1 The Nursing Home Inspection Process

SUMMARY

Both the Minnesota Department of Health (MDH) and the U.S. Department of Health and Human Services share responsibility for ensuring that Minnesota's nursing homes provide an acceptable level of care for their residents. Because the federal government dictates the overall structure and content of the inspection program, the State of Minnesota has few opportunities to make significant changes in how it conducts nursing home inspections. The federal government mandates how often the state must inspect nursing homes, the steps the state must follow when conducting inspections, and the standards the state must apply. Although MDH and other states have asked the federal government for more flexibility in conducting inspections, the federal government has not issued any waivers that allow states to significantly change or implement an alternative inspection program.

The current nursing home inspection process emerged in the mid-1980s, as Congress responded to reports of resident abuse and inadequate enforcement of nursing home regulations. In a 1986 report on nursing home quality, the Institute of Medicine found "serious, even shocking inadequacies" in the enforcement of regulations.[1] As a result of this report and the efforts of advocacy groups and professional organizations, Congress passed a major reform of nursing home regulation as part of the Omnibus Budget Reconciliation Act of 1987.[2]

Since that time, Congress and the U.S. Department of Health and Human Services have periodically modified inspection requirements in response to studies that have shown continued weak and inconsistent enforcement of nursing home regulations and quality of care problems. Most significantly, the Nursing Home Oversight Improvement Program was implemented in 1998, which, among other things, enhanced federal review of state inspections and required the federal government to terminate funding for states that fail to conduct adequate inspections.

This chapter addresses the following question about how the Minnesota Department of Health (MDH) inspects nursing homes:

- **What are the respective roles of the Minnesota Department of Health and U.S. Department of Health and Human Services in conducting nursing home inspections?**

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1 Institute of Medicine, Committee on Nursing Home Regulation, *Improving the Quality of Care in Nursing Homes* (Washington DC: National Academy Press, 1986), 146.

2 *Pub. L.* 100-203, Dec. 22, 1987.

To answer this question, we examined state and federal laws, rules, regulations, and guidelines related to nursing homes inspections, as well as a wide variety of research reports by state and federal agencies. We also interviewed state policymakers, nursing home inspectors and their supervisors, and a sample of nursing home administrators from throughout the state.

FEDERAL REGULATION OF INSPECTIONS

State and federal laws define a nursing home as a facility (or that part of a facility) that provides health evaluation and treatment services to five or more residents who do not need an acute care facility (such as a hospital) but who require nursing supervision or rehabilitation services on an inpatient basis.[3] In lay terms, this means a facility that provides a room, meals, recreational opportunities, and help with daily living activities such as dressing, eating, bathing, walking, and using the bathroom. Residents generally have health problems that keep them from living on their own and may require daily medical attention.

The federal government and states share responsibility for ensuring that nursing homes provide an acceptable level of care to residents.

The federal government and states share responsibility for ensuring that nursing homes provide an acceptable level of care to 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.[4] The agency sets nursing home standards; interprets federal regulations, guidelines, and polices; and establishes and monitors inspection procedures. It contracts with MDH to conduct nursing home inspections in Minnesota.[5] In addition to conducting inspections, MDH licenses nursing homes for state purposes and certifies their eligibility for participation in the Medicare and Medicaid programs. Finally, the department is

Nursing home residents generally need help with many activities of daily living.

3 *Minn. Stat.* (2004), §144A.01, subd. 5-6; and *42 U.S. Code*, §1396r, (a) (2000).

4 CMS was formerly called the Health Care Financing Administration.

5 The Minnesota Department of Health contracts with the State Fire Marshall's Office in the Minnesota Department of Public Safety to determine facility compliance with the federal Life Safety Code, which is necessary for participation in the Medicare and Medicaid programs. State Fire Marshall findings are included in the inspection reports issued by MDH.

responsible for explaining program participation requirements to providers to help them comply with federal requirements.[6]

Overall, we found that:

- **The federal government sets forth the overall structure and content of the nursing home inspection program, and Minnesota has very few opportunities to make significant changes in the program.**

Federal regulations outline both the general parameters of the inspection process as well as the specifics of how each inspection must be done. They dictate: (1) how frequently the state must inspect nursing homes, (2) the steps the state must follow when conducting inspections, and (3) the standards that the state must apply. We discuss each of these areas in greater detail below.

