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# **Annual Quality Improvement Report on the Nursing Home Survey Process**

**Minnesota Department of Health**  
*Report to the Minnesota Legislature 2011*

**Released June 2012**

# **Annual Quality Improvement Report on the Nursing Home Survey Process**

**June 2012**

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*Annual Quality Improvement Report on the Nursing Home Survey Process  
FFY 2011*

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# I. Executive Summary

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Minnesota Statutes, section 144A.10, subdivision 17 (2004) requires the Commissioner to submit to the legislature an annual survey and certification quality improvement report with an analysis of several items including:

- The number, scope, and severity of citations by region within the state;
- Cross-referencing of citations by region within the state and between states within the CMS region in which Minnesota is located;
- The number and outcomes of independent dispute resolutions;
- The number and outcomes of appeals;
- Compliance with timelines for survey revisits and complaint investigations;
- Techniques of surveyors in investigations, communication, and documentation to identify and support citations;
- Compliance with timelines for providing facilities with completed statements of deficiencies; and,
- Other survey statistics relevant to improving the survey process.

The Minnesota Department of Health (MDH) is also to identify inconsistencies, patterns, and areas for quality improvement in the report.

This report was prepared by staff of the Licensing and Certification Program, Division of Compliance Monitoring. This report is the eighth annual report on the nursing home survey process, and is based on analysis of data representing status of the program during Federal Fiscal Year 2011 (FFY11), which occurred from October 1, 2010 through September 30, 2011.

While this is a legislatively mandated report, its development allows the Department to reflect on our past successes. Some successes seen in FFY11 include improved overall consistency and accuracy. From a large scale perspective, FFY11 was the fourth consecutive year Minnesota has shown a decrease in number of deficiencies issued per survey, and we are right in the middle when comparing the average number of deficiencies per survey to the other states within our federal region. On a smaller scale, data produced from a quality improvement method called Mix-Max surveys<sup>1</sup> shows that the top ten deficiencies in FFY11 were issued at similar rates for Mix-Max surveys versus non Mix-Max surveys. This indicates there is an overall low variability between districts and reflects survey consistency statewide.

Conversely, this report also highlights opportunities for improvement. Some of these areas include the continuous goal of meeting 100% our time requirements and the need for even better communication and regular training opportunities with providers and stakeholders.

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<sup>1</sup> More information regarding Mix-Max Surveys is found later in this report  
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## II. Introduction

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### A. Survey Process

#### 1. General

The Licensing and Certification Program of the Division of Compliance Monitoring of MDH surveys nursing homes that provide care to Medicare and Medicaid clients using federal standards. MDH is under contract with the Center for Medicare and Medicaid Services (CMS) to conduct all federal inspections. MDH contracts with the Minnesota State Fire Marshal's (SFM) office to conduct the Life Safety Code (LSC) portion of the inspection, which must be completed within seven days of the health portion of the survey. It is federally mandated that these surveys be conducted at least every 15 months.

The LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The LSC, which is revised periodically, is a publication of the National Fire Protection Association (NFPA), which was founded in 1896 to promote the science and improve the methods of fire protection. The basic requirement for facilities participating in the Medicare and Medicaid programs is compliance with the 2000 edition of the LSC.

Surveys are performed by teams of state employees (usually three or four people) who are specialists in inspecting nursing home care. The surveyors have backgrounds in nursing, social work, dietetics, sanitation, health care administration and counseling. These individuals must complete required training and pass a test administered by the federal government to qualify as nursing home surveyors.

Surveys are unannounced and are conducted to make sure that the nursing home is meeting state and federal standards. Surveys review quality of care and quality of life in the facility, whether residents' rights are observed, and whether the facility meets environmental standards of cleanliness and is hazard-free. Facilities that do not meet all these standards must correct these deficiencies or they face a variety of federal sanctions. A deficiency means a provider's failure to meet state licensure or federal certification requirements. Deficiencies range in scope and severity from isolated violations with no actual harm to residents to widespread violations that cause injuries or put residents in immediate jeopardy of harm.

When surveyors find a facility out of compliance with a federal regulatory requirement, the survey team issues a deficiency and the facility is then required to correct the deficiency to come into compliance with regulatory requirements. A Statement of Deficiencies (CMS-2567) is provided to the nursing home, which contains the findings of the survey. A written Plan of

Correction (PoC) is then required and state surveyors may conduct a revisit to determine whether substantial compliance has been achieved.

## **2. The Revisit Process**

Since the PoC serves as the facility's allegation of compliance, a post certification revisit (PCR) is conducted to determine whether substantial compliance has been achieved. Substantial compliance cannot be certified and any remedies imposed cannot be changed until facility compliance has been verified. Revisits may be conducted anytime for any level of noncompliance subject to the allowed number of revisits, and both paper reviews and onsite reviews are considered to be revisits. Two revisits are permitted at the State's discretion without prior approval from the regional office; a third revisit may be approved only by the Regional Office. See Appendix A for more information regarding the federal revisit policy and timing.

