

Complaint Investigations of Minnesota Health Care Facilities

*Report to the Minnesota Legislature
explaining the investigative process and
summarizing investigations from July 1, 2001
to June 30, 2004*

Minnesota Department of Health

March 2005



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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 FY 02 to FY 04; 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, trends relating to the safety of vulnerable adults, and areas for further focus in the future. 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.

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 surgical outpatient 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 (MDH) Division of Health Policy, Information and 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 13 investigators assigned to the Office; 10 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
FFY04	13	2	2	5	22	Total Oper. Budget: \$1,910,796 Medicare 37.30% Medicaid 28.90% State Licensure 33.80%
FFY03	13	2	2	5	22	Total Oper. Budget: \$1,776,396 Medicare 37.10% Medicaid 30.70% State Licensure 32.30%
FFY02	14	2	2	5	23	Total Oper. Budget: \$1,535,056 Medicare 45.90% Medicaid 35.0% State Licensure 19.0%

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
FY02, FY03, FY04**

Complaints Received	FY02	FY03	FY04
Nursing Home	774	835	838
Hospital	384	398	316
Home Health	260	294	324
Other Licensed Entities	112	104	124
* Total Complaints Received	1530	1631	1602
	FY02	FY03	FY04
<i>Facility Reported Incidents</i>			
Nursing Home	4160	4613	3785
Hospital	143	220	156
Home Health	262	311	303
Other Licensed Entities	104	107	92
** Total Facility Reported Incidents Received	4669	5251	4336
*** Grand Total	6199	6882	5938

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 FY02, FY03 and FY04; 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 FY02, FY03, FY04

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	15	179	28	193	37	168
Physical Abuse	58	409	65	374	53	310
Sexual Abuse	19	106	20	137	15	92

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	9	90	18	86	9	62
Exploitation by other	6	114	5	112	4	76

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	300	333	344	441	316	351
Falls	49	1012	50	1019	54	980
Medications	53	96	54	144	51	90
Decubiti	38	14	40	8	33	10
Dehydration	5	1	9	0	10	1
Nutrition	8	0	12	1	9	2
Neglect, Failure to notify MD	15	8	17	2	6	0
Neglect of Supervision	23	413	59	495	33	417

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	22	1003	35	1147	18	968

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	101	52	107	53	131	39
Nursing, Infection Control, Medications	118	5	100	8	136	10
Other	113	8	108	7	120	10

**Table 4: Hospital Allegations from Complaints / Facility Reported Incidents
FY02, FY03, FY04**

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	4	7	5	12	1	2
Physical Abuse	13	20	16	9	10	10
Sexual Abuse	18	22	16	41	10	24

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	5	5	1	1	1	1
Exploitation by other	0	0	2	2	0	0

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	96	11	101	21	34	1
Falls	8	8	4	13	4	5
Medications	16	5	25	8	9	4
Decubiti	22	0	12	2	9	2
Dehydration	0	0	0	0	0	0
Nutrition	1	0	0	0	0	0
Neglect, Failure to notify MD	1	0	3	0	0	0
Neglect of Supervision	16	55	15	85	6	78

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	11	5	4	8	5	8

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	92	7	133	16	119	18
Nursing, Infection Control, Medications	18	0	19	0	64	0
ER Services	14	0	11	0	11	0
Discharge Planning	31	1	19	2	15	1
EMTALA	25	0	17	0	20	0
Other	20	1	17	0	27	0

**Table 5: Home Health Care Allegations from Complaints / Facility Reported Incidents
FY02, FY03, FY04**

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	9	20	15	22	21	15
Physical Abuse	15	33	20	26	20	31
Sexual Abuse	7	17	8	10	9	11
Accident	0	7	0	26	0	4

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	18	41	37	66	24	75
Exploitation by other	6	13	4	25	6	20

