homes and conformance to the Principles of Documentation also issued by CMS. The draft deficiencies are then reviewed by the OHFC managers, similar to the process followed by the supervisors and managers in the L&C program. Since OHFC staff and L&C staff are part of the same division, there are opportunities for informal discussion about deficiencies among the staff of those programs. OHFC and the Licensing and Certification Program managers consult with the Compliance Monitoring Division Director's Office prior to issuing immediate jeopardy findings.

Only when this process is completed and determinations made as to whether the allegations will be substantiated or not, and whether deficiencies or orders will be issued, will the "exit" conference be initiated. This is conducted as a phone call with the facility's administrator. The date of this exit is the date that is identified on any deficiencies or orders issued as a result of the investigation. OHFC places priority on the completion of any necessary federal certification deficiencies and these will be issued shortly after the exit conference, in compliance with federal timelines.

Once deficiencies are issued, the OHFC investigator will complete the required investigative report. Federal provisions as well as the VAA specify the components that are to be contained in these reports. As noted previously, the VAA requires that the investigative reports be completed within 60 days of the date the report was received. Information relating to OHFC's compliance with this provision is contained in Part 1 of this report.

The conclusion of the report identifies whether the allegations are substantiated, unsubstantiated, or inconclusive. If maltreatment findings are substantiated, the report also identifies whether the facility or an individual is responsible.

Immediate Jeopardy and Substandard Quality of Care Determinations

If it is determined that investigative findings identify that an immediate jeopardy or substandard quality of care¹² exists, a partial extended survey will be completed. This is defined as follows:

Partial extended survey means a survey that evaluates additional participation requirements and verifies the existence of substandard quality of care during an abbreviated standard survey.

During FFY 05, OHFC conducted 4 partial extended surveys out of the 278 on-site nursing home investigations. The completion of the partial extended survey was required as the result of the issuance

¹² "Immediate jeopardy" is defined as a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. "Substandard quality of care" means one or more deficiencies related to the requirements under 42 CFR 483.13, resident behavior and facility practices (Tags 221-226), 42 CFR 483.15, quality of life (Tags 240-258), or 42 CFR 483.25, quality of care (Tags 309-333), that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of or widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F).

of 7 federal deficiencies. Of the seven, 3 were both immediate jeopardy (IJ) and substandard quality of care tags (SQC), 3 were IJ only, and 1 was SQC only. One nursing home received 4 of the 6 immediate jeopardy tags on 2 separate onsite investigations. Table 10 summarizes the tags issued.

Table 10: Deficiencies Issued as a Result of Partial Extended Survey FFY05

Nursing Home	Tag and Scope and Severity	Immediate Jeopardy	Substandard Quality of Care
#1	F309K	Yes	Yes
#2	F225H	No	Yes
#3	F441K	Yes	No
#4a	F223J	Yes	Yes
	F490J	Yes	No
#4b	F225J	Yes	Yes
	F490J	Yes	No
	7 tags	6 tags	4 tags

The requirements for a partial extended survey are specified in Section III of Chapter 7 of the SOM and provide as follows:

When conducting the extended/partial extended survey, at a minimum, fully review and verify compliance with each tag number within 42 CFR 483.30, Nursing Services; 42 CFR 483.40, Physician Services; and 42 CFR 483.75, Administration. Focus on the facility’s policies and procedures that may have produced the substandard quality of care. As appropriate, include a review of staffing, inservice training and the infection control program. An extended/partial extended survey explores the extent to which structure and process factors such as written policies and procedures, staff qualifications and functional responsibilities, and specific agreements and contracts of the facility may have contributed to the outcomes. If the extended/partial extended survey was triggered by a deficiency in quality of care, conduct a detailed review of the accuracy of resident assessment. During the partial extended survey, consider expanding the scope of the review to include a more comprehensive evaluation of the requirements at 42 CFR 483.13, 42 CFR 483. 15, and/or 42 CFR 483.25 in which substandard quality of care was found.

However, determining whether a partial extended survey will be required as a result of an OHFC investigation is not as precise as determining whether an extended survey will be required as the result of findings made during a survey. In survey situations, one of the final stages of the survey is deficiency determination. If that process identifies immediate jeopardy concerns or that findings constituting substandard quality of care have been identified, the facility is informed that the survey will be expanded and an extended survey will be conducted.

An investigative situation often requires follow-up interviews and record review that cannot be completed during the onsite investigative visit. Therefore, it is not always possible to precisely determine whether a partial extended survey will be needed while the investigator is onsite. In situations when immediate jeopardy may be identified, the OHFC investigator consults with OHFC managers to discuss the findings and determine whether facts support the IJ recommendation. OHFC managers also discuss these findings with the Director's Office before the final IJ determination is made.

As outlined in the triage policy, allegations that appear to create an immediate jeopardy situation must be investigated onsite within 2 working days. In these situations, the investigator reviews the allegation and if it appears the IJ allegation will be substantiated, then determines whether sufficient corrective measures have been implemented by the facility to assure that residents are not at risk. If the allegation was triaged at the IJ level, verifying whether or not an IJ exists can often be made at the time of the onsite investigation.

There have been situations when the initial allegation was not triaged at the IJ level, and subsequent investigative findings identify the existence of the immediate jeopardy and that acceptable corrective action has not occurred. An example would be a situation when it is determined, after the onsite investigation, that the facility failed to appropriately identify or investigate abuse allegations and the perpetrator is still in the facility. In these situations, the investigator may have to return to the facility in order to complete the partial extended survey.

Similarly, if based on the onsite review it appears that deficiencies comprising substandard quality of care are identified, the investigator discusses these issues with OHFC management and a decision may be made to complete the necessary steps required for the partial extended survey, even if a final determination has not been made. This assures that sufficient information is gathered onsite and will also avoid another onsite visit to the facility if the substandard quality of care determination is finalized at a later date. A final decision as to whether a facility meets the criteria for substandard quality of care cannot be made until deficiencies have been identified and the scope and severity of those deficiencies has been determined. If substandard quality of care is determined and the partial extended survey has not been conducted, it will be necessary for the investigator to complete the partial extended survey before the investigation can be concluded.

Results of OHFC Complaint Investigations FFY05

During FFY05, 53 of 278 onsite nursing home investigations resulted in the issuance of 82 federal certification deficiencies. These deficiencies were issued to 41 separate nursing homes. 12 nursing homes were issued deficiencies as the result of more than one OHFC onsite investigation.

A total of 35 state licensing correction orders were issued to 28 different nursing homes during FFY05 as a result of an onsite OHFC investigation. No state penalty assessments were issued as a result of those 35 correction orders. The potential fine amounts for these correction orders ranged from \$0 per day/per order to \$350 per day/per order.