## **3. QIS Process**

In 2005, CMS piloted a new nursing home survey process called the Quality Indicator Survey (QIS). The QIS originally started out as a pilot project with five states. In 2007, Minnesota was chosen by CMS to be the first state to implement QIS statewide beyond the demonstration states. Minnesota's training was completed in March of 2010. All surveys completed in FFY11 were done by QIS.

National implementation of the QIS is progressing state by state as resources are available to conduct training of state and federal surveyors. Once a state is selected by CMS to implement the QIS process, the timeframe for achieving statewide QIS implementation can range from one to three years. The rate at which implementation occurs is dependent on the number of surveyors needing QIS training and other issues determined by the State. As of FFY11, the QIS survey process is now fully integrated in Minnesota. CMS expects to have training of all surveyors nationwide completed by 2018.

The QIS is a computer assisted long-term care survey process used by selected State Survey Agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the Federal requirements<sup>2</sup>. The QIS was designed to do the following:

- Improve consistency and accuracy of quality of care and quality of life problem identification by using a more structured process;
- Enable timely and effective feedback on survey processes for surveyors and managers;
- Systematically review requirements and objectively investigate all triggered regulatory areas within current survey resources;

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<sup>2</sup> See *CMS Quality Indicator Survey* at <http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/medicine/hcpr/qis/Documents/QIS-brochure-SC-08-21-01-2008.pdf>

- Provide tools for continuous improvement;
- Enhance documentation by organizing survey findings through automation; and
- Focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns.

One of the benefits of QIS survey process is the data that can be produced. The University of Colorado, under contract with CMS, creates and processes the Desk Audit Reports for State Agencies (DAR-SA) and Desk Audit Reports for Regional Offices (DAR-RO). These reports are derived from QIS data and are used by state agencies and CMS regional offices to evaluate variation in QIS survey results and to conduct quality assurance activities. This data can help survey staff identify variances and opportunities for quality improvement, and take corrective action when appropriate. Information regarding these reports will be discussed later.

#### **4. Survey Techniques**

There are varieties of techniques surveyors use to document, identify, and support deficiencies. In conducting the survey, surveyors use the worksheets in conjunction with the Guidance to Surveyors. The Guidance to Surveyors assists in gathering information in order to determine whether the facility has met the requirements<sup>3</sup>. An example might include the following:

*The facility has care plan objectives, which are measurable. If the resident does not meet her/his goals, does the documentation reflect how the lack of implementation of the care prevents the resident from reaching her/his goals?*

In addition, the surveyors include information about how the facility practice affected residents, the number of residents affected, and the number of residents at risk. There are also record reviews, observations, and formal and informal interviews conducted. This is important since the documentation gathered will be used both to make deficiency determinations and to categorize deficiencies for severity and scope.

Throughout the survey, surveyors discuss observations, as appropriate, with team members, facility staff, residents, family members, and the ombudsman. Maintaining an open and ongoing dialogue with the facility throughout the survey process is very important to MDH. This gives the facility the opportunity to provide additional information before the survey team makes any deficiency determinations.

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<sup>3</sup> See SOM Appendix P – Survey Protocol for LTC Facilities, [http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_p\\_ltcf.pdf](http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_p_ltcf.pdf)  
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## **B. Complaint Investigation Process**

### **1. General**

The Office of Health Facility Complaints (OHFC) is a section within the Division of Compliance Monitoring and is responsible for investigating complaints and facility reported incidents of alleged violations of compliance with state and federal regulations in licensed health care facilities in Minnesota. Although OHFC was created by the Legislature in 1976 to review and investigate allegations of non-compliance with state regulations, investigations of federal noncompliance were later added to OHFC's responsibilities to widen the safety net for vulnerable adults in Minnesota who reside in licensed facilities.

Minnesota state and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC. In addition, state law 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 626.5572 Vulnerable Adults Act (VAA) as cases of suspected abuse, neglect, financial exploitation, unexplained injuries, and errors as defined in Minnesota Statutes 626.5572. Under Federal regulations, Medicaid/Medicare certified facilities are also required to report to OHFC allegations of alleged violations of abuse, neglect, and misappropriation. These state and federal reports are referred to as "Facility Self Reports."

A complaint is an allegation of noncompliance with federal and/or state requirements. Complaints are received from a number of sources and/or individuals who are not reporting on the behalf of a facility (Facility Self Report). The complaint process must ensure that a person who has complained, in good faith, about the quality of care or other issues relating to a licensed or certified health care facility is not retaliated against for making the complaint. The complaint resolution process must include procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of the complaint and procedures to ensure that the identity of the complainant will be kept confidential. All complaints are reviewed and triaged to achieve the best outcome for vulnerable adults. Therefore, OHFC may investigate complaints under state and/or federal regulations.

The CMS State Operations Manual (SOM) outlines the protocols to be followed by the state survey agency for complaint and Facility Self Report 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.