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	90	41	88	31	92	32
Falls	14	22	10	23	14	40
Medications	15	17	22	16	39	12
Decubiti	8	1	5	0	9	0
Dehydration	2	0	1	0	2	0
Nutrition	2	0	0	0	3	0
Neglect, Failure to notify MD	2	0	3	0	3	0
Neglect of Supervision	11	40	14	43	31	33

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	3	18	6	36	5	34

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	43	7	52	8	65	9
Nursing, Infection Control, Medications, Shortage Staff	43	5	37	2	31	2
Other	35	1	29	1	24	2

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

FY02, FY03, FY04

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	9	25	11	19	11	23
Physical Abuse	5	18	7	26	9	23
Sexual Abuse	2	11	6	14	4	8
Accident	0	6	0	3	0	3

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	2	9	3	5	6	7
Exploitation by other	0	7	1	10	0	7

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	30	26	25	29	22	17
Falls	2	25	2	14	2	24
Medications	5	15	5	16	8	11
Decubiti	0	0	1	1	1	0
Dehydration	0	0	0	0	0	0
Nutrition	2	0	0	0	1	0
Neglect, Failure to notify MD	0	0	1	0	0	0
Neglect of Supervision	9	32	13	39	17	54

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	1	17	3	16	4	17

	FY 2002	FY 2002	FY 2003	FY 2003	FY 2004	FY 2004
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	52	4	40	5	53	5
Nursing, Infection Control, Medications, Shortage Staff	16	1	17	2	19	1
Other	33	4	25	3	34	3

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 reviews of Minnesota's complaint process for federal fiscal year '02 and '03 will be discussed 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 would 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

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 is available at the following website:

http://www.cms.hhs.gov/manuals/107_som/som107index.asp.

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.

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 FY02, FY03 and FY04 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 MDH 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 that 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, 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
FY02, FY03, FY04**

	FY02	FY03	FY04
Onsite	627	509	516
Desk	123	121	152
Refer to Survey	68	57	64

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 FY02, FY03, FY04

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 Onsite Investigations FY02, FY03, FY04

	FY02		FY03		FY04	
	Number	Percent	Number	Percent	Number	Percent
Substantiated	189	30.2	183	36.0	192	37.2
Inconclusive	298	47.5	203	39.9	165	32.0
Un-substantiated	140	22.3	123	24.1	159	30.8
Total	627	100	509	100	516	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 exclusion, as are other individuals who have maltreated an individual for whom disqualification is required.

Number of employees with substantiated maltreatment findings:

FY02	FY03	FY04
72	75	92

Number of hearings requested:

FY02	FY03	FY04
23	21	20

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

FY02	FY03	FY04
37	52	64

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 fiscal years, OHFC conducted 142 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 would be the determination as to whether there was 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 02, OHFC conducted 39 onsite investigations, 31 of which were the subject of a complaint, the remaining 8 were based on a facility reported incident. 12 of those investigations were substantiated, 21 were inconclusive and 6 were unsubstantiated. 29 of the investigations involved deaths in nursing homes.

In FY 03, OHFC conducted 56 onsite investigations, 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, 36 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.

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.

OHFC's multiple roles and responsibilities as the "lead agency" for purposes of VAA implementation; as the entity responsible to review and process complaints related to health care facilities under state law, as well as the entity responsible for complaints against certified health care providers adds a number of variables to this discussion.

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.

The federal thresholds for being in conformance with these elements are high, 90% or higher. CMS reviews for FFY 02 and 03 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 those two years is attached as Appendix C.

These federal reviews indicate 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 date for reports, which would include VAA mandated reports, has been approximately 90 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 02, 58% of the onsite investigations needed to be initiated within 10 days or less. This percentage increased to 61% in FY 03 to 64% in FY 04. 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

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.

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 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 Department has recently received the federal budget authorization for FFY05. The federal budget authorizes OHFC to hire two additional investigators.