Inspection Frequency

The federal government sets forth how often nursing homes must be inspected:

- **Federal law and regulations require that the Minnesota Department of Health inspect nursing homes every 12 months, on average.**

Nursing homes must have a "surprise" inspection no later than once every 15 months.

All nursing facilities must be inspected no later than once every 15 months, with an average time statewide between inspections of 12 months. Federal regulations do not allow states to inspect nursing homes with "good" inspection records less frequently than homes with "bad" records. In addition, CMS requires that at least 10 percent of inspections be "staggered" (started outside of normal business hours). To meet this requirement, the state must begin some inspections on weekends or holidays, some in the early morning (before 8:00 AM), and some in the evening (after 6:00 PM). Furthermore, the federal government requires that all nursing home inspections be unannounced.

About 420 Minnesota nursing homes participated in the Medicare and Medicaid programs during federal fiscal year 2003.[7] The department inspected all of these nursing homes within 14.7 months of their prior inspection, with an average time between inspections of 12 months.[8] In addition, 12 percent of the 403 inspections conducted were staggered, with 21 inspections beginning before 8:00 AM, 16 inspections after 6:00 PM, and 10 beginning on a weekend or holiday.[9]

For the most part, nursing home providers, state policymakers, and nursing home inspectors generally agree that requiring annual inspections of all nursing homes

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6 The department has additional responsibilities related to nursing homes, such as investigating complaints, which were outside the scope of our evaluation. Nursing home inspectors also inspect other types of health care facilities, such as hospitals and intermediate care facilities for the mentally retarded. These activities were likewise outside the scope of our evaluation.

7 The federal fiscal year runs from October 1 through September 30.

8 Centers for Medicare and Medicaid Services, *Federal Fiscal Year 2003 State Performance Standard Review Report* (Washington, DC, March 15, 2004), 1.

9 *Ibid.,* 2. Because nursing homes may go up to 15 months between inspections, the number of nursing homes that MDH inspected during federal fiscal year 2003 was less than the total number of nursing homes in the state.

is, at times, an inefficient use of staff resources. The requirement does not permit the state to focus efforts on the nursing homes that need oversight the most. To help increase the efficiency and effectiveness of the inspection process, the Legislature has repeatedly required the Commissioner of Health to seek federal permission to implement an alternative inspection process that would change how often nursing homes must be inspected.[10] In response, the department submitted a proposal to CMS that would have increased the time between "full" inspections up to 30 months for some homes with "good" compliance records. Other states have proposed similar approaches, including ones to conduct abbreviated annual inspections for homes with "good" compliance records.

Because of federal requirements, MDH cannot inspect nursing homes with "good" inspection records less frequently than those with "bad" records.

To date, CMS has not approved an alternative inspection program put forth by any state, including Minnesota. According to CMS, the social security law does not allow states to obtain waivers to implement an alternative inspection program for nursing homes participating in the Medicare program, although states could implement an alternative inspection program for homes that only participate in the Medicaid program. However, because this would involve only a few nursing homes, it is generally not feasible for states to do so.

For the last several years, CMS has been studying the feasibility of an alternative inspection process. Recently, the agency announced that it would be establishing a few pilot sites around the country to implement a "revamped" inspection process. Designed to address concerns about inspection consistency and efficiency, pilot sites will make greater use of computers to make initial determinations of deficiencies rather than relying on the judgment of inspection teams. The alternative process will not result in less frequent inspections for facilities, but may allow inspectors to spend somewhat less time in "good" facilities and more time in "bad" ones.

Inspection Steps

In addition to requiring an inspection no later than once every 15 months:

- **Federal regulations require that each nursing home's annual inspection be a "standard" or full inspection consisting of seven federally mandated steps.**

Federal regulations do not allow states to do shorter or abbreviated inspections of nursing homes with "good" records of compliance or to cut short an inspection when inspectors do not detect any problems in a facility. On the other hand, state inspectors must extend the inspection if they suspect that a facility is providing substandard care to its residents.

As shown in Table 1.1, the standard inspection consists of seven federally mandated steps. First, inspectors prepare off-site by reviewing information about the nursing home and its residents to help identify areas of concern. Immediately upon arriving at the facility, the inspection team meets with the nursing home administrator to explain the inspection process and request specific information;

10 *Laws of Minnesota* (2000), ch. 312, sec. 2, 5; *Laws of Minnesota* (1Sp2001), ch. 9, art. 5, sec. 38; *Laws of Minnesota* (2002), ch. 379, art. 1, sec. 113; and *Laws of Minnesota* (2004), ch. 247, sec. 6.