If an investigation is conducted under the state VAA, the determination will be one of the following:

- *Substantiated* – A substantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred;

- *Not substantiated*– An unsubstantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur; or
- *Inconclusive* – A finding of inconclusive means that there is not a preponderance of evidence to show that maltreatment did or did not occur.

A preponderance of evidence is a legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation, just enough evidence to make it more likely than not that, the allegation is true. Findings of the investigations are posted on the MDH website.

If an investigation substantiates noncompliance with state and/or federal regulations, deficiencies and/or state orders may be issued against the facility. The facility is responsible to correct violations and assure compliance with applicable regulations within a specific timeframe to avoid further licensing sanctions and/or penalties. Deficiencies of state and/or federal regulations are posted on the MDH website.

### III. Data Information Requirements

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Minnesota is part of CMS Region V, which is comprised of six states. The following sections detail information related to survey results in FFY11 within our region as well as within the state.

#### A. Number of Deficiencies Within Region V

##### 1. Health Deficiencies Issued

For FFY11, Minnesota issued an average of 6.4 deficiencies per survey. This is down from last year's average of 7.8. This is the fourth consecutive year that Minnesota has shown a decrease in number of deficiencies issued per survey, from 10.0 in FFY08, to 8.8 in FFY09, and 7.8 in FFY10. The implementation of the QIS survey process, as well as CMS' issuance of revised guidance on specific deficiency tags likely has played a role in the decrease of average number of deficiencies issued.

The table below shows the average number of health deficiencies per survey for all the states comprising CMS Region V for FFY11.

**Table 1. Average Number of Health Deficiencies by States within CMS Region V**

State	Surveys	Deficiencies Issued	Average
Michigan	452	3,318	7.3
Indiana	493	3,309	6.7
Minnesota	386	2,460	6.4
Illinois	770	4,853	6.3
Wisconsin	367	2,187	6.0
Ohio	910	4,565	5.0

*Source: Federal CASPER Data System, FFY11*

##### 2. Life Safety Code Deficiencies Issued

The average number of deficiencies per LSC survey during FFY11 for Minnesota was 1.5 (table 2). Minnesota has issued and continues to issue the fewest number of LSC deficiencies in the region for the past several years.

**Table 2. Average Number of Deficiencies by State – LSC**

State	Surveys	Deficiencies Issued	Average
Illinois	770	4,590	6.0
Michigan	452	2,727	6.0
Wisconsin	367	2,152	5.9
Ohio	910	3,758	4.1
Indiana	493	1,720	3.5
Minnesota	386	596	1.5

Source: Federal CASPER Data System, FFY11

## **B. Deficiencies and Remedies**

### **1. Time Requirements for Statement of Deficiencies**

As previously mentioned, the Statement of Deficiencies (CMS-2567) contains the findings of the survey. Minnesota Statutes, section 144A.101, subdivision 2 requires the facilities be provided with a draft Statement of Deficiencies at the time of the survey exit, and with completed CMS-2567 forms within 15 working days of the exit conference.

#### **Draft Statement Left at Facility**

Of the surveys with deficiencies exited during FFY11, draft statements of deficiencies were left at 100% of the facilities at the time of their survey exits (completed statements of deficiencies are then mailed to the facility after the survey exit).

#### **15-Day Requirement**

Ninety- five percent (95%) of the surveys with deficiencies met the 15-day requirement for delivering final CMS-2567 forms. Only 18 surveys exceeded the 15-day requirement. Of these 18 surveys, 16 of them were late due to the 2011 state government shutdown<sup>4</sup>. If the state shutdown had not occurred, 99% of the surveys would have met the 15-day requirement (same percentage as FFY10).

The two other surveys that were late were related to review time needed due to the seriousness and complexity of deficiencies issued.

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<sup>4</sup> The 2011 state government shutdown lasted 21 days and affected MDH's ability to meet strict time requirements.  
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## **2. Opportunity to Correct vs. No Opportunity to Correct**