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:

	FY02	FY03	FY04
Complaint substantiated	33.2 hrs	42.7 hrs	39.1 hrs
Complaint un-substantiated	22.1 hrs	25.6 hrs	23.8 hrs
Inconclusive	24.1 hrs	25.4 hrs	25.2 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 evaluated and approved 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 investigate work unit. In January 2005, 3 of the 12 investigators transferred to another unit within the Department. The time devoted to hiring and training 3 additional positions will have an impact on workload performance.

Areas of Focus

Prior to the development of the OHFC website, information concerning OHFC findings was not easily accessible to the public. However, the information on the website only reflects those situations when an onsite investigation has been completed. We need to continue to evaluate what other sources of information could be provided to better inform the public about the activities of OHFC.

OHFC needs to review the data that is available to better determine if trends that can affect the safety of vulnerable adults can be better identified. We need to analyze the number of onsite investigations and determine whether increases in certain licensed categories, such as home care, are evidence of a problem. OHFC also “codes” allegations in very distinct ways and we need to examine how this information might be used to better predict concerns in a facility.

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 from OHFC Complainants and Reporting Entities



Protecting, Maintaining and Improving the Health of Minnesotans

03/07/2005

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

03/07/2005

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
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General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC116



Protecting, Maintaining and Improving the Health of Minnesotans

03/07/2005

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:

- X Whether we have legal authority to investigate the complaint (for example, we have no authority over issues involving payments, billings or conservatorship).
- X Whether the severity of the issue meets our criteria for investigating a complaint.
- X 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).
- X 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:

- X 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;
- X 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;
- X 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
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Health Policy, Information and Compliance Monitoring Division
85 East Seventh Place, Suite 300
P.O. Box 64970
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9/04 - HFC118



Protecting, Maintaining and Improving the Health of Minnesotans

03/07/2005

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.

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Health Policy, Information and Compliance Monitoring Division
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St. Paul, MN 55164-0970
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General Information: (651) 215-8702 - 1-800-369-7994

9/04 - HFC114



Protecting, Maintaining and Improving the Health of Minnesotans

03/07/2005

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
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St. Paul, MN 55164-0970
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General Information: (651) 215-8702 - 1-800-369-7994

2/05 - HFC117



Protecting, Maintaining and Improving the Health of Minnesotans

03/07/2005

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

03/07/2005

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

03/07/2005

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 2002

(October 1, 2001 – September 30, 2002)

STANDARD 6: The conduct and reporting of complaint investigations, both long term care and hospital complaints, including hospital federal allegation and EMTALA complaints, are timely and accurate, and comply with general instructions for complaint handling and with the State's own policies and procedures.

Results: Standard Partially Met

Emphasis A: The SA maintains and follows guidelines for the prioritization of complaints.

Threshold Criterion: The State Agency has and follows written criteria governing the prioritizing and/or categorization for one-hundred percent (100%) of complaints.

Results: Criterion Not Met

Score: 97.5% of long term care (LTC) complaints were prioritized and/or categorized according to SA written criteria. The SA and the RO have mutually agreed upon the State's policy and procedure criteria for hospital complaint triage and investigation.

LTC: 40 complaints were reviewed. 39 complaints were prioritized and/or categorized in accordance with the State's written criteria.

Narrative of Findings: A sample of 40 LTC complaints were reviewed. Each case was evaluated to determine if the SA appropriately categorized and/or prioritized the complaint. In 39 of the reviewed complaints, the criterion was met. In one case, Winthrop Good Samaritan Center (#245314), the SA categorized the complaint as alleging actual harm that is not minimal harm. However, the complaint did not allege harm or immediate jeopardy, and should have been categorized as "other." The incorrect categorization only resulted in the complaint being investigated earlier than was necessary. The SA agreed that the case was incorrectly categorized.

In addition, as per the review protocol, the regional office reviewed the SA's policy and procedure for hospital complaint triage and investigation. The SA and the regional office have mutually agreed upon the policy and procedure criteria for triage and investigation of complaints involving accredited and non-accredited hospitals.