Table 1.1: The Federal Nursing Home Inspection Process

Step 1:	Off-site preparation
Step 2:	Entry conference and on-site preparation
Step 3:	Initial nursing home tour
Step 4:	Resident sample selection
Step 5:	Information gathering
	A. General observation of the facility
	B. Kitchen/food service observation
	C. Resident review
	D. Quality of life assessment
	E. Medication pass
	F. Quality assessment and assurance review
	G. Abuse prevention review
Step 6:	Deficiency determination
	A. Determination of substandard quality of care
Step 7:	Exit conference

SOURCE: Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), ch. 7, sec 7200.

Likewise, MDH cannot do abbreviated inspections in nursing homes with "good" records.

this is followed by a facility tour. Using the information provided by the facility and what inspectors learned during the tour, the team then selects a sample of residents to focus on during the information-gathering portion of the inspection. During this phase, the team meets on a daily basis to compare notes, discuss new areas of concern, and make adjustments to the inspection as deemed necessary. Inspectors observe the care and services that facility staff provide to residents, such as preparing and serving meals, administering medications, and helping, as necessary, with activities such as bathing, toileting, walking, and grooming. Inspection team members also interview residents and staff and review resident records. Once the team is satisfied that they have gathered enough information, it meets to determine whether the facility has failed to meet any regulatory requirements. The team prepares a draft inspection report that discusses each violation of federal regulations (commonly referred to as a deficiency) that the team has identified, and then meets with nursing home personnel and interested residents and family members to present its preliminary list of deficiencies.

Inspectors spend much of their time observing and talking with residents and staff.

After the inspection team leaves the facility, it finalizes the "Statement of Deficiencies" and submits it to the team's district supervisor who is responsible for reviewing the document and submitting a final copy to the facility and CMS. The facility must submit a "Plan of Correction" within ten days that indicates how and when it will correct each of the deficiencies that it has received.[11] Inspectors normally conduct an unannounced revisit to verify that the plan of correction has been implemented and that the deficiencies no longer exist. For the most part, MDH generally gives a facility 40 days from the end of the inspection to correct deficiencies before MDH imposes any sanctions on the facility.

11 Facilities may also dispute a deficiency and request a hearing before MDH or an administrative law judge within this ten-day period. Chapter 2 discusses how often this happens and the outcome of such hearings.

While the state is unable to make significant changes in how inspections are done:

- **Minnesota has expanded the federal nursing home inspection process in several ways.**

The state goes beyond federal inspection requirements by adding other tasks, including requirements to: (1) interview family council members; (2) expand the number of evening observations nursing home inspectors must make each month; (3) conduct a "verify and clarify" session with the provider to discuss possible areas of concern prior to the exit conference; and (4) leave a draft inspection report with nursing homes after the inspection, with the final report due within 15 days. Some of these activities were added to make the inspection process more "user friendly" for providers. Others, such as expanding the inspection to include final interviews with family council members, were at the urging of advocacy groups.

State law requires inspectors to leave a draft inspection report with facilities when they leave.

For the year ending September 30, 2004, MDH inspectors, working in teams of three to five registered nurses, spent an average of about 150 hours per facility to complete the state and federally mandated inspection tasks.[12] As would be expected, it took longer to inspect larger nursing homes than smaller ones. For example, a facility with 40 or fewer beds averaged about 72 hours per inspection while a facility with 116 to 160 beds averaged 176 hours.[13]

Nursing home inspectors must meet with each facility's resident council.

Inspection Standards

The federal *State Operations Manual* (*SOM*) sets forth the federal standards that inspectors must apply during an inspection as well as guidelines to help them apply those standards.[14] As currently written:

12 Minnesota Department of Health analysis of data from the Online Survey and Certification Reporting System, December 2, 2004. State inspectors spent an additional 54 hours per facility, on average, conducting follow-up inspections to ensure that facilities corrected deficiencies.

13 Minnesota Department of Health, *Federal Fiscal Year 2005 Initial Budget Request* (St. Paul, July 15, 2004), unnumbered.