Table 11: Deficiencies and Correction Orders Issued FFY05

Note: Deficiencies and Correction Orders do not correspond as listed

Deficiencies:	Correction Orders:
F309 – Failure to Provide Necessary Care 10-D; 4-G*; 1-K	MN Rule 4658.0520 subp 1 Adequate Care (7) \$350
F157 – Failure to Report Significant Change 6-D; 5-G*	4658.0085 Notification of Change in Condition (6) \$350
F225 – Not Employ Persons Guilty of Abuse 2-D; 1-E; 1-H; 1-J	4658.0525 3A Pressure Sores (1) \$350 5B Incontinence (1) \$350 6A ADL (1) \$350 6B ADL (1) \$350 9 Hydration (2) \$350
F314 – Proper Treatment for Pressure Sores 1-D; 4-G	4658.0800 Infection Control (3) \$300
F324 – Provide Supervision to Prevent Accidents 1-D; 3-G	4658.1325 subp 7 Administration of Medications (1) \$350
F426 – Pharmacy Services 4-D; 1-E	4658.1315 Unnecessary Drugs (1) \$300
F497 – Education/Performance Reviews for NAs 2-D; 3-E	4658.1300 Medication (1) \$0
F312 – ADL Care for Dependent Residents 2-D; 2-E	4658.0520 subp2B Clean Skin/Free from Odors (1) \$350
F327 – Provision of Sufficient Fluids 1-D; 2- G	4658.0505 DON Responsibilities (1) \$300
F441 – Infection Control Program 2-D; 1-K	4658.0450 Clinical Records (1) \$300
F226 – Policies to Prevent Abuse 2-D	4658.0405 Plan of Care (1) \$300
F282 – Services Provided in Accordance with Care Plan 2-D	4658.0100, subp 1 Employee Orientation (1) \$100
F316 – Appropriate Treatment for Incontinent Residents 2-D	MN Statutes 626.557 subd 4 VAA Reporting (1) \$100
F490 – Effective Administration of Facility 2-J	MS 626.557 subd 3(a) VAA Rptg (1) \$250
F201 – Transfer/Discharge Issues 1-D	MS 144A.611 Nurse Aide Trng Reimb (1) \$0
F202 - Documentation for Transfer Discharge 1-D	MS 144.651 subd 29 Bill of Rights Transfer Issues (1) \$250
F205 - Bed Hold Policy 1-C	MS 144.057 Background Study (1) \$0
F223 - Residents to be Free From Abuse 1-J	
F224 - Facility Policies to Prevent Abuse 1-G	
F271 - Physician Orders at Time of Admission 1-D	
F274 - Assessment of Significant Change 1-D	
F279 – Development of Care Plans 1-D	
F310 – ADLs do Not Decline unless Unavoidable 1-D	
F325 – Residents Maintain Nutritional Status 1-D	
F329 - Freedom from Unnecessary Drugs 1-G	
F430 - Report of Med Irregularities are Acted Upon 1-G	
F444 - Washing Hands when Indicated 1-D	
F514 - Clinical Records Meet Appropriate Standards 1-D	

- 1 of each G is pending an IIDR review

53 post certification revisits were conducted by OHFC during FFY 05. These revisits were generally conducted onsite. A phone or written verification of compliance occurs rarely, if at all.

During FFY 05, 5 federal civil money penalties were recommended by OHFC. CMS imposed 10 civil money penalties. OHFC recommended the imposition of 1 denial of payment for new admissions and 0 were imposed by CMS, since the nursing home was in compliance prior to the effective date.

During FFY 05, the remedies, other than civil money penalties, recommended and imposed as the result of onsite investigations is as follows:

TYPE	RECOMMENDED	IMPOSED
State Monitoring	28	8
Discretionary Denial of Payment	1	0
23-Day Termination	4	0

During FFY 05, the following civil money penalties were recommended and imposed:

TYPE	RECOMMENDED	IMPOSED
Per Instance	4	8
Per Day	1	2

Two of the amounts of the per instance CMPs recommended by OHFC were increased by CMS prior to issuance.

Referrals to the Nurse Aide Registry or to Licensure Boards

OHFC is required to make referrals to appropriate licensure boards under the provisions of Minn. Stat. §626.557, subd. 9c, clause (g) that states:

(g) The lead agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

It is the practice of OHFC to refer all substantiated maltreatment reports involving licensed nurses to the Board of Nursing (BON). The report, including private data, is sent without identifying any particular nurse. The BON then determines which nurse(s), if any, to contact. In addition, if an investigation identifies that maltreatment by unlicensed personnel occurred due to inadequate training, supervision, or direction by a licensed nurse or nurses, the report will be forwarded to the BON for review.

Similarly, the nursing home administrator is responsible for the operation and management of the nursing home. In accordance with the Board of Examiners for Nursing Home Administrators (BEMA), OHFC refers all substantiated maltreatment reports to BEMA for its review.

42 CFR 488.335 (f) also requires that OHFC report substantiated findings of abuse, neglect or misappropriation of resident property to the Nurse Aide Registry. During FFY 05, 62 findings were made against nursing assistants and submitted to the Registry.

Access to OHFC Investigative Reports

A copy of each completed OHFC investigation, including a copy of any deficiencies or correction orders issued as a result of the investigation, can be accessed at the following link:

<http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm>

Timelines for the Issuance of Deficiencies and Conducting of Revisits

Minnesota Statutes §144A.101 contains two provisions setting timelines for the performance of survey related functions – the issuance of federal deficiencies and the timing of revisits when remedies are in place. These provisions do not apply to the complaint investigation process. Minnesota Statutes § 144A.101, subdivision 1 states that this section “applies to survey certification and enforcement activities by the commissioner related to **regular, expanded, or extended surveys** under Code of Federal Regulations, title 42, part 488.” As previously discussed, complaint investigations conducted by OHFC are “abbreviated standard surveys” or “partial extended surveys.” Specific definitions of the terms “abbreviated standard survey,” “extended survey,” and “partial extended survey” are found in 42 CFR 483.301. The term “expanded survey” is defined in Section 7001 in Chapter 7 of the SOM. The Department is not aware of a federal definition for a “regular” survey, and it has been the Department’s interpretation that this term means a “standard survey” as defined in 42 CFR 483. 301.

The Department believes that it is appropriate to evaluate how well OHFC complies with these measures as they are important to the certification process.

Issuance of Certification Deficiencies

Minnesota Statutes §144A.101, subdivision 2 requires that draft statements of deficiencies be provided to the nursing home at the time of the exit conference and that completed statements of deficiencies be issued within 15 days of the exit.

As previously discussed, the exit conference process for an OHFC investigation is different than the process used for standard surveys. This exit is conducted by phone and the investigator informs the facility administrator of the conclusion of the investigation and whether deficiencies will be issued. At the time of this phone call, the statement of deficiencies should be ready for mailing. Of the 53 sets of federal deficiencies issued in FFY05, 2 sets were not issued within 15 working days of the date of exit. 96% of the deficiencies were mailed within the 15 working day time timeline that is non-binding by law on OHFC.

