Evaluation Report Summary

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Nursing Home Inspections

February 2005

Most of the inspection problems we found are relatively minor. However, the state should do more to improve the consistency and usefulness of nursing home inspections.

Major Findings:

- The federal government determines the overall structure and content of the nursing home inspection program and does not allow states to implement alternative programs.
- Minnesota Department of Health (MDH) inspection teams have varied considerably in the average number of deficiencies issued. In the previous round of inspections, teams in one part of the state issued more than three times as many deficiencies as teams in another part of the state.
- In 2003, MDH strongly "reminded" inspection teams to cite nursing homes for all deficient practices that they observed, including isolated practices that did not have a negative effect on residents.
- As a result, by May 2004, the variation among inspection teams had decreased significantly. At the same time, however, the average number of deficiencies issued statewide increased from 6.2 to 9.7, putting Minnesota above the national average of 8.4 deficiencies per nursing home.
- The department has undertaken additional activities over the last year or two to address concerns about inspection practices. We found that some inconsistencies remain, but mostly on minor issues that do not threaten the overall integrity of the nursing home inspection program.

Recommendations:

- The Minnesota Department of Health should implement an ongoing, centralized quality assurance program that, among other things, periodically examines inspection reports from across the state.
- The department should provide more timely assistance to inspectors in interpreting federal regulations and guidelines, especially in the area of isolated events that do not involve resident harm.
- The department should develop a user-friendly way to summarize and report on the seriousness of the deficiencies that individual nursing homes receive.

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Report Summary

The federal government and states share responsibility for ensuring that nursing homes provide an acceptable level of care for their residents. The Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services oversees the inspection program for nursing homes that participate in the federal Medicare and Medicaid programs. It sets nursing home standards; provides official interpretations of federal regulations, guidelines, and policies; and establishes and monitors inspection procedures. The federal government contracts with the Minnesota Department of Health (MDH) to conduct nursing home inspections in Minnesota. In addition, MDH licenses all nursing homes operating in the state and certifies that those participating in the federal Medicare and Medicaid programs meet certain standards of care.

Nursing home inspection requirements are dictated by the federal government and are sometimes unclear, contradictory, and/or duplicative.

The Federal Government Does Not Permit States to Significantly Change the Nursing Home Inspection Program

Federal law and regulations outline both the general parameters of the inspection process and the specifics of how each inspection much be conducted. They dictate: (1) how frequently the state must inspect nursing homes, (2) the steps it must go through in conducting the inspections, and (3) the standards that it must apply. Although MDH and other states have asked CMS for more flexibility in conducting inspections, federal law does not allow states to obtain waivers to significantly change or implement an alternative inspection program for homes that participate in the Medicare program.

To comply with federal requirements, MDH inspection teams, usually three to five registered nurses, conduct unannounced inspections of each of the state's 420 nursing homes no later than once every 15 months. The average time between inspections statewide is 12 months. Each annual inspection is a "full" inspection consisting of seven federally mandated steps. During the inspection, team members observe the care and services that residents receive; meet with residents, family, administrators, and staff; examine the physical condition of the facility; and review individual resident and facility records. Team members apply a set of complex and prescriptive federal regulations that facilities must adhere to at all times. Though detailed, the regulations are sometimes unclear, contradictory, and/or duplicative, and therefore difficult to apply consistently. CMS has been slow in responding to inspectors' need for greater clarification, and MDH generally has not provided written, definitive guidance for inspectors. Consequently, inspection teams must often rely on their professional judgment to make many compliance-related determinations.

The Recent Increase in Deficiencies is Largely Due to Inspectors Issuing More Deficiencies for "Less Serious" Violations

As of May 2004, state inspectors issued an average of 9.7 deficiencies per nursing home—57 percent more than they issued in the prior round of inspections (6.2 deficiencies) and nearly double the 5.1 deficiencies that they issued three inspections previously. In contrast, deficiencies per facility nationwide increased only 3 percent over the four inspection periods, from 8.1 to 8.4 deficiencies.

Inspectors assign each deficiency a letter code (A through L) to designate its scope and severity. Scope refers to the number of residents or staff affected or involved (isolated, pattern, or widespread) and severity refers to the amount of potential or actual discomfort or harm involved for residents (potential for minimal discomfort; actual discomfort or the

Deficiencies found in inspections can range widely in scope and severity.

potential for harm; actual harm; or immediate jeopardy). Level "A" deficiencies are the least serious.

In facilities' most recent round of inspections, inspectors issued 66 percent more level "D" deficiencies (isolated events that resulted in minimal resident discomfort or have the potential for harm) and 89 percent more level "E" deficiencies (a pattern of such violations) than in their previous inspections. In contrast, only 2.6 percent of the deficiencies issued most recently were for practices that harmed residents or placed them in immediate jeopardy—levels "G" and above, 55 percent fewer than in the previous inspections.