14 Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004).

- **The federal standards and guidelines that state inspection teams must use to inspect nursing homes are prescriptive and complex.**

The *SOM* covers hundreds of pages and contains 274 regulatory standards that nursing homes must meet at all times. The standards cover 16 different categories of operation, including administration, dietary services, infection control, life safety, physical environment, quality of care, quality of life, resident assessment, and resident rights. Some requirements must be met for each resident and any violation of these requirements, even for one resident, is a deficiency. For example, each resident must have a comprehensive care plan. Other requirements focus on facility systems and are evaluated comprehensively rather than in terms of a single incident. For example, a facility must have a medication error rate below 5 percent.[15]

Inspectors grade the seriousness of each deficiency by assigning it a letter code.

For each deficiency, inspectors must use professional judgment to assess how many residents or staff are affected by or involved in the deficient practice (scope) and the amount of actual or potential discomfort or harm involved for residents (severity). As shown in Table 1.2, these two determinations result in the inspection team assigning a letter code (A through L) to each deficiency, with level "A" deficiencies being the least serious.

Table 1.2: Deficiency Scope and Severity Grid

Severity	Scope		
	Isolated	Pattern	Widespread
Level 4: A situation that has caused or is likely to cause serious resident injury, harm, impairment, or death.	J	K	L
Level 3: A situation that has caused resident harm.	G	H	I
Level 2: A situation that has caused minimal discomfort to a resident OR has the potential to cause resident harm.	D	E	F
Level 1: A situation that has the potential of causing no more than minimal discomfort to a resident.	A	B	C

NOTE: Harm is defined as a situation that compromises a resident's ability to maintain or reach his or her highest practicable physical, mental, or psychosocial well being, as defined by an accurate and comprehensive assessment, care plan, and provision of services. A nursing home with one or more quality of life, quality of care, or resident behavior and facility practices deficiencies issued at level "F" or "H" or above (the shaded area of the grid) is considered to be providing "substandard" care to its residents.

SOURCE: Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), Appendix P, V, B-C.

To determine a deficiency's scope, inspectors must classify each deficiency in one of three ways: isolated, pattern, or widespread. Federal guidelines say that a deficiency is isolated when one or a very limited number of residents or staff are affected or the situation has occurred only occasionally or in a very limited number of locations in the facility. For example, if 60 of 70 residents in a facility are incontinent and the facility failed to provide adequate care or services to restore or improve bladder function for 2 of these residents, the deficiency should be classified as isolated. A deficiency represents a pattern when it affects more

15 However, a single medication error that is considered severe enough may result in a deficiency.

than a very limited number of residents or staff, occurs in several locations, or the same resident has been affected by repeated occurrences of the same deficient practice. If the above facility did not provide adequate care or services to 10 of its 60 incontinent residents, the resulting deficiency should be issued as a pattern. A deficiency is identified as widespread when it refers to the entire facility or when a system failure has affected or has the potential to affect a large number of residents. For example, a facility failing to provide adequate care or services to improve or restore bladder function to 30 of its 60 incontinent residents should be issued a deficiency classified as widespread.

Inspectors must also determine the severity of a deficiency on a scale from one to four. Level one refers to deficiencies that have the potential for causing no more than a minor negative impact on, or minimal physical, mental, or psychosocial discomfort to, a resident. For example, a facility should receive a level one deficiency if it failed to post its inspection results or only made them available upon request. Level two deficiencies are those that have resulted in resident discomfort or have the potential to harm residents. Federal regulations define harmful situations as those that compromise residents' ability to maintain or reach their highest practicable physical, mental, and psychosocial well being, excluding situations that are of a "limited consequence" to residents. For example, a nursing home should receive a level two deficiency if inspectors observed staff failing to wash their hands properly between caring for residents but no one became seriously ill as a result. Level three deficiencies are those that have actually resulted in resident harm. The hand-washing example should be a level three deficiency if there was evidence that a resident caught a contagious disease as a result of staff failing to wash their hands properly after providing resident care. Level four represents immediate jeopardy situations whereby the facility must undertake immediate corrective action to address problems that have resulted in or are likely to cause serious injury, harm, impairment, or death to a resident. For example, if a resident with dementia was found outside during an inspection heading toward a busy highway and the nursing home did not have a working system in place to monitor residents with dementia, the facility should be issued a level four deficiency.