Action(s) Taken: The LTC error case was discussed with the SA at the conclusion of the review. Since there was no negative impact on the State's ability to timely initiate the investigation, no action is requested at this time.

Emphasis B: The SA investigates the complaints it receives alleging "immediate jeopardy" (IJ) to patient health and safety within the prescribed time limits.

Threshold Criterion: The SA investigates one hundred percent (100%) of complaints for all nursing homes and hospitals 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. **(This only applies to nursing homes and hospitals.)**

Results: Criterion Met

Score: 100%

LTC: Six IJ complaints were reviewed. Six IJ complaints were investigated within two working days. 100% of IJ complaints were investigated within two working days.

Hospitals: One IJ complaint was reviewed. One IJ complaint was investigated within two working days. 100% of IJ complaints were investigated within two working days.

Narrative of Findings: The regional office reviewed a sample of 40 LTC complaints. The SA determined six (6) complaints alleged immediate jeopardy to patient health and safety. For complaints that allege immediate jeopardy, the SA must initiate the complaint investigation within 2 working days. In all six (6) cases, the SA met the criterion.

One (1) hospital complaint was selected for review. The case was evaluated to determine if the SA investigated the immediate jeopardy complaint within two working days of receipt by the SA. The one (1) reviewed case met the criterion.

Action(s) Taken: None.

Emphasis C: The SA investigates all EMTALA complaints referred by the Regional Office within prescribed time limits.

Threshold Criterion: The SA investigates one hundred percent (100%) of all EMTALA complaints within five working days consistent with CMS and State Policy.

Results: Criterion Not Met

Score: Four (4) EMTALA complaints were reviewed. Three (3) EMTALA complaints were investigated within five (5) working days. 75% of EMTALA complaints were investigated within five working days or the approved date for extensions granted by the RO. No (0) EMTALA complaints were granted extensions by the RO.

Narrative of Findings: There were four (4) EMTALA cases selected for review. Each case was evaluated to determine if the SA investigated the complaint within five working days from the date the regional office authorized the survey. The date of regional office authorization was counted as day zero. Three (3) of the four (4) selected cases met the criteria. For St. Joseph's Medical Center (#240075), the regional office authorized a survey on April 11, 2002. The investigation was initiated on April 19, 2002, which is the sixth working day.

Action(s) Taken: The SA must develop and implement a system to ensure the timely investigation of EMTALA complaints.

The SA determined an incorrect date was entered onto their data entry form for the error case. The SA submitted a plan to ensure correct dates are entered onto their complaint form, with supervisory review to verify the date corresponds with the date of the receipt of the CMS-1666. The RO approves this plan.

Emphasis D: The SA investigates all accredited hospital "non-immediate jeopardy" complaints that allege non-compliance with conditions of participation within prescribed time limits.

Threshold Criterion: The SA investigates one hundred percent (100%) of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with conditions of participation within 45 days consistent with CMS policy.

Results: Criterion Met

Score: The SA investigated 100% of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with conditions of participation within 45 days consistent with CMS policy. Four cases were reviewed. Four cases were investigated within 45 days.

Narrative of Findings: There were four cases selected for review. Each case was evaluated to determine if the SA investigated each non-immediate jeopardy complaint within 45 working days from the date the regional office authorized the survey. The date the regional office authorized the survey was counted as day zero. The survey entrance date should be on or before the 45th day. All four (4) of the four (4) cases met the criterion.

Action(s) Taken: None.

Emphasis E: The SA investigates the LTC complaints it receives alleging "actual harm" to patient health and safety within prescribed time limits.

Threshold Criterion: The SA triages and initiates investigation of one-hundred percent (100%) of the complaints it receives alleging or involving actual harm to individuals consistent with CMS and State policy.