The recent increase in deficiencies is due largely to a change in inspection practices. In 2003, MDH reiterated to inspection teams that they must issue deficiencies for all deficient practices that they observe, including isolated events that do not have negative consequences for residents. Previously, some teams did not issue a deficiency if, in their professional judgment, a deficient incident did not represent an overriding problem but was simply an isolated occurrence with no negative outcome.

Variation in Inspection Practices Throughout the State Has Decreased

In facilities' most recent round of inspections, teams in the Duluth district issued the most deficiencies per facility (13.2) while inspection teams in the Mankato district issued the fewest (7.4), a difference of 78 percent. However, the difference was not as great as it was for the previous inspections. Nursing homes in the Duluth district received, on average, 11.4 deficiencies compared with an average of 3.1 deficiencies in the Mankato district, a difference of 268 percent.

During the same time period, there was a 359 percent increase in level "D" deficiencies in the Fergus Falls district and a 174 percent increase in the Mankato district. Level "E" deficiencies in these two districts increased 143 and 157 percent, respectively. Inspection teams in these two areas of the state have traditionally issued the fewest deficiencies while teams in the Duluth area have issued the most. The average number of deficiencies issued at levels "D" and "E" in the Duluth area increased 47 and 45 percent, respectively.

As part of our study, we reviewed a sample of 100 nursing home inspection reports. We found that inspectors were generally consistent in classifying the seriousness of the deficiencies that they identified. Although there were some differences among teams from different parts of the state, the problems were generally minor and did not threaten the overall integrity of the inspection program. Inspection teams tended to understate the seriousness of deficiencies more often than they overstated it—generally in respect to the number of residents or staff affected by a deficiency. We found only a few instances where we thought that teams understated resident harm (where we thought a deficiency should have been issued at level "G" or higher), and no instances where teams overstated resident harm (where we thought a level "G" or higher deficiency should have been issued at a lower level).

MDH Needs to Develop a Better Ongoing Quality Assurance Program for Reviewing Inspection Reports

The department engages in a variety of activities, both ongoing and one-time projects, to help ensure that inspection teams apply regulations consistently throughout the state. For the most part though, MDH relies on district supervisors to review the inspection reports issued by their staff. Although central office managers and district supervisors routinely review the more serious deficiencies (levels "G" and above) before inspection teams are permitted to cite them, there is no similar check on lower-level deficiencies (which

comprise the vast majority of deficiencies and are among the fastest growing) other than what might be performed by district supervisors. However, most district supervisors told us they do not have enough time to routinely review all deficiencies before inspection reports are finalized. Furthermore, their review does not help identify differences that may exist among teams in different parts of the state.

Over the last year or two, the Minnesota Department of Health (MDH) has focused on making inspections more consistent statewide.

To supplement its ongoing activities, MDH has engaged in various one-time projects. These activities include having district supervisors accompany inspectors from other districts on inspections to mentor and coach them and a central office review of physical environment deficiencies. While these actions have yielded some useful information, they were undertaken largely in reaction to criticism from providers and legislators. In our opinion, this approach does not permit MDH to be proactive in monitoring its own activities nor does it allow the department to respond to criticism in a timely manner.

MDH Should Provide More Information About the Seriousness of Nursing Home Deficiencies to Consumers

In March 2004, MDH made nursing home inspection reports and facilities' plans of correction available on-line. However, the department failed to provide any summary information about each report to help put the overall number of deficiencies in perspective. The total number of deficiencies that a facility receives may be less important to consumers and policy makers than the seriousness of the deficiencies. Not all states publish inspection reports on-line, but many provide more summary information to help consumers distinguish among the seriousness of deficiencies and to rate facilities relative to the statewide average or to others in their geographic region. For example, some states compute overall inspection scores based on the number, scope, and severity of facilities' deficiencies.

The department is already moving forward on some of the initiatives that we recommend as a result of studies that it undertook in early 2004. For example, the department has created a quality assurance position that it hopes to fill in early 2005 and is working to create a nursing home "report card" that will include, among other items, information on inspection results. It has also retained a temporary long term care committee that it created in 2003 to continue to work on communication problems among MDH, providers, and others.

The full evaluation report, *Nursing Home Inspection* (#pe05-05), includes the agency's response and is available at 651/296-4708 or:

www.auditor.leg.state.mn.us/ped/2005/pe0505.htm

Summary of Agency Response:

In a letter dated January 21, 2005, Minnesota Department of Health Commissioner Dianne Mandernach wrote: "While we have made significant progress during this past year in addressing certain issues, we still have important work to accomplish and the recommendations in the report will help us focus our attention on the most productive areas. In this regard, we intend to share the report with our Long Term Care Ad Hoc Committee and seek their advice in developing a plan to implement the report's recommendations."