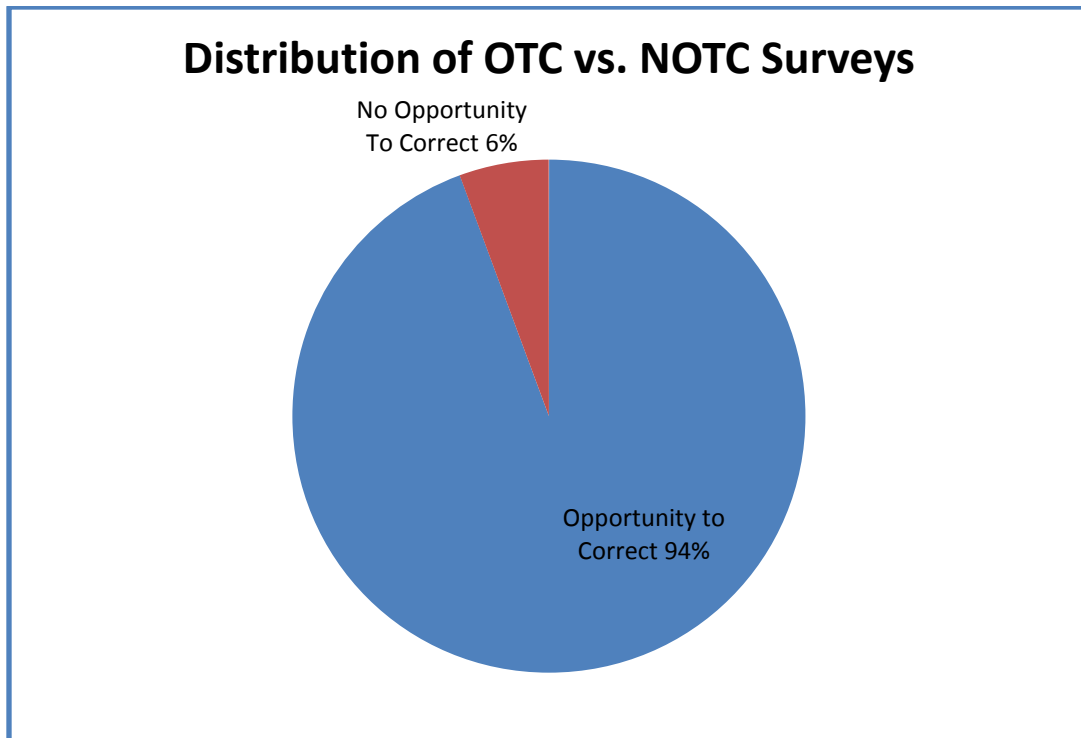
Once a survey is completed, facilities may be given an opportunity to correct identified deficiencies before remedies are imposed. Please note neither CMS nor the state agency has an obligation to give a facility an opportunity to correct deficiencies prior to imposing remedies.

However, there are mandatory criteria for having no opportunity to correct deficiencies before remedies are imposed. These two “categories” of surveys are known as Opportunity to Correct (OTC) and No Opportunity to Correct (NOTC). While there are a number of triggers for a facility to not have the opportunity to correct before remedies are imposed, the most common reason is due to the current survey resulting in deficiencies of actual harm (Level G or above – more detail regarding scope/severity of federal deficiencies to follow).

In FFY11, the distribution of OTC and NOTC<sup>5</sup> surveys is as follows:

- **Opportunity To Correct Surveys - 418**
- **No Opportunity To Correct Surveys – 25**

**Figure 1. Distribution percentages of OTC vs. NOTC Surveys**



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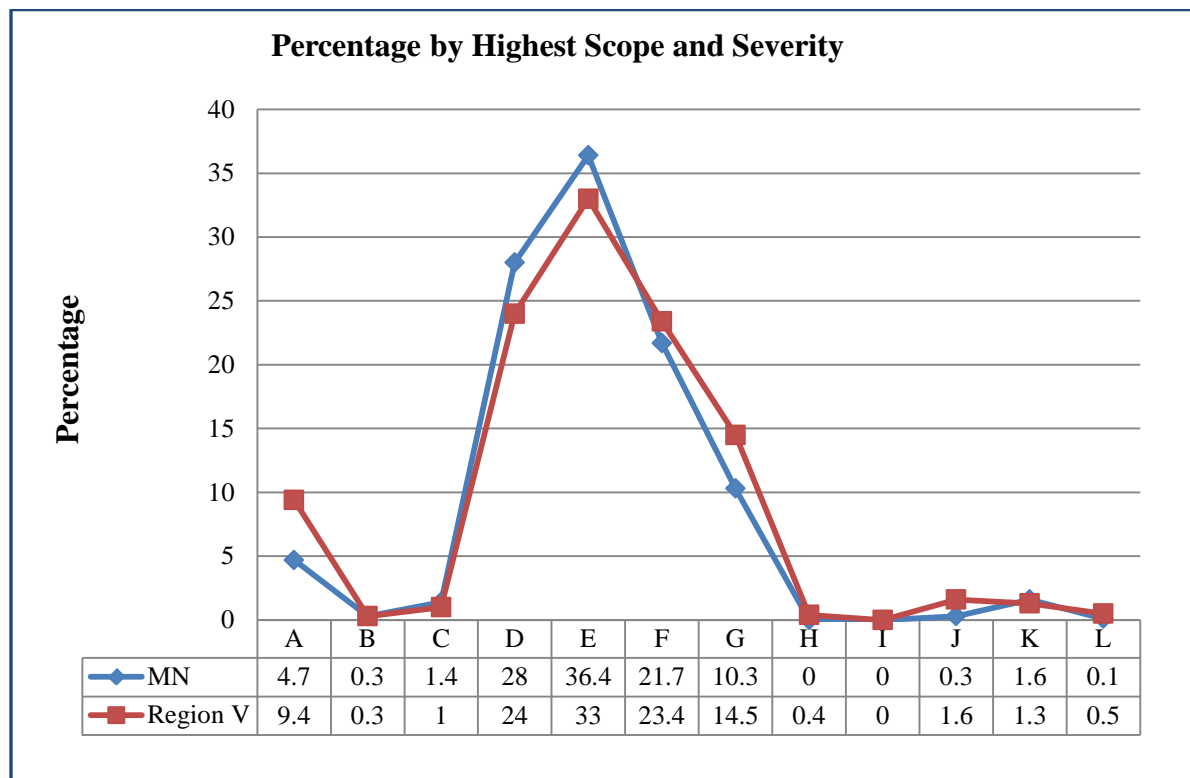
<sup>5</sup>This number includes OHFC complaints.