Results: Criterion Not Met

Score: Thirty-five (35) complaints alleging “actual harm” to patient health and safety were reviewed. 94.3% of complaints alleging “actual harm” to patient health and safety were investigated within 10 working days from the date that the SA received the complaint.

Narrative of Findings: In the sample of 40 LTC cases, the SA determined 35 alleged actual harm. Each case was evaluated to determine if the SA initiated an investigation within 10 working days. In 34 of the 35 cases that alleged actual harm, the SA met the criterion. For Episcopal Church Home (#245452), the SA determined a complaint on June 12, 2002 alleged actual harm. The investigation was initiated in 12 working days, on June 28, 2002.

Action(s) Taken: During FY 2002, the SA developed and implemented a plan to ensure the timely investigation of complaints that allege actual harm. The SA evaluated and revised its procedures, and conducted monthly audits to monitor its compliance with the 10 day requirement. The monthly audits showed 100% compliance. The SA must review and revise its existing plan to ensure that for all complaints alleging actual harm, the investigation is initiated within 10 working days. The SA must also evaluate its monitoring methods to determine why the late case was not identified through their monitoring, and revise the system accordingly.

The SA reviewed the late case and determined an incorrect date was entered into their tracking system. The SA reviewed its dating system for complaints to insure the date of receipt is accurate. Modifications have been made to their system for reviewing complaints when a decision related to the action to be taken cannot be made by intake staff. In addition, supervisory staff will review complaints daily to insure that decisions are made timely. The RO approves this plan.

Emphasis F: The SA maintains and follows guidelines for the prioritization of complaints, which do not allege or involve immediate jeopardy, or actual harm to individuals.

Threshold Criterion: The SA initiates an investigation for one-hundred percent (100%) of the complaints consistent with CMS and State policy for complaints that do not allege or involve immediate jeopardy or actual harm to individuals. **(For LTC only.)**

Results: Criterion Met

Score: Nine (9) complaints, which do not allege or involve immediate jeopardy, were reviewed. 100% of complaints, which do not allege or involve immediate jeopardy, were investigated according to State policy.

Narrative of Findings: Of the 40 sampled long term care cases, nine (9) did not allege or involve immediate jeopardy or harm. Each of the nine (9) cases was evaluated to determine if the SA investigated in accordance with SA policy. All nine (9) cases met the criteria.

Action(s) Taken: None.

Emphasis G: The State Agency (SA) enters appropriate (certification-related) complaint data into the OSCAR complaint subsystem.

Threshold Criterion: No less than one-hundred percent (100%) of SA citations from complaint investigations that are violations of federal requirements are encoded into OSCAR in accordance with SOM 3281-3284. The average time from the latest date of either the completion of the investigation by the SA or the IDR to entry into OSCAR does not exceed (20) calendar days.

Results: Criterion Not Met

Score: Forty (40) complaint investigations were reviewed. 97.5 % of complaints investigated by the State were entered into OSCAR.

Narrative of Findings: In FY2002, the states were not evaluated against the 20 calendar day average time for data entry because of system changes that were taking place during the fiscal year. All 40 sampled long term care complaints were evaluated to determine if the case had been entered into the OSCAR system. Thirty-nine (39) cases were entered into OSCAR. One (1) case had not been entered into OSCAR (Park River Estates Care Center, #245448).

Action(s) Taken: The SA should develop a plan to ensure data entry for all complaint cases.

The SA submitted a plan to develop a quality assurance report, which will be produced weekly, to identify the number of days remaining to enter the data into the OSCAR system. The RO requests the SA identify the staff responsible for reviewing and responding to the report.

STATE: MINNESOTA

STATE PERFORMANCE STANDARD REVIEW SUMMARY

**REVIEW PERIOD: Fiscal Year 2003
(October 1, 2002 – September 30, 2003)**

STANDARD 6: The conduct and reporting of complaint investigations, both long term care and hospital complaints, including hospital federal allegation and EMTALA complaints, are timely and accurate, and comply with general instructions for complaint handling and with the State's own policies and procedures.