Timelines for Survey Revisits

Minnesota Statutes §144A.101, subdivision 5 requires that revisits be conducted within 15 days of the date that corrections will be completed by the nursing home in situations where a category 2 or category 3 remedy is in place. The Department's compliance with this provision is discussed on pages 20 –21 of the Department's 2005 Annual Quality Improvement Report on the Nursing Home Survey Process. Seven revisits were identified as not complying with the statutory provision; 4 of those were revisits conducted by OHFC. A summary of these 4 situations follows:

- The nursing home submitted a plan of correction on January 20, 2005 identifying a compliance date of 1/28/05. The nursing home needed to submit additional information and the plan of correction was not approved until 2/8/05. The revisit was conducted on 2/16/05 and the facility was determined to be in compliance as of 1/28/05. While the revisit was conducted 19 days after the stated compliance date, it was only 8 days after the plan of correction was accepted. A revisit cannot be scheduled prior to having an acceptable plan of correction. The timing of the revisit did not result in any increased civil money penalty for the nursing home.
- The nursing home submitted a plan of correction on July 27, 2005 identifying a compliance date of 8/5/05. The plan of correction was not accepted until 8/26/05. The revisit was conducted on 8/29/05, which was 24 days after the compliance date, but 3 days after the plan of correction was approved. The nursing home was found to be in compliance as of 8/5/05. The timing of the revisit did not increase the remedy imposed on the nursing home.
- The nursing home submitted a plan of correction on November 1, 2004 identifying a compliance date of 10/28/04. The plan of correction was not accepted until 11/9/04. The revisit was conducted on 11/23/04, which was 26 days after the compliance date, but 14 days after the plan of correction was approved. The nursing home was found in compliance as of 10/28/04. The submission date and the approval date of the plan of correction were after the 10/30/04 effective date of a denial of payment for new admissions. However, since compliance was verified as of 10/28/04, the denial of payment was rescinded.
- On November 1, 2004, the nursing home was notified that denial of payment for new admissions would be effective on 11/21/04. The plan of correction was submitted on 11/15/04 identifying a compliance date of 11/12/04. Additional information was required and the nursing home submitted this on 11/24/04. The plan of correction was approved on 11/29/04, 1 working day after receipt of the required information. The revisit was completed on 12/6/04, which was 21 days after the compliance date, but 7 days after the plan of correction was approved. The nursing home was found to be in compliance as of 11/12/04. The revisit date was after the effective date of the denial of payment; however, since compliance was determined prior to that date, the remedy did not become effective.

In all four of these situations, the revisits were conducted within 15 days of the date of an acceptable plan of correction. In all four situations, compliance was able to be verified as of the stated compliance date, therefore, remedies were not increased or imposed by the facility's failure to initially submit an acceptable plan of correction.

IIDR and IDR

Any deficiency issued by OHFC is subject to the IIDR or IDR process utilizing the same process that is in place for deficiencies issued by the Licensing and Certification program.

During FFY05, 19 of the 82 deficiencies issued by OHFC were the subject of either an IIDR or IDR. Table 12 summarizes the type of review requested and scope and severity of tags disputed.

Table 12: IDR and IIDR Reviews Requested and Tags Disputed FFY05

	IDR	IIDR
Total requested	20	29
# of tags disputed	60	86
# that involved OHFC	3	8
# of OHFC tags disputed	3	16
Scope and severity of OHFC tags	2 D 1 H	4 D 7 G 4 J 1 K
Resolution of OHFC tags	1 tag rescinded @ s/s D 1 tag valid @s/s H 1 tag withdrawn by facility @ s/s D	1 ALJ review and 1 tag valid @ s/s D 1 ALJ review pending - 2 tags @ s/s G 6 reviews withdrawn by nursing home prior to IIDR involving 13 tags: 3 @ s/s D 5 @ s/s G 4 @ s/s J 1 @ s/s K

Reconsiderations and Appeals

Under the provisions of the VAA and federal regulations relating to findings of maltreatment against nursing home personnel, if a facility or an individual is determined to have neglected, abused or financially exploited a nursing home resident, the facility or individual can request an informal reconsideration. If the facility or individual is not satisfied with the decision after this reconsideration process, a fair hearing under the provisions of MN Statute 256.045 can be requested. A hearing judge employed by the Department of Human Services conducts the fair hearings.

During FFY 05, 39 hearings were requested as the result of 88 substantiated findings in nursing home investigations.

Under the federal regulations, specific findings of neglect, abuse or financial exploitation are also submitted to the Nurse Aide Registry once any requested reconsiderations or hearings have been

completed. During FFY 05, findings of neglect, abuse, or financial exploitation for 62 individuals were added to the registry.

Under the provisions of Minnesota Statutes §626.557, subd. 9d, clause (b), a vulnerable adult or other interested party not satisfied with the results of an investigation can request a review of these findings under the provisions of Minnesota Statutes §256.021. During FFY05, 7 requests were made for these reviews.

Areas of Focus for FFY 06

1. Comparison with Region V States

Complaint activities are increasingly being scrutinized by CMS Regional Office staff to assure that complaint allegations are appropriately triaged, that required investigations are initiated within the specified time limits and that the complaint process, including any issued deficiencies, is completed in accordance with the federal process.

During the past year, there have been discussions between CMS Regional Office personnel, OHFC staff and Division management regarding OHFC performance issues. One of the areas, which we expect to be discussed in greater detail during the coming year, is the reason for the significant difference in the number of complaint investigations and the number of deficiencies issued as the result of complaint investigations between Minnesota and the other states in CMS Region V.

Tables 13 and 14 identify the number of complaint investigations conducted in FFY05 by states in Region V and the number of deficiencies that have been issued as the result of these investigations. It is readily apparent that Minnesota is an outlier compared to the other states in our CMS Region. Division staff will obtain information about the complaint processes in these other states and will work with Regional Office staff on these matters. Areas to be researched include the number of staff in other states assigned to conduct complaint investigations, the types of complaints completed in those states, whether complaint staff in those states have obligations similar to those of OHFC under the VAA; the level of state and federal funding supporting the complaint functions; and any state laws that have different complaint procedures than what is used in Minnesota.

Table 13: FFY05 Complaint Surveys in Region V by State & Nursing Home Count as of 9/30-05

Illinois	3,075 surveys (807 nursing homes)
Indiana	1,461 surveys (511 nursing homes)
Michigan	742 surveys (429 nursing homes)
Minnesota	272 surveys (403 nursing homes)
Ohio	2,078 surveys (971 nursing homes)
Wisconsin	782 surveys (401 nursing homes)
Region V	8,410 surveys (3522 nursing homes)

source: Federal CASPER (Certification and Survey Provider Enhanced Reporting) System

Table 14: FFY05 Deficiencies by Scope and Severity Issued as a Result of a Complaint Survey in Region V by State

S/S	B	C	D	E	F	G	H	I	J	K	L	Total
Region V	171	106	2,571	738	100	733	22	0	186	38	24	4,689
Illinois	81	63	748	113	26	218	2	0	88	16	17	1,372
Indiana	11	1	503	259	22	263	17	0	13	12	1	1,102
Michigan	6	0	347	95	9	105	1	0	4	1	0	583
Minnesota	0	1	44	6	0	16	1	0	4	1	0	73*
Ohio	61	30	602	132	33	64	0	0	16	2	1	941
Wisconsin	12	11	327	133	10	67	1	0	48	4	5	618

source: Federal CASPER (Certification and Survey Provider Enhanced Reporting) System

* This table does not include 9 deficiencies included in the Department's count of 82 deficiencies issued in FFY05 as 7 of the deficiencies were subject to IIDRs, all of which have been subsequently withdrawn by the nursing home. The remaining 2 deficiencies are subject to a pending IIDR

The MDH is aware there is a pending report on the complaint process to be issued by the Department of Health and Human Services Office of Inspector General, and it is possible that the report may recommend additional changes to the federal complaint process. As noted in a General Accountability Office report issued in December 2005, CMS is working on revised definitions of actual harm and immediate jeopardy that might alter the triaging decisions currently utilized by OHFC.

2. Accuracy and Consistency

As part of its 2006 Quality Improvement Plan, OHFC will focus on ensuring the accuracy and consistency of the investigative process, ensuring compliance with state and federal requirements for triaging complaints and facility reported incidents and improving communications and coordination with internal and external stakeholders.