The distribution of OTC versus NOTC surveys is important to note since it indicates that 94% of the time in FFY11, the facility was given the opportunity to correct the identified deficiencies before remedies and other sanctions were imposed.

As mentioned above, the most common reason a facility is not given the opportunity to correct before remedies are imposed is due to the survey resulting in deficiencies of actual harm (Level G or above). During a survey, each federal deficiency is assigned a scope and severity, ranging from A through L. Scope and severity is a system of rating the seriousness of deficiencies. Scope ranges from isolated findings to widespread findings of a deficient practice. Severity ranges from finding there is a potential for minimal harm if the deficient practice is not corrected, to findings of immediate jeopardy to resident health or safety. The highest levels of deficiencies found determine the overall scope and severity of the survey. See Appendix B for the Grid used to determine scope and severity.

Figure 2 reflects the scope and severity percentages by survey. Compared to the rest of Region V, Minnesota has a slightly higher percentage of surveys that would allow facilities the opportunity to correct prior to remedy imposition.

**Figure 2. Minnesota compared to Region V – Percentage by Highest Scope and Severity**



Source: Federal CASPER Data System, FFY11

Table 3 reflects the total number of surveys during FFY11 in Region V, broken down by scope and severity level.

**Table 3. Total Number of Surveys by Highest Scope and Severity Level**

State	Highest Scope and Severity Level												Total Surveys
	A	B	C	D	E	F	G	H	I	J	K	L	
IL	66	0	13	134	215	174	139	6	0	15	11	8	781
IN	56	0	0	109	148	102	62	0	0	8	7	3	495
MI	20	2	1	50	139	127	94	3	1	8	8	1	454
MN	18	1	5	103	134	80	38	0	0	1	6	0	386
OH	118	6	10	271	281	146	70	1	0	3	5	0	911
WI	42	1	1	72	98	91	43	1	0	15	2	2	368
Region V	320	10	30	739	1,015	720	446	11	1	50	39	14	3395

### 3. Remedies

Once the seriousness of the overall survey is determined, and the decision is made to impose remedies, the remedy (or remedies) imposed is in accordance with the scope and severity matrix in Appendix B.<sup>6</sup>

As explained in the previous section, the highest levels of deficiencies of the survey determine the overall scope and severity of the survey. If the scope and severity of the survey met the criteria for no opportunity to correct, then immediate sanctions are required to be imposed.

The chart below is a complete listing of remedy categories available, though MDH recommended only a few of these for imposition during FFY11. Many factors are used to determine which and/or how many remedies to impose within the available remedy categories for particular levels of noncompliance.

<sup>6</sup> CMS makes the final determination on the imposition of all Category 2 and Category 3 remedies.

Remedy Categories		
Category 1	Category 2	Category 3
Directed plan of correction	Denial of payment for all new Medicare and/or Medicaid admissions (DOPNA)	Temporary management
State monitoring	Denial of payment for all Medicare and/or Medicaid residents by CMS	Termination of the provider agreement
Directed in-service training	Civil money penalties (CMPs)	Alternative or additional State remedies approved by CMS

Even though there were 25 NOTC surveys in FFY11, there are other opportunities for remedies to be triggered during the survey process. An example of this would include not being in substantial compliance at the time of an onsite revisit. Therefore, the number of remedies imposed during a fiscal year is expected to be higher than the total number of NOTC surveys.

Table 4 below illustrates the total number of enforcement remedies imposed in FFY11.

**Table 4. Total Number of Remedies Imposed**

Type of Remedy	Total
Imposed State Monitoring	49
Imposed CMPs	50
Imposed DOPNA	5
<b>Total Remedies Imposed</b>	<b>104</b>

*Source: Federal CASPER Data System, FFY11*

Different levels of remedies may be required (or optional). In cases where federal Category 2 or Category 3 remedies are in place, Minnesota Statutes, Section 144A.101, subdivision 5, requires revisits be conducted within 15 calendar days of the date by which corrections are to be completed.

During FFY11, there were 34 surveys where CMS imposed federal Category 2 or 3 remedies. Twenty-five of these 34 cases (76%) received revisits within the 15 calendar day requirement. Of the 9 cases that did not meet the requirement, 6 (67%) were due to factors beyond MDH's control. These factors include Federal Monitoring Surveys conducted by CMS and the 2011 state government shutdown.