A deficiency's letter code helps determine what sanctions MDH could impose on the facility.

The "seriousness" of a facility's deficiencies (their scope and severity) helps determine the sanctions for nursing homes that fail to correct deficiencies within an allowable time frame. As shown in Table 1.3, there are three categories of required sanctions. Generally, nursing homes do not face sanctions for deficiencies issued at levels "A" through "C."[16] Category 1 sanctions are reserved for deficiencies issued at levels "D" and "E" and require that facilities implement a plan of correction developed by the state, have their staff attend a specific training program, or be subject to state monitoring. Conversely, category 3 sanctions are reserved for the most serious deficiencies and include the state assuming management of the facility, terminating the facility's participation in the Medicare and Medicaid programs, or closing the facility. Except in instances of immediate jeopardy to residents (a deficiency issued at level "J" or above) or when facilities receive level "G" or higher deficiencies in two consecutive inspections, facilities are generally given an opportunity to correct deficiencies before any sanctions are imposed—usually 40 days. MDH must deny Medicare

16 Although the federal government does not require that sanctions be imposed on facilities for low-level deficiencies (levels "B" and "C"), the state may choose to impose sanctions from category 1 when facilities fail to correct their deficiencies.

Table 1.3: Required Sanctions for Noncompliance

Category 1: Deficiencies issued at levels "D" and "E"

Directed plan of correction;
State monitoring; and/or
Directed in-service training.

Category 2: Deficiencies issued at levels "F" through "I"

Denial of payment for new Medicare and Medicaid admissions[a];
Denial of payment for all Medicare and Medicaid residents;
Civil money penalties of $50-$3,000 per day of noncompliance; and/or
Civil money penalties of $1,000-$10,000 per incident of noncompliance.

Category 3: Deficiencies issued at levels "J" and above

Temporary management;
Termination from the Medicare/Medicaid programs; and/or[b]
Facility closure.

NOTE: The Minnesota Department of Health may impose a category 2 sanction to supplement a category 1 sanction for deficiencies issued at levels "D" and "E." In general, a category 1 or 2 sanction can also be imposed whenever a category 3 sanction is required, and a category 1 sanction may also be imposed when a category 2 sanction is required. Civil penalties increase to $3,050-$10,000 per day when they are imposed in addition to a category 3 sanction. The state may also assume temporary management (a category 3 sanction) when a facility has been issued a level "I" deficiency. Also, a facility cited for providing substandard care cannot operate a nurse aide training and competency evaluation program for two years.

[a]The state must deny Medicare and Medicaid payments for new admissions when a facility is not in substantial compliance within three months of the inspection and when a facility has been cited for substandard care on three consecutive annual inspections. In the latter situation, state monitoring must also be imposed.

[b]The state must recommend termination from the Medicare and Medicaid programs when a facility is not in substantial compliance within six months of the inspection.

SOURCE: Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), ch. 7, sec. 7210G and 7400.

and Medicaid reimbursements for new admissions when facilities have not corrected their deficiencies within three months of the department's inspection. Facilities must be terminated from the program if deficiencies are not corrected within 6 months.

FUNDING

In keeping with the high degree of federal involvement in the nursing home inspection program:

- **State funds cover less than 10 percent of the total cost of nursing home inspections and complaint investigations.**

The federal government is the major source of funding for the inspection program, with the state contributing less than 10 percent of the total cost for nursing homes. In fiscal year 2004, MDH spent about $12 million from state and

federal sources on activities related to nursing home inspections, including costs related to investigating complaints against nursing homes.[17] The state's share (about $1.1 million) is the result of state negotiations with CMS and has historically been low when compared with that of other states. According to a 2000 analysis of costs by the Health Care Financing Administration, Minnesota was the only state in the Chicago region that paid less than 10 percent of total inspection costs.[18] Other states paid at least 16 percent, with one state paying almost 25 percent of total costs.

17 Cecelia Jackson, "Re: FFY 2004 Nursing Home Expenditures" (December 23, 2004), electronic mail to jo.vos@state.mn.us.

18 Health Care Financing Administration, "Nursing Home Survey, State Licensure Cost Shares" (Chicago, May 2000). Minnesota is part of the Chicago region, which also includes Illinois, Indiana, Michigan, Ohio, and Wisconsin.