MDH is reviewing differences between language in the VAA and the federal regulation relating to the reporting and possible investigation of injuries of unexplained sources. Steps to minimize any confusion about the reporting requirements will be implemented when this review is completed.

3. Training

As a result of an anticipated allocation from monies collected through Civil Money Penalties, OHFC will develop state wide training programs to better assist facilities to be aware of allegations of abuse and neglect, to provide information as to the steps to be taken in the facility's internal investigation and to provide information as to the type of allegations that need to be submitted to the state agency under federal and state requirements. This statewide training will follow the model used for training sessions conducted during the past year through collaborative efforts between MDH, providers, advocates, and other stakeholders. Survey staff and investigators will participate in the training initiatives.

The CMS final evaluation of FFY05 Performance Standards for OHFC was received on February 28, 2006. The current evaluation differs from previous evaluations and now identifies a CMS concern with OHFC's triage process in areas of potentials for immediate jeopardy (IJ). In 7 of 12 cases reviewed, CMS indicates OHFC failed to identify an IJ when it should have done so. Moreover, CMS

raises concerns about the process used by OHFC to triage Facility Reported Incidents (FRIs) and signaled an interest in looking further into this matter. A corrective action plan is required and OHFC will be reviewing its triaging processes accordingly.

A copy of OHFC's Quality Improvement Plan for 2006 is included as Appendix D.

Appendix A: OHFC Policy and Procedures

MINNESOTA OFFICE OF HEALTH FACILITY COMPLAINTS

Policy and Procedures

Arnold Rosenthal, Director

SUBJECT:

Prioritization of complaints/reports

- I. The Office of Health Facility Complaints will prioritize all complaints and reports of maltreatment related to possible violation of the rules, regulations and statues in order to insure appropriate response and to manage the workload.
- II. Procedures
 - A. Investigation of complaints which allege immediate jeopardy will be initiated within two working days of receipt of the allegation. Immediate jeopardy are those situation which are present and on-going and are life threatening or have the potential to be life threatening; could result in potentially severe temporary or permanent injury, disability or death; present a serious safety hazard to patient; creates a condition which needs immediate attention. (If the immediate jeopardy has been removed, a two day investigation is not required.
 1. Neglect which is life-threatening
 2. Physical plant problems which could be life-threatening
 3. Inadequate temperature which may be life-threatening
 4. Physical or sexual abuse when the perpetrator is still working in the facility and no action has been taken to protect patient/resident
 - B. Investigation of complaints, which allege a higher level of actual harm, will be initiated within ten working days of receipt of the allegation. Actual harm situations are those that result in serious adverse consequences to patient health and safety but do not constitute an immediate crisis. To delay an investigation would not increase the risk of harm or injury.

1. Neglect which results in actual harm to the resident/patient, i.e., fractures, dehydration, decubitus, and significant weight loss which are avoidable; death; laceration requiring medical treatment; inadequate pain management; inappropriate use of restraints resulting in serious injury, failure to obtain appropriate medical intervention, medication errors resulting in the need for medical attention
 2. Physical abuse
 3. Mental abuse resulting in the patient/resident feeling intimidated/threatened
 4. Inadequate staffing which has a negative impact on resident health and safety
 5. Resident to resident abuse in which no action has been taken to protect resident
- C. Investigation of complaints which have not resulted in a higher level of actual harm but which have the potential to do so will be initiated within 45 days of receipt of the complaint or will be referred to survey as an “Area of Concern” if a survey will be initiated within 180 days.
1. Resident care issues
 2. Inadequate staffing which has a negative impact on resident health and safety
 3. Patient rights issues
- D. Investigation of complaints which will be referred to L & C as “Areas of Concern” for consideration during the survey.
1. Neglect issues which do not result in actual harm or which are not recurring, i.e., medication errors in which no adverse consequences occur
 2. Verbal or mental abuse which does not result in resident feeling frightened or threatened
 3. Patient rights issues
 4. Physical plant complaints which do not pose immediate threat to welfare of patients
 5. Dietary complaints

6. General complaints which do not govern care of patient and which do not fall within category A or B
 7. Housekeeping complaints
- E. Complaints for which no determination may be made.
1. Complaints which do not provide enough information
 2. Complaints which are not a violation of the rules and regulations
 3. Self investigations done by the facility
 4. Too much time evolved since incident or situation occurred
 5. Cases in which further investigation is not necessary (medical record review does not reveal problems)

P:HFC001

1/12/00

Revised 4/7/03

Revised 1/25/05

Appendix B: Sample Letters to OHFC Complainants and Reporting Entities



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Name
Address 1
Address 2
City, state, zip

Dear _____:

On January 5, 2005, this Office received a copy of a letter regarding your concerns at Facility Name.

We realize that your concern is important to you. We wish we were able to conduct an on-site investigation for each complaint but that is not always possible. In order to review your concerns we:

- * have asked the agency to send us a copy of the agency's response to you. We will notify you regarding our determination.
- * have requested a copy of medical records. We will notify you regarding our determination.
- * are in the process of obtaining additional information. We will notify you regarding our determination.

Thank you for bringing this matter to our attention.

Intake Unit
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8713 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC109



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Name
Street
City, state, zip

Dear (____)

Thank you for bringing to our attention your concerns regarding Facility Name. Before we can determine what assistance this Office can offer, we need more information.

Please call our local number or call our toll free number, 1-800-369-7994, to further discuss your concerns.

Intake Unit
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8713 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC116



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Name
Street
City, state, zip

Dear Name:

The Office of Health Facility Complaints received your concern regarding
[Delete statements you don't need]

- * inadequate care at XYZ.
- * abuse at XYZ.
- * a theft at XYZ.
- * the conditions at XYZ.
- * an injury that occurred at XYZ.
- * patient rights at XYZ.

We look at a number of factors when deciding whether to investigate a complaint. These include:

- Whether we have legal authority to investigate the complaint (for example, we have no authority over issues involving payments, billings or conservatorship).
- Whether the severity of the issue meets our criteria for investigating a complaint.
- Whether we have the resources available to investigate the complaint (we are not able to investigate all of the approximately 6800 complaints/reports we receive each year).
- Whether a survey (inspection) of the facility has been completed since the incident you describe has occurred (survey results are available at www.health.state.mn.us or by calling 651 (215-8701).

After thoroughly reviewing your complaint, we have determined that we are unable to do an on-site investigation of the facility at this time. [Delete statements you don't need]

- * As part of this process, appropriate medical records were reviewed and we were unable to find a violation.
- * There are no apparent violations of regulations we enforce.
- * The length of time that has passed is a significant factor.
- * According to information we received from the provider, the situation has been corrected.

- * According to information we received, it appears that no maltreatment occurred.
- * Based on information from police, there is insufficient evidence to justify further investigation.

We understand that you may remain concerned about the issue you brought to our attention. We will keep the information you have provided in a confidential file. This will allow us to have a record of complaints at the facility and will help us, if we receive similar complaints in the future.

In the meantime, we want to make sure your concerns are addressed. Therefore, we offer the following suggestions:

- Schedule a meeting with the facility administrator or the director of nursing. Tell them about your concern, and ask them to respond with a plan for addressing it, or;
- If you have not already done so and if the resident remains at the facility or you believe the issue you brought to our attention persists, contact the Ombudsman's Office (651) 296-0381 or 1-800-657-3591), or;
- Contact us again if the issue remains unresolved or if you have questions or other concerns.