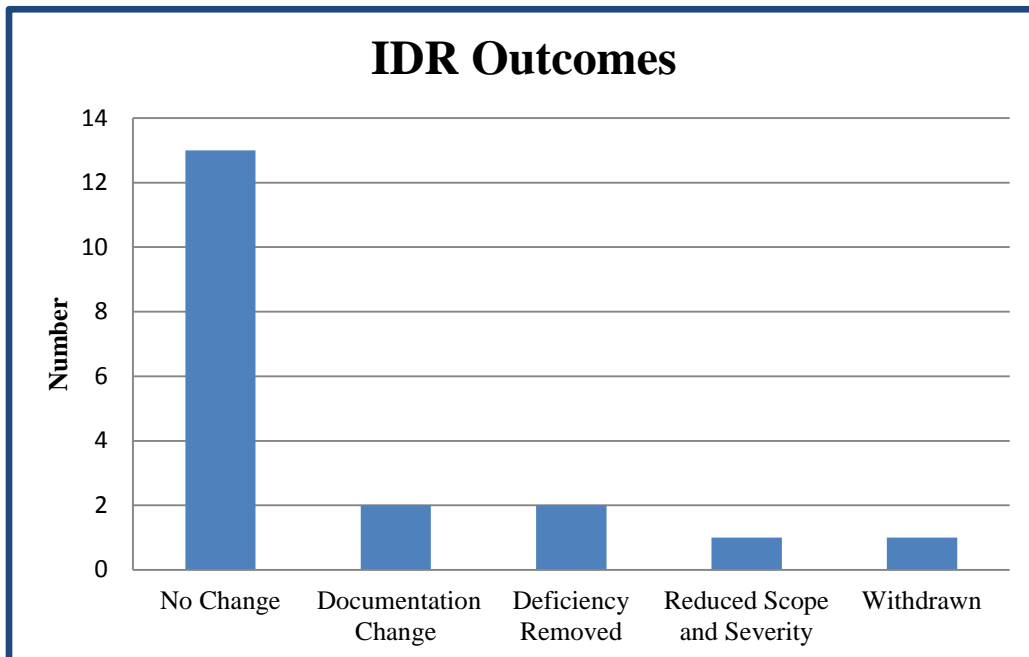
#### 4. Appeals, IDRs and IIDRs

Facilities have the right to formally appeal CMP's imposed. The appeals process is a federal process. Facilities communicate directly with the CMS Region V Office in Chicago. For FFY11, no appeals were initiated at the federal level from facilities in Minnesota.

However, there are other ways at the state level for facilities to appeal survey findings. Federal regulations require CMS and each state to develop an Informal Dispute Resolution process (42 CFR 488.331). In Minnesota, there are two types of dispute resolution processes: Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR). The State statutory provisions for these two processes are found under Minnesota Statutes, Section 144A.10, subdivisions 15 and 16. IDR and IIDR decisions made by MDH are subject to CMS oversight.<sup>7</sup> The purpose of this informal process is to give providers one opportunity to refute cited deficiencies after any survey.

The IDR is performed by an MDH supervisor who has not previously been involved in the survey or complaint investigation. For surveys exited during FFY11, there were 14 requests involving 19 deficiencies. Of the disputed deficiencies, 13 resulted in no change, 2 resulted in a change in documentation, 2 deficiencies were removed, the scope and severity was reduced for 1 deficiency, and 1 deficiency (IDR request) was withdrawn.