Results: Standard Partially Met

Emphasis A: The SA maintains and follows guidelines for the prioritization of complaints.

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

Results: Criterion Met

Score: 95% of long term care complaints were prioritized and/or categorized according to SA written criteria.

LTC: Forty complaints were reviewed. Thirty-eight complaints were prioritized and/or categorized in accordance with the State's written criteria.

Non Accredited Hospitals: Seven complaints were reviewed. Seven complaints were prioritized and/or categorized in accordance with the State's written criteria.

Narrative of Findings: Forty LTC complaints were reviewed. The CMS RO found that 38 cases were correctly triaged. Two cases were improperly triaged: For Concordia Care Center, 24-5603, complaint number H5603030, the State Agency triaged the complaint as actual harm. The RO determined the complaint allegation represented immediate jeopardy. For Richfield Health Center, 24-5492, complaint number H5492023, the State Agency triaged the complaint as actual harm. The RO determined that the complaint alleged poor care but did not allege resident harm.

Seven non-accredited hospital complaints were reviewed. There were no immediate jeopardy cases during the review period. The complaints were evaluated to determine if the State Agency had appropriately used its policies and procedures to triage and

prioritize complaints. The State Agency triaged all seven cases using their policies and procedures.

Action(s) Taken: The State Agency should ensure that all complaint allegations are triaged correctly.

Emphasis B: The SA investigates all complaints it receives for Medicare/Medicaid certified facilities in Long Term Care and accredited and non-accredited hospitals alleging “Immediate Jeopardy” to resident and/or patient health and safety within prescribed time limits.

Threshold Criterion: The SA investigates one-hundred percent (100%) of complaints it receives for Medicare/Medicaid certified facilities for all Long Term Care and accredited and non-accredited Hospitals 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.

Results: Criterion Met

Score:

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

Hospitals: Zero IJ complaints were reviewed. Zero IJ complaints were investigated within two working days. 100% of IJ complaints are investigated within two working days.

Narrative of Findings: Six LTC complaints, triaged by the State Agency as immediate jeopardy to resident and patient health and safety, were reviewed. Each reviewed case was evaluated to determine if the State Agency investigated within 10 working days of receipt of the complaint. The date the State Agency received the complaint was counted as “Day Zero.” The State Agency investigated all six cases within 10 working days.

There were no non-LTC complaints triaged as immediate jeopardy to resident and patient health and safety.

Action(s) Taken: None

Emphasis C: The SA investigates all EMTALA complaints referred by CMS within prescribed time limits.

Threshold Criterion: The SA investigates one hundred percent (100%) of all EMTALA complaints within 5 working days consistent with CMS and State policy.

Results: Criterion Met

Score: Six EMTALA complaints were reviewed out of a universe of eleven. All six EMTALA complaints were investigated within five working days. 100% of EMTALA complaints were investigated within five working days or the approved date for extensions granted by the RO. No EMTALA complaints were granted extensions by the RO.

Narrative of Findings: Six EMTALA cases were selected for review. Each EMTALA case was evaluated to determine if the State Agency investigated case within five working days from the date CMS RO authorized the survey. The date that the RO authorized the survey was counted as “Day Zero.” The survey entrance date must be on or before the fifth working day. In six of the six reviewed cases, the investigation began within five working days of CMS RO authorization. No extensions were requested or granted for the cases.

Action(s) Taken: None

Emphasis D: The SA investigates all certified accredited hospital “non-Immediate Jeopardy” complaints that allege non-compliance with conditions of participation within prescribed time limits.

Threshold Criterion: The SA investigates ninety percent (90%) of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with Conditions of Participation within 45 calendar days consistent with CMS policy.

Results: Criterion Met

Score: The SA investigated 100% of all accredited hospital non-immediate jeopardy complaints that allege non-compliance with conditions of participation within 45 working days consistent with CMS policy. Three cases were reviewed. Three cases were investigated within 45 calendar days.

Narrative of Findings: There were 26 cases where the State Agency was authorized to conduct a survey of certified accredited hospitals for non-immediate jeopardy complaints. Three cases were selected for review. Each case was evaluated to determine if the State Agency investigated the complaint within 45 calendar days from the date of CMS authorization to conduct the survey. In all three cases, the State Agency investigated the complaints within 45 calendar-day timeframe.

Action(s) Taken: None

Emphasis E: The SA investigates the Medicare/Medicaid certified Long Term Care complaints it receives alleging “actual harm” to residents, within prescribed time limits.

Threshold Criterion: The SA investigates ninety-five percent (95%) of the complaints for Medicare and Medicaid certified facilities it receives alleging or involving actual harm to residents consistent with CMS and state policy.

Results: Criterion Met

Score: Twenty-six complaints alleging “actual harm” to patient health and safety were reviewed. 100% of complaints alleging “actual harm” to patient health and safety were investigated within 10 working days from the date that the SA received the complaint.

Narrative of Findings: The RO reviewed 26 LTC complaints alleging actual harm to residents. The State Agency investigated all 26 of the complaints alleging actual harm to residents within 10 working days.

Action(s) Taken: None

Emphasis F: The SA maintains and follows guidelines for the investigation of Long Term Care complaints, which do not allege or involve immediate jeopardy, or actual harm to residents.

Threshold Criterion: The SA initiates an investigation for ninety-five percent (95%) of the complaints consistent with CMS and State policy for complaints that do not allege or involve immediate jeopardy or actual harm to individuals.

Results: Criterion Not Met

Score: Eight complaints, which do not allege or involve immediate jeopardy, were reviewed. 62.5% of complaints, which do not allege or involve immediate jeopardy, were investigated according to State policy.

Narrative of Findings: Eight of the reviewed Long Term Care (LTC) complaints did not allege or involve immediate jeopardy (IJ) or harm. Each of the eight cases was evaluated to determine if the State Agency investigated in accordance with the State Agency policy. The State Agency revised its policy for timeframes for conducting non-IJ/non harm surveys. Each case was reviewed using the policy that was current at the time the complaint was received. Five of the eight cases were investigated within the

prescribed timeframes. According to the State Agency policy that was in effect at the time of the three complaints that were not investigated timely, the investigations should have been initiated no later than 30 days from receipt of the complaint.

Provider	Provider #	Complaint #	Complaint Received	Investigation Initiated	# of days
Walker Methodist	24-5055	H5492023	10/09/02	11/15/02	31
Edina Care & Rehab Center	24-5275	H5275015	10/15/02	11/21/02	37
Auburn Manor	24-5604	H5604009	01/21/03	02/21/03	31

Action(s) Taken: The State Agency must ensure that all complaints are investigated within established timeframes. The State Agency revised its policies regarding complaint investigation timeframes. Effective April 7, 2003, investigation of complaints which have not resulted in actual harm but which have the potential to do so will be initiated within 45 days of receipt of complaint.

Emphasis G: The SA enters appropriate (certification-related) complaint data into the OSCAR complaint subsystem.

Threshold Criterion: No less than ninety percent (90%) of SA citations from complaint investigations, that are violations of Federal requirements (deficiencies cited), are encoded into OSCAR in accordance with SOM 3281-3284. The average time from the latest date of the SA's completion of the investigation to entry into OSCAR/ASPEN Central Office does not exceed 70 calendar days**.

Results: Criterion Met

Score: 40 complaint cases were reviewed. 100% of complaints investigated by the State were entered into OSCAR.

Narrative of Findings: Forty LTC complaint cases were reviewed to determine if they were entered into OSCAR or ACTS. All 40 cases were entered into either OSCAR or ACTS.

Action(s) Taken: None