We want to make sure all patients and residents in Minnesota's health care facilities receive quality care. If you have any questions about the information in this letter or any other care-related concerns, please call (651) 215-8713 or 1-800-369-7994.

Intake Unit
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8713 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC118



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Administrator
Facility
Street
City, state, zip

SUBJECT: Incident of (date)

On January 5, 2005, the Office of Health Facility Complaints (OHFC) received a report of possible maltreatment related to the following vulnerable adult(s):

Resident's name

As you are aware, the Vulnerable Adults Act, Minnesota Statute 626.557, requires us to notify you regarding the initial disposition of the report. The information has been reviewed and it has been determined that no further action by this office is necessary at this time.

Intake Unit
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8713 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC114



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Name
Street
City, state, zip

Dear Name:

Thank you for contacting this office with your concerns regarding XYZ. Based on information you provided, we believe your concerns may be more specifically addressed by the [Delete statements you don't need]

* Minnesota Board of Medical Practice. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-617-2130.

* Minnesota Ombudsman for Mental Health. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-296-3848 (local) or 1-800-657-3506 (Outstate).

* Minnesota Advocacy Center for Long Term Care. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-854-7360.

* Minnesota Office of Ombudsman for Older Minnesotans. We therefore have forwarded a copy of your concerns to that office. The telephone number is 1-800-657-3591.

* Minnesota Board of Pharmacy. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-617-2201.

* Ombudsman for Corrections. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-643-3656.

* Family and Children Services Division at DHS. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-[Click **here** and TYPE Telephone Number].

* Managed Care Section MDH. We therefore have forwarded a copy of your concerns to that office. The telephone number is 612-[Click **here** and TYPE Telephone Number].

Intake Unit
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8713 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

2/05 - HFC117



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Name
Street
City, state, zip

Dear (____):

Your complaint regarding XYZ/H000000 has been assigned to name investigator, who will contact you prior to the completion of the investigation.

The investigator may want to talk with you during the investigation. The enclosed Tennessee Statement provides information regarding interviews.

If you have any questions or concerns please contact the investigator at 651-215-0000 or use the toll free number 1-800-369-7994.

Sincerely,

Arnold Rosenthal, Director
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8708 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC123



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Name
Street
City, state, zip

Dear (____):

The attached investigative report indicates that evidence of maltreatment was inconclusive as it relates to XYZ.

An inconclusive finding indicates that there was not sufficient evidence to verify or confirm your allegations that the facility did not properly provide the necessary nursing care. It is important to stress that the findings made by the Department in complaint investigations must be based on a consideration of all of the evidence that is obtained during the course of the investigation. Unless the Department can determine by a preponderance of the evidence that neglect or a violation of the applicable regulations has occurred, it is not legally possible for the Department to substantiate a complaint. The report summarizes the findings based on a review of the facility's records and interviews with facility staff.

Minnesota Statute 656.557, Subd. 9d. allows for administrative reconsideration of the final disposition of your complaint. If you wish to request administrative reconsideration, please submit the request to Arnold Rosenthal, Director, at the address below within 15 calendar days of the receipt of this notice. When requesting an administrative reconsideration, please submit evidence or information that would support your request.

If your request is denied, or we fail to act upon the request, or if you wish to contest the outcome of the reconsideration, you may request, in writing, a review from the Reconsideration Review Panel, Minnesota Department of Human Services, Aging and Adult Services, 444 LaFayette Rd., St. Paul, MN, 55155.

If you have any questions, please contact me.

Sincerely,

[Click **here** and TYPE Investigator Name], R.N., Special Investigator
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) [Click **here** and TYPE Investigator Telephone #] Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994
Enclosure

9/04 - HFC125



Protecting, Maintaining and Improving the Health of Minnesotans

03/08/2006

Administrator
Facility
Street
City, state, zip

Re: H000000

Dear (____):

Enclosed is a copy of an investigative report related to a complaint investigation recently completed by this office. If you have questions relative to this case, please contact the investigator identified in the report.

In accordance with Minnesota Statute 626.557, Subd. 9d., the following information relates to your right to contest the final determination made by the Office of Health Facility Complaints.

How to challenge a finding of maltreatment

- You may request the Department of Health to reconsider the finding of maltreatment by submitting a request for reconsideration to this office **within 15 days** after receiving this notice. Your request for reconsideration should identify why you believe the Department's finding is wrong and provide information to support this claim.
- If you request reconsideration, the Department will review its previous determination and either uphold or reverse the finding of maltreatment.
- If the Department upholds the finding of maltreatment, or fails to respond to your request within fifteen (15) days after receiving your request for reconsideration, you will be entitled to a fair hearing before a Department of Human Services referee.
- If, as a result of the reconsideration, it is determined that maltreatment did not occur, the Department's investigative report will be modified as necessary.
- You may request a fair hearing before a Department of Human Services referee by notifying this office in writing **within 30 days** of receiving this notice.
- Please mail or fax your request to me at the address below.
If you have any questions you may contact me at (651) 215-8708.

Sincerely,

Arnold Rosenthal, Director
Office of Health Facility Complaints
Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 215-8708 Fax: (651) 215-8712
General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC142

Appendix C: Results of Federal Review of MN Performance on Standard 6 (conduct and reporting of complaints investigations)

STATE: MINNESOTA

STATE PERFORMANCE STANDARD REVIEW SUMMARY

REVIEW PERIOD: Fiscal Year 2004

(October 1, 2003 – September 30, 2004)

STANDARD 6: The conduct and reporting of complaint investigations are both timely and accurate, and comply with CMS general instructions for complaint handling.

Results: Standard Partially Met

Emphasis A: The SA maintains and follows guidelines for the prioritization of complaints for Medicare/Medicaid certified facilities in Long Term Care, Non-accredited Hospitals, Home Health, and End Stage Renal Disease (ESRD) facilities.

Threshold Criterion: The SA has and follows written criteria governing the prioritizing and/or categorization for ninety percent (90%) of complaints.

Results: Criterion Not Met

Score: 89.1 % of complaints were prioritized and/or categorized according to SA written criteria.

Both LTC and NLCT must be MET

(1) LTC: 40 complaints were reviewed; of those, 35 complaints were prioritized and/or categorized in accordance with the State's written criteria, with a score of 88 % correct.

The long term care portion of the review is Not Met

(2) NLTC: 6 complaints were reviewed; of those, 6 complaints were prioritized and/or categorized in accordance with the State's written criteria, with a score of 100 % correct.

The NLTC portion of the review is Met

Narrative of Findings:

1. Long Term Care

A random sample of 40 LTC complaint allegations were selected from the State Agency's Complaint Investigation Log and ACTS. The universe from which the sample was selected included all NF, SNF, and SNF/NF facilities for the time period October 1, 2003 through September 30, 2004. The results indicated that 35 of the 40 complaints were prioritized appropriately. The RO reviewed the SA's complaint triage and prioritization policy and recommends that the SA fully incorporate the ACTS triage and priority parameters into their complaint guidelines. While this Performance Standard has limited review parameters, several comments were made in consideration of how the SA receives information and processes complaints. With the ACTS system, a real time accounting of the triage and priority should be demonstrated, however, in review of the complaints eighteen of the 40 had dates of the information coming into a "Common Entry Point" or received by the SA prior to the start of the time frame established by the SA as the date the complaint was received. Comments from the SA were considered in the evaluation of this emphasis.

1st half of FY 2004

Facility	CEP date	Received	Onsite Completion	Triage	
245097		11/17/2003	11/18/2003	12/02/2003	"B"
245105		02/12/2004	02/12/2004	03/15/2004	"B"
245120		02/25/2004	03/04/2004	03/16/2004	"C"
245186		12/09/2003	12/23/2003	01/08/2004	"B"
245262		01/07/2004	01/22/2004	01/27/2004	"B"
245269	10/23/2003	11/06/2003	11/20/2003	04/07/2004	"B"
245310	10/17/2003	10/28/2003	11/10/2003	01/05/2004	"B"
245317	02/13/2004	02/20/2004	02/24/2004	04/30/2004	"A"
245350	02/18/2004	02/23/2004	03/02/2004	04/14/2004	"B"
245359	10/06/2003	10/23/2003	10/30/2003	02/26/2004	"B"
245365	12/22/2003	01/26/2004	02/09/2004	03/15/2004	"B"
245409		10/16/2003	10/27/2003	04/21/2004	"B"
245418	09/23/2003	10/06/2003	10/20/2003	11/24/2003	"B"
245458		11/24/2003	12/04/2003	01/29/2004	"B"
245464	11/03/2003	11/25/2003	12/11/2003	01/16/2004	"B"
245494		11/05/2003	11/13/2003	12/09/2003	"B"
245530		11/26/2003	12/01/2003	03/25/2004	"A"
245542		09/30/2003	10/14/2003	03/09/2004	"B"
245574		10/10/2003	10/21/2003	01/22/2004	"B"
245604		01/17/2004	03/02/2004	03/26/2004	"C"

2nd half of FY 2004

Facility	Received	ACTS	Completed	SA Triage	RO Triage
245603	06/02/2004	06/03/2004	06/17/2004	Non IJ-High	Same
245275	07/28/2004	08/09/2004	No Survey	No Action*	Non-IJ Low
245260	09/15/2004	09/22/2004	No Survey	No Action	Same
245479	04/26/2004	04/27/2004	06/18/2004	Non IJ-High	Same
245084	05/18/2004	05/18/2004	Unfinished	Non IJ-High	Same
245513	07/12/2004	07/13/2004	07/14/2004	IJ	Same

245347	04/12/2004	04/13/2004	Unfinished	Non IJ-High	Same
245272	03/19/2004	04/16/2004	No Survey	No Action	Same
245183	09/22/2004	09/23/2004	10/19/2004	Non IJ-High	Same
245371	09/03/2004	09/08/2004	09/17/2004	Non IJ-Med	Same
245417	07/12/2004	07/14/2004	08/25/2004	Non IJ-High	Same
245189	02/13/2004	04/26/2004	No Survey	No Action*	Non IJ-Low
245387	04/20/2004	07/13/2004	No Survey	No Action*	Non IJ-Low
245328	02/25/2004	04/26/2004	No Survey	No Action	Same
245186	08/24/2004	08/24/2004	Unfinished	Non IJ-High	Same
245414	01/29/2004	04/26/2004	No Survey	No Action	Same
245331	08/02/2004	08/03/2004	No Survey	No Action	Same
245493	04/08/2004	04/09/2004	04/30/2004	Non IJ-High* IJ	
245295	06/16/2004	07/13/2004	No Survey	No Action	Same
24E185	03/02/2004	04/16/2004	No Survey	No Action*	Non IJ-Med

*Indicates error in the prioritizing and/or categorizing of the complaint.

2. Non-Long Term Care

First Half of Year

A random sample of 3 complaint allegations was selected from the State Agency's Complaint Investigation Log. The universe from which the sample was selected included all non-accredited hospitals, ESRD facilities, and Home Health Agencies for the time period October 1, 2003 through March 31, 2004. The results indicated all complaints were prioritized appropriately. The RO reviewed the SA's complaint triage and prioritization policy and has recommended that the SA fully incorporate the ACTS triage and priority parameters into their complaint guidelines.

Second Half of Year

The ACTS complaint log was used to select a random sample of 3 complaints. The universe from which the sample was selected included 2 complaints for non-accredited hospitals and 1 Home Health Agency for the time period April 1, 2004 through September 30, 2004. There were no ESRD or immediate jeopardy complaints to include in this review period. The results indicated that all complaints were triaged consistently with the SA and CMS policies. The review of the Minnesota Office of Health Facility Complaints policy and procedures indicated that they are not current with the RO process. The policies reference actions no longer accurate since the implementation of ACTS. The policies also reference CMS forms as HCFA. We no longer send out a CMS-1666 form to authorize complaints that are in ACTS. There is no mention of the ACTS process in the SA policies.

Action(s) Taken:

We recommend that the SA review and update their policies and procedures to incorporate the ACTS guidelines (See program memo S&C-04-09) into their policies and procedures. The SA should develop an action plan to detail what steps will be taken to ensure that all complaint allegations are triaged correctly and entered in ACTS timely. In addition, the Office of Health Facility Complaints currently operates independently of the Facility & Provider Compliance Division with regards to passing on information either investigated or not investigated from one

division to the other. The action plan should address a tracking mechanism and/or communication mechanism of survey assignments. The SA tracking mechanism should include a means for alerting SA personnel of approaching key dates and a means of quickly identifying when those dates are missed, which piece of the process is missing and what corrective action is taken to prevent the error from occurring again. The second component should address a system for forwarding information gathered in the Office of Health and Facility Compliance to the Facility & Provider Compliance Division. We believe that better coordination of the two Divisions will produce a more comprehensive review of the compliance process and add more continuity.

Emphasis B: The SA investigates all complaints it receives in Medicare/Medicaid certified facilities within the prescribed time limits for Long Term Care, ESRD, Home Health, non-accredited hospitals and deemed hospitals.

Results: Emphasis Met (All three Threshold Criteria must be met for the Emphasis to be met – two of the three Criteria were found not met during this review).

Threshold Criterion 1 : The SA investigates one-hundred percent (100%) of complaints it receives for Medicare/Medicaid certified facilities where it determines there is a present or ongoing immediate jeopardy to resident and/or patient health and safety, within no more than two (2) working days of receipt by the SA. (LTC, ESRD, Home Health, non-accredited hospitals, deemed hospitals).

Results: Criterion Met

Score: LTC: 13 IJ complaints were reviewed.
13 IJ complaints were investigated within two working days. 100 % of IJ complaints are investigated within two working days.

ESRD: 0 IJ complaints were reviewed.
0 IJ complaints were investigated within two working days. 100 % of IJ complaints are investigated within two working days.

Home Health: 0 IJ complaints were reviewed.
0 IJ complaints were investigated within two working days. 100 % of IJ complaints are investigated within two working days.

Non-Accredited Hospitals: 0 IJ complaints were reviewed.
0 IJ complaints were investigated within two working days. 100 % of IJ complaints are investigated within two working days.

Deemed Hospitals: 1 IJ complaint was reviewed.
1 IJ complaint was investigated within two working days. 100 % of IJ complaints are investigated within two working days.

Narrative of Findings:

LTC

From the ACTS log of IJ Complaints for Nursing Homes, thirteen (13) complaints were received and 13 show no errors in meeting the 2 day investigation. Comments from the SA were considered in the evaluation of this emphasis.

Non-LTC

Review of ACTS timeline reports and SA Complaint Log for Fiscal Year 2004 indicate one Immediate Jeopardy complaints was identified.

24-0075

St. Josephs Medical Center

- ◆ Initial complaint received: 03/02/2004
- ◆ Initial Survey conducted: 03/03/2004 – 03/10/2004
- ◆ Survey started on the **1st day**.

Action(s) Taken:

None required.

Threshold Criterion 2 : The SA investigates all complaints in LTC Medicare and Medicaid certified facilities it receives alleging or involving actual harm to individuals within an average of 10 working days with all complaints completed by 20 working days. (LTC only)

Results: Criterion Met

Score: LTC:

205 complaints alleging or involving actual harm were reviewed.

6 is the State Average of all complaints investigated alleging or involving actual harm. (Must be equal to 10 working days or less).

(The portion of the scoring report measuring 20 day completion is in a developmental stage for FY2004, and the collected and analyzed data will be used to improve this measure for the future.)

Narrative of Findings:

According to ACTS from 01/01/2004 through 09/30/2004, 205 complaints alleging or involving actual harm were reviewed. The average number of days between the received start and survey start dates was six (6) days (negative intervals excluded from average calculations).

Although the number of working days to complete an investigation is not being scored in this year's report, the RO analyzed this data to prepare for this requirement in the future. The total number of Federal intakes where the received end and survey exit dates are more than 20 working days was 118. 42% of these complaints alleging or involving actual harm were

completed by 20 working days. Therefore 58% of these complaints alleging or involving actual harm were not completed within 20 working days.

Action(s) Taken:

None required.

Threshold Criterion 3 : The SA investigates all certified deemed hospital non-immediate jeopardy complaints that allege non-compliance with conditions of participation within an average of 45 calendar days with all complaints completed by 60 calendar days. (Deemed Hospitals)

Results: Criterion Met

Score: Deemed Hospitals:

There were 28 non-immediate jeopardy complaints that allege non-compliance with conditions of participation.

A) 29.42 is the State Average of all complaints investigated that alleged non-compliance with Conditions of Participation. (Must be equal to 45 calendar days or less).

B) 100 % of these non-immediate jeopardy complaints that allege non-compliance with conditions of participation were completed by 60 calendar days.

Narrative of Findings:

The ACTS timeline reports were used to determine if the SA conducted non-Immediate jeopardy investigations within an average of 45 days and completed within 60 days. The report indicated there was a total of 28 complaints that met the criteria with an average of 29.42. There was 1 investigation completed outside the 45 and 60 - day timeframe. The RO granted an extension on this case, therefore the SA should not be penalized for this case, and it is not counted as an error. Comments from the SA were considered in the evaluation of this emphasis.

- Ridgeview Medical Center 24-0056 #MN9436
RO approval: 3/15/2004
Survey Start date: 10/4/2004
Survey Exit Date: 10/7/2004
203 days – RO granted an extension on this case. The SA should not be penalized for this case.

Action(s) Taken:

None required.

Emphasis (C) - EMTALA: The SA investigates EMTALA complaints referred by the RO according to CMS policy.

Threshold Criterion: No less than 80% of approved EMTALA complaints are investigated according to CMS policy.

If 80% of all reviewed EMTALA complaints are investigated according to CMS policy with no more than 2 “No” answers (using the worksheets), score Emphasis as MET.

Results: Criterion Met

Score: There were 19 EMTALA approved complaints included in the sample and reviewed.
12 of these EMTALA complaints were investigated according to CMS policy (no more than 2 “no” answers).
100 % of these EMTALA complaints were investigated according to CMS policy (no more than 2 “no” answers).

Narrative of Findings:

The universe for Standard 6 / Emphasis C consisted of EMTALA investigations conducted at non-accredited and accredited hospitals during the Fiscal Year 2004 (October 1, 2003 – September 30, 2004). The universe was taken from the EMTALA Log. There were 12 EMTALA cases selected. The SA met the criteria for 12 of 12 facilities.

Each case was evaluated to determine whether or not the State Agency met the following requirements:

1. Was the complaint completed within 5 working days from the RO Approval Date/Extension Date?
2. Was a completed package sent to the RO within ten (10) working days following the survey exit date when a suspected violation is identified or 15 days when no violation is found? A complete packet is defined as containing the following items listed below:
 - CMS Form 670 (either sent to the RO or inputted into ACTS).
 - CMS Form 2567 (if applicable).
 - CMS Form 1541B, with recommendation for action included or sent in the survey packet.
 - Written summary of interviews (can be either in the narrative or surveyor notes).
 - Copies of pertinent hospital policies and procedures that relate to the identified deficiencies, if applicable.
 - Summary listing of all patients comprising the sample (including an explanation of how and why the cases were selected for review).
 - Copies of medical records for substantiated cases, medical records of individuals named in complaints and any medical records for which a QIO review was requested.
3. Was the sample selection based on the Case Selection Methodology outlined in Appendix V, Task 2 of the State Operations Manual?

4. Does the State Agency documentation support the State Agency's recommendation(s)?
5. Did the CMS-2567 reflect the State Agency's documentation and/or recommendation(s)?

- A case meets the requirements if it meets at least three of the above requirements.

Note: Federal holidays were **not** omitted when counting the number of days between the authorizing date and the date the investigation was completed, nor for the date the investigation was completed and the date the completed packet was sent to the RO.

Non-Long Term Care information reviewed:

- **There were 12 EMTALA cases selected.**
- **The SA met the criteria for 12 of 12 facilities.**

24-0141

Fairview Northland Regional Hospital; Survey completed on 11/25/2003.

- ◆ All requirements were met.

24-1322

Falls Memorial Hospital; Survey completed on 12/10/2003.

- ◆ All requirements were met.

24-0001

North Memorial Medical Center; Survey completed on 12/18/2003.

- ◆ The completed survey packet was not received in the RO until 01/21/2004, 24 working days after the EMTALA investigation was completed. Even though there were no EMTALA violations, the package still needs to be received within 15 working days.
- ◆ There was no recommendation for action listed on the CMS-1541B form.

24-0080

Fairview University Medical Center; Survey completed on 01/12/2004.

- ◆ The complete survey packet was not received in the RO until 02/03/2004, 17 working days after the EMTALA investigation was completed. Even though there were no EMTALA violations, the package still needs to be received within 15 working days.

24-0037

Queen of Peace Hospital; Survey completed on 02/11/2004.

- ◆ All requirements were met.

24-0087

Stevens Community Hospital; Survey completed on 02/27/2004.

- ◆ All requirements were met.

24-0038

United Hospitals; Survey authorized on 04/15/2004, completed on 04/21/2004.

- ◆ All requirements were met.

24-0210

Healtheast St. John's Hospital; Survey authorized on 06/24/2004, completed on 06/28/2004.

- ◆ All requirements were met.

24-1308

Lakeview Hospital; Survey authorized on 09/20/2004, completed on 04/22/2004.

- ◆ There was no recommendation indicated on the CMS-1541B.

24-1317

Cook County Hospital; Survey authorized on 08/25/2004, completed on 08/31/2004.

- ◆ There was no recommendation indicated on the CMS-1541B.

24-1318

Ely Bloomenson Hospital; Survey authorized on 07/28/2004, completed on 08/03/2004.

- ◆ There was no recommendation indicated on the CMS-1541B.

24-3301

Children's Health Care; Survey authorized on 04/07/2004, completed on 04/13/2004.

- ◆ The State Agency cited the facility for failing to follow its rules in regards to providing a medical screening exam, but did not include a copy of the hospital's policies in the package.

Action(s) Taken:

None required.

Emphasis D: The SA investigates complaints for Medicare/Medicaid certified LTC Facilities according to CMS general instructions for complaint handling.

Threshold Criterion : No less than 80% of LTC complaints are investigated according to CMS general instructions for complaint handling.

If 80% of all LTC complaints are investigated according to CMS policy with no more than 2 "No" answers (using the worksheets), score this Emphasis as MET otherwise score as Not Met.

Results: Criterion Met

Score: Medicare/Medicaid certified LTC Facilities :
40 complaints were included in the sample and reviewed,
36 of these complaints were investigated according to CMS general instructions for complaint handling (no more than 2 "no" answers).
90 % of these complaints were investigated according to CMS general instructions for complaint handling (no more than 2 "no" answers).

Narrative of Findings:

A random sample of 40 LTC complaint allegations were selected from the State Agency's Complaint Investigation Log and ACTS. The universe from which the sample was selected included all NF, SNF, and SNF/NF facilities for the time period October 1, 2003 through September 30, 2004, and was the same sample as used for Emphasis A. The results indicated that all complaints were investigated appropriately. Of the 6 review criteria, there were 5 of 40 cases reviewed with one "no" answer, which were not considered an error case for this review.

<u>Criterion</u>	<u>Number & Percentage Met</u>	<u>Number of N/As</u>
# 1	27 / 30 met or 90% (3 No's)	10
# 2	26 / 30 met or 86% (4 No's)	10
# 3	6 / 12 met or 50% (6 No's)	28
# 4	30 / 30 met or 100%(0 No's)	10
# 5	9 / 11 met or 82% (2 No's)	29
# 6	19 / 25 met or 76% (6 No's)	15

Action(s) Taken:

None required.

Appendix D: OHFC Quality Improvement Plan

2006 Quality Improvement Plan for Office of Health Facility Complaints

Vision of Minnesota Department of Health:

Keeping All Minnesotans Healthy

Mission of Office of Health Facility Complaints Program:

To protect and improve the health, safety, comfort and well-being of individuals receiving services from federally certified and state licensed health care providers.

This mission is accomplished through:

1. Investigating complaints by or on behalf of patients, residents, and clients of federally certified and state licensed health care providers;
2. Investigating facility reported incidents made by federally certified and state licensed health care providers;
3. Enforcing compliance with federal and state statutes, regulations and guidelines.

Purpose of the Ongoing OHFC Quality Improvement Plan:

To ensure that activities carried out by OHFC staff are performed accurately and consistently over time and by all staff in accordance with established state and federal requirements to protect patient, resident, and client health, well-being, safety and comfort; to identify areas for improvement in performance and in systems, and to make those improvements.

Intent of the OHFC Quality Improvement Process:

Identify and correct known, suspected or potential problems with the investigative, intake, communication, and other processes and identify opportunities for further improvements.

Goal 1. Ensure accuracy and consistency of the investigation process.

Objective 1. Identify acceptable outcome measures of investigative performance, analyze information and develop methods to reduce variation.

Expected Outcome: Investigative techniques and decision-making process will be applied in a timely, accurate and consistent manner by OHFC investigators.

Actions:

- A. Investigators will participate in state and federal training.

- B. Investigators will receive onsite mentoring and coaching from experienced investigators and/or supervisors.
- C. OHFC policies and procedures will be reviewed annually and updated as appropriate.
- D. Supervisory/management review of substantiated maltreatment and 2567s prior to being issued: (i) will continue to be used to identify variations in investigative processes and documentation, with individual mentoring and coaching provided to investigators; (ii) will be shared with investigators as a group through staff meetings, in-service training, and updating of policies and procedures, as appropriate.
- E. Investigators will participate in monthly staff meetings.
- F. Timeline requirements for initiation and completion of investigations will be reviewed with investigators at a staff meeting. Reports on timeline compliance will be provided to program manager/supervisory staff and investigators on a monthly basis, and action plans will be developed as needed to ensure timely initiation and completion of investigations.

Data/measurement:

- A. Staff participation in training will be documented.
- B. Supervisory/management staff will document coaching and mentoring of investigative staff.
- C. Supervisory/management staff will document policy & procedure review.
- D. Variances will be noted by OHFC supervisory/management staff and will be communicated to OHFC staff, division management, training staff, etc. as appropriate.
- E. Attendance at staff meetings will be documented. Occurrence of staff meetings will be documented in Groupwise.
- F. Reports from federal data bases will be reviewed on a monthly and quarterly basis to track compliance with timeline requirements.
- G. Meet CMS Performance Standards.

Goal 2. Ensure compliance with state and federal requirements for triaging complaints and facility reported incidents.

Objective 2. Identify acceptable outcome measures of intake performance, analyze information and develop methods to improve performance.

Expected Outcome: Intake procedures, triage process/procedures and decision making process will be applied in a timely, accurate and consistent manner by OHFC intake staff.

Actions:

- A. Intake policies and procedures will be reviewed annually and updated as appropriate.
- B. OHFC will provide training to intake staff to assure they are up to date on state and federal regulations, procedures, processes, systems (e.g., ACTS), etc.
- C. Intake staff will participate in staff meetings.
- D. Supervisory staff will continue to conduct ongoing review of a portion of all complaints and facility reported incidents to assure proper review and provide necessary direction and assistance to Intake staff.

Data/measurement:

- A. Supervisory/management staff will document policy & procedure review.

- B. Staff participation in training will be documented.
- C. Attendance at staff meetings will be documented. (OR Occurrence of staff meetings will be documented in Groupwise)
- D. Variances in intake and triage procedures will be noted by OHFC supervisory/management staff and will be communicated to OHFC staff, division management, training staff, etc. as appropriate.
- E. Meet CMS Performance Standards.

Goal 3. Improve communication and coordination with internal and external stakeholders.

Objective 3: Ensure integration and coordination of quality improvement findings and activities with pertinent staff and external stakeholders as appropriate.

Expected Outcome: Informal and formal information collection methods will demonstrate improvements in stakeholder satisfaction with OHFC communication and quality improvement activities.

Actions:

- A. OHFC staff will participate in videoconferences, in-service programs, and all other available training.
- B. OHFC supervisor/manager (and staff) will review form letters used to communicate with providers, licensed and unlicensed health care provider staff, and consumers, and update content of form letters as appropriate.
- C. OHFC supervisor/manager will provide prompt review of requests for reconsideration.
- D. OHFC will work with division / MDH staff to develop a satisfaction survey for providers and consumers.
- E. OHFC will provide prompt follow-up of provider /consumer concerns by reviewing any pertinent findings with all staff.

Data/measurement:

- A. Staff participation in training will be documented.
- B. OHFC supervisor/manager will document review and updating of form letters.
- C. OHFC supervisor & manager will monitor compliance with 15 day time frame (Minnesota Statutes 626.557, Subdivision 9d(b)) and will identify targets for improvement (which may be stated as a quality improvement initiative).
- D. Once developed and collected, satisfaction survey results will be reviewed on an on-going basis and will be tabulated on a quarterly and annual basis.
- E. Feedback from providers/consumers during follow-up after concerns have been addressed, and results of satisfaction survey, will be monitored by program supervisor/manager.