**Figure 3. Outcomes of Informal Dispute Resolutions**

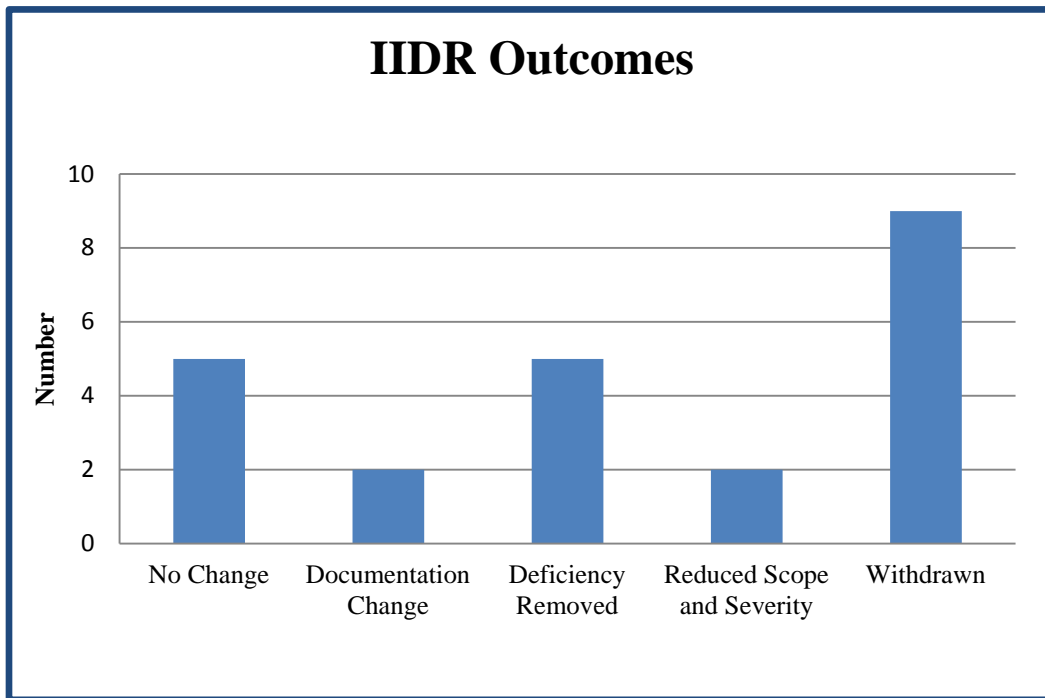


Source: Federal Aspen Central Office Data System, FFY11

<sup>7</sup> State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR. *Annual Quality Improvement Report on the Nursing Home Survey Process FFY 2011*

The IIDR involves a recommendation by an Administrative Law Judge (ALJ) from the Minnesota Office of Administrative Hearings (OAH). The ALJ's recommendation is advisory to the Commissioner, who reviews the case and can accept or modify the ALJ's recommendation. For surveys exited during FFY11, there were 9 requests involving 23 deficiencies. Of the disputed deficiencies, 5 resulted in no change, 2 resulted in a change in documentation, 5 deficiencies were removed, the scope and severity was reduced for 2 deficiencies, and 9 deficiencies were withdrawn by the facility prior to the hearing.

**Figure 4. Outcomes of Independent Informal Dispute Resolutions**



*Source: Federal Aspen Central Office Data System, FFY11*

It is interesting to note that there was a 46% decrease in the number of IDR's requested, and a 64% decrease in the number of deficiencies disputed when comparing FFY10 to FFY11. For IIDR's, there was an 18% decrease in the number of requests and a 4% decrease in the number of deficiencies disputed. MDH believes that this significant improvement in disputed cases is the result of quality improvement efforts, as well as the outcome of the QIS process, which inherently improves accuracy in survey results.

## **IV. Areas of Special Focus: FFY11 and FFY12**

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### **A. General**

#### **1. Training and Workforce Planning**

The QIS software continues to evolve and MDH survey staff is using the most up-to-date version. Not only are QIS surveys implemented statewide, but MDH has proactively added three more surveyors to become QIS trainers. Since these trainers are trained at a higher level that allows them to train other surveyors, this advanced training was an important investment in our future and in succession planning.

Also in FFY11, MDH began recruiting surveyors with more diverse backgrounds, including reaching out to multiple disciplines involved in long-term care for an enhanced survey team.

#### **2. DAR-SA and DAR-RO**

Desk Audit Reports for State Agencies (DAR-SA) and Desk Audit Reports for Regional Offices (DAR-RO) are used by state agencies and CMS regional offices to evaluate variation in QIS survey results. This data can help survey staff identify variances and opportunities for quality improvement, and take corrective action when appropriate.

As mentioned in last year's report, MDH found the data reports to be very difficult to read and time consuming to analyze. In response to these concerns, CMS established a national QIS technical advisory work group, of which MDH is an active participant. This work group discusses the technical aspects of QIS and works on making improvements to the system, including making the reports more user-friendly. In FFY11, MDH appointed an employee to CMS's national committee working to increase the usability of the reports. Our participation on this committee has resulted in positive changes and additional resources. For example, a request for a training DVD to use the DAR-SA report was completed by CMS and continues to be a resource for all states implementing QIS.

## **B. Quality Improvement**

### **1. Falls Prevention Program**

Falls among the elderly are driving up health care costs and significantly affecting the quality of life for older adults. Deficiencies related to accidents and falls are a concern, as is the morbidity and mortality associated with falls.

As part of the MN Falls Prevention Initiative<sup>8</sup>, volunteers were trained to implement fall prevention programs in their facility using a comprehensive approach that includes screenings for fall risks. Training and monitoring protocols were developed to support the sustainability of these efforts. Information and materials were placed on MDH's website for all providers to access. Providers were also invited to participate in an ongoing statewide regulatory conference call.

MDH believes that these efforts have improved fall rates in facilities. In FFY10, 210 deficiencies were cited for the deficiency F323 Accidents/Supervision. Comparatively, in FFY11, 147 deficiencies were cited for F323. This represents a 30% decrease in the deficiency related to falls and accidents and indicates success in the efforts of the facilities and the trainers.

### **2. Mix-Max Surveys**

During FFY11, surveys were coded as Mix-Max when there was a mixture of 2 surveyors from one team and 2 surveyors from another team to form a 4-person survey team. Mix-Max surveys were developed as an ongoing check and balance for potential variability between survey teams. Approximately 10% of our surveys were conducted by a Mix-Max team in FFY11 (a percentage that MDH intends to increase in FFY12).

The table below lists the top 10 deficiencies issued in FFY11, and also compares the percentage of time the deficiency was issued for Mix-Max surveys versus non Mix-Max surveys.

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<sup>8</sup> Civil money penalties are monies paid by nursing homes for non-compliance. This money is then used to fund programs and activities that improve nursing home residents' quality of care and quality of life.

**Table 5. Percent Issued, Top 10 Deficiencies – Non Mix-Max vs. Mix-Max**

Deficiency	% Issued Non Mix-Max Surveys	% Issued Mix-Max Surveys
F329 Unnecessary Medications	37%	38%
F272 Comprehensive Assessment	33%	35%
F323 Accidents/Supervision	33%	32%
F282 Prov. Care According to Care Plan	32%	35%
F371 Food Handling & Sanitation	31%	24%
F279 Comprehensive Care Plan	28%	1%
F309 Quality of Care	27%	24%
F428 Drug Regimen Review	26%	21%
F226 Develop/Implement Abuse/Neglect, ETC Policies	25%	18%
F441 Infection Control	24%	21%

With the exception of one outlier (F279 – Comprehensive Care Plan), the top 10 deficiencies in FFY11 were issued at similar rates for Mix-Max surveys versus non Mix-Max surveys. This indicates there is an overall low variability between districts and reflects survey consistency statewide.

Mix-Max surveys will continue to be a method of quality improvement for FFY12. MDH expects the number of Mix-Max surveys to increase in the next fiscal year, partially due to the additions of new disciplines surveying, but also because it is a useful quality assurance tool that results in positive experiences gained from mixing members of survey teams statewide.

### **3. Other Quality Improvement Techniques**

MDH uses a variety of techniques for training and evaluating their surveyors to assure that they are issuing deficiencies accurately and consistently. These include, but are not limited to the following:

- 1. Deficiency Review.** Our deficiency review process was enhanced in FFY11 by increasing scheduled time for detailed review. This practice is done by district supervisors across the state to ensure consistency and accuracy.
- 2. Onsite Review.** Supervisors and Assistant Program Managers going onsite with staff to review survey technique, especially as it relates to investigative technique.

MDH continues to communicate and offer regular training opportunities to providers and other stakeholders. In FFY11, these opportunities included:

- 1. Stakeholder Meetings.** Meetings with provider association representatives and stakeholders on a quarterly basis to discuss a variety of survey and LTC related issues.
- 2. Provider Training.** Training on revised federal guidelines that include quarterly conference calls for providers and surveyors.

## V. Appendices

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APPENDIX A: CMS Revisit/Date of Compliance Policy

APPENDIX B: Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix

## Appendix A

### Revisit/Date of Compliance Policy<sup>9</sup>

Revisit	Substantial compliance	Old deficiencies corrected but continuing	Old deficiencies corrected but continuing	Noncompliance continues	Any noncompliance
<b>1st revisit</b>	Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the 1st revisit, or correction date on the PoC.	1. A 2nd revisit is discretionary if acceptable evidence is provided.  When evidence is accepted with no 2nd revisit, compliance is certified as of the date confirmed by the evidence.  2. When a 2nd revisit is conducted, acceptable evidence is required if the facility wants a date earlier than that of the 2 <sup>nd</sup> revisit to be considered for the compliance date.	1. A 2nd revisit is required.  2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd revisit to be considered for the compliance date.	1. A 2nd revisit is required.  2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd revisit to be considered as the compliance date.  3. A remedy must be imposed.	
<b>2nd revisit</b>	Compliance is certified as of the date of the 2nd revisit or the date confirmed by the acceptable evidence, whichever is sooner.				1. A remedy must be imposed if not already imposed.  2. Either conduct a 3rd revisit or proceed to termination.
<b>A 3rd REVISIT MUST BE APPROVED BY THE REGIONAL OFFICE</b>					
<b>3rd revisit</b>	Compliance is certified as of the date				Proceed to termination.

Examples of acceptable evidence may include, but are not limited to:

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-service training.
- Interviews with more than one training participant about training.
- Contact with resident council, e.g., when dignity issues are involved.

Givens:


































- An approved PoC is required whenever there is noncompliance.
- Remedies can be imposed anytime for any level of noncompliance.
- Revisits can be conducted anytime for any level of noncompliance.


<sup>9</sup> See *SOM Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities*, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf>




## Appendix B

### ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX<sup>10</sup>

Immediate jeopardy to resident health or safety	J  PoC  Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2 	K  PoC  Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2 	L  PoC  Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1 
Actual harm that is not immediate	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1 	I  PoC  Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F  PoC  Required* Cat. 2 Optional: Cat. 1 
No actual harm with potential for minimal harm	A  No PoC  No remedies   Commitment to  Correct  Not on CMS-52567	B  PoC     	C   PoC    
	Isolated	Pattern	Widespread

 Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

 Substantial compliance

<sup>10</sup> See SOM Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf>