

# Inspection Consistency and Other Issues

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## SUMMARY

*The Minnesota Department of Health (MDH) has undertaken various activities over the last year to help address concerns about the number and classification of deficiencies. To a great extent, the department's actions have led to a large increase in the number of "low-level" deficiencies that nursing homes receive, further straining the adversarial relationship between the department and nursing home providers. Part of the problem is due to the complex and sometimes unclear federal standards and guidelines that state inspectors must apply. Lack of clear guidance from MDH has, at times, resulted in inspection teams applying regulations differently, which explains some of the variation in deficiencies issued per nursing home across the state. Although we did not find major problems with how inspectors classify deficiencies once identified, the department could do more to ensure that inspection teams apply federal regulations and guidelines in a consistent and meaningful manner by: (a) developing an ongoing, centralized quality assurance program that, among other things, periodically examines inspection reports from throughout the state; (b) providing more written guidance to inspectors, especially in key areas such as issuing deficiencies for isolated occurrences with no negative outcomes; and (c) providing more meaningful information about inspection results to consumers.*

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Legislators, nursing home providers, and other stakeholders are concerned about the consistency with which Minnesota Department of Health (MDH) inspectors in different parts of the state apply nursing home regulations and the significant increase in the number of deficiencies issued over the last year. This chapter addresses these concerns by examining two major questions:

- **How consistent are Minnesota Department of Health nursing home inspection teams in applying nursing home regulations across the state?**
- **What has the Minnesota Department of Health done to help ensure that inspectors apply nursing home requirements in a consistent and meaningful manner, and how well have these activities worked?**

To answer these questions, we analyzed data from the Centers for Medicare and Medicaid Services (CMS) on the number and type of deficiencies written by state inspectors in each of the state's ten districts. We reviewed a sample of 100 nursing home inspection reports as well as 11 inspection reports involving

substandard resident care or immediate jeopardy deficiencies. We supplemented these data by interviewing at least one-half of the nursing home inspectors in each district, all district supervisors, and twenty nursing home administrators from throughout the state.<sup>1</sup> We also talked with state and federal officials, including state officials in other states. Finally, we reviewed nursing home laws, regulations, rules, guidelines, interpretations, and other state and federal documents.

## CLARITY OF INSPECTION STANDARDS

As noted in Chapter 1, the federal regulations that nursing home inspectors must apply are complex. In examining the regulatory standards and the accompanying guidelines that CMS provides, we concluded that:

- **Federal nursing home regulations and guidelines are sometimes unclear, contradictory, and/or duplicative; as a result, inspection teams must often rely on their professional judgment to make compliance-related decisions.**

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**Federal nursing home regulations are difficult to apply consistently.**

Federal nursing home standards are inherently difficult to apply in a consistent and meaningful manner for several reasons. First, the regulations and guidelines are sometimes unclear and confusing, especially language that defines resident harm. According to CMS' *State Operations Manual (SOM)*, deficiencies issued at or above level "G" must either (1) result in actual harm that "has compromised the resident's ability to maintain and/or reach his or her highest practicable physical, mental, and psychosocial well being;" or (2) present a situation of immediate jeopardy whereby "noncompliance has caused or is likely to cause serious injury, harm, impairment, or death."<sup>2</sup> The definition specifically excludes practices that are of "limited consequence" to a resident. For example, repeated falls that result in minor bruises, cuts, or skin tears would likely be cited as a level "D" rather than level "G" deficiency, even if the facility failed to assess the resident for falls or to implement preventive measures. On the other hand, repeated falls that result in bone fractures or breaks would likely be issued at a level "G" or above.

In 2003, the General Accounting Office (currently known as the Government Accountability Office or GAO) noted that nationwide, ". . . the continuing prevalence of and state surveyor [inspector] understatement of actual harm deficiencies is disturbing."<sup>3</sup> GAO attributes part of the problem to the confusing definition of harm used by CMS, which suggests that harmful situations must represent life-altering situations for residents. In response to GAO's concern, CMS indicated that it would delete the reference to "limited consequence" in its

<sup>1</sup> In all, we interviewed 52 inspectors and 9 area supervisors (one position was vacant at the time of our study). We selected which nursing home administrators to interview based on the results of their most recent inspections as of May 2004. Using the random sample of inspection reports that we reviewed, we tried to interview one administrator from a facility with an above average number of deficiencies and another from a facility with a below average number of deficiencies in each MDH district, for a total of 20 administrators.

<sup>2</sup> Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), Appendix P, Part 1, IV, B.

<sup>3</sup> U.S. General Accounting Office, *Nursing Home Quality* (Washington, DC, July 2003), unnumbered.

next revision of the *SOM*.<sup>4</sup> However, when the manual was revised in May 2004, CMS did not clarify its definition of harm.

Second, federal regulations and guidelines sometimes contradict one another. On the one hand, the *SOM* states that some requirements, especially quality of life or certain facility system requirements, are best evaluated comprehensively rather than in terms of a single incident.<sup>5</sup> The *SOM* goes on to state that inspection teams must consider the sum of staff actions or decisions for a resident to determine if a quality of life requirement has been met. On the other hand, the *SOM* says that a single incident that is considered severe enough may result in a deficiency. The *SOM* gives little guidance, however, to help inspectors determine when it is appropriate to cite single violations of quality of life standards as deficiencies, especially for isolated events that have resulted in only minimal discomfort to residents. Also, while the *SOM* defines a faulty practice as one that does not meet regulatory requirements, it also says that a faulty or deficient practice does not necessarily constitute a deficiency.<sup>6</sup> Yet, inspection teams are encouraged to cite all violations, even those that involve a single resident or event that has no adverse outcome.

Third, some deficiencies are, in practice, duplicative. For example, inspectors may cite nursing homes for storing dangerous cleaning products in unlocked cabinets under two different quality of care deficiencies or as a physical environment deficiency. Likewise, inspectors can cite facilities for having stained carpeting and furniture as either a quality of life deficiency or a physical environment deficiency. Nursing homes that do not completely close a resident's privacy or window curtain when providing personal care can receive a resident rights deficiency or a quality of life deficiency. Because quality of care or quality of life deficiencies can lead to findings of substandard care and thus harsher sanctions than most other types of deficiencies, the decision regarding which deficiency to issue may have important consequences for providers.

Finally, regulations often use words such as "timely," "adequate," "prompt," and "appropriate" but do not always provide further explanation or guidance for actually interpreting what is timely, adequate, prompt, or appropriate. For example, standards require that facilities address resident grievances promptly, but little guidance is offered to define prompt. Likewise, facilities must have sufficient staff to provide the services that residents need. However, the *SOM* provides little guidance to help inspectors determine whether residents are not receiving needed services because of insufficient staff or for other reasons, especially when facilities may be staffing at levels required by state laws and rules.

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**Many inspection teams want more direction from MDH in some key areas.**

When we talked with inspection teams about the inspection process, about half of the teams told us that lack of clear direction from MDH and CMS was a major problem for them in applying the federal regulations. Many indicated that they need more direction in a number of areas such as issuing deficiencies for isolated events that do not result in negative outcomes or determining resident harm.

<sup>4</sup> *Ibid.*, 46. As we discuss later, Minnesota inspectors do not issue "G" level deficiencies for violations that do not significantly alter a resident's lifestyle or are of "limited consequence."

<sup>5</sup> CMS, *State Operations Manual*, Appendix P, Part 1, II, Task 6, D.

<sup>6</sup> *Ibid.*

Furthermore:

- **MDH has issued few guidelines to help inspectors interpret and apply federal standards in a consistent and meaningful manner throughout the state.**

The department issues “information bulletins” via its website to notify state inspectors and nursing home providers about a variety of issues, such as changes in state or federal regulations, inspection activities, and other miscellaneous information.<sup>7</sup> It issued 17 nursing home-related bulletins in 2004, 9 in 2003, and 8 in 2002. However, most of the bulletins issued in 2004 do not provide additional insight into problem areas for inspectors; rather they restate federal or state requirements or notify providers about information sources that might be of interest to them.

## CONSISTENCY AMONG DISTRICTS

We examined inspection consistency in Minnesota in two ways. First, we looked at how the number of deficiencies cited by inspection teams in various parts of the state differed and possible reasons why. Second, we looked at how consistently inspection teams assigned scope and severity levels to the deficiencies that they identified.

### Issuing Deficiencies

The Minnesota Department of Health uses teams of nursing home inspectors assigned to one of ten districts to conduct inspections. There are four districts in the Twin Cities area and district offices in Bemidji, Duluth, Fergus Falls, Mankato, Rochester, and St. Cloud. Each district has a supervisor and seven to nine inspectors. Inspectors typically work in teams of three or four, with one of them designated as team leader. Each district is responsible for inspecting anywhere from 32 to 64 nursing homes annually.<sup>8</sup>

We found that:

- **Although inspection teams throughout the state differ significantly in the average number of deficiencies issued to nursing homes, the differences have decreased dramatically in the last year.**

As shown in Table 3.1, in the 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 even greater for the previous inspections. Nursing

<sup>7</sup> The federal government has a similar website to notify state staff and providers about changes in its regulations or practices and to provide points of information.

<sup>8</sup> State inspectors are also responsible for inspecting other types of health care facilities and programs, including hospitals, home health agencies, and intermediate care facilities for the mentally retarded. Inspectors estimate that they spend about 75 to 80 percent of their time inspecting nursing homes.

**Table 3.1: Average Number of Deficiencies Issued to Minnesota Nursing Homes by District**

District	Fourth Most Recent Inspection	Third Most Recent Inspection	Second Most Recent Inspection	Most Recent Inspection	Percentage Change <sup>a</sup>
Bemidji	5.6	6.5	8.0	10.7	35%
Duluth	7.1	9.2	11.4	13.2	16
Fergus Falls	3.0	3.1	3.7	10.2	178
Mankato	3.4	3.7	3.1	7.4	142
Metro A	6.7	5.4	7.9	11.1	41
Metro B	6.2	5.9	7.0	8.5	20
Metro C	5.0	5.3	5.9	10.1	71
Metro D	6.4	4.8	6.2	8.1	31
Rochester	4.7	6.8	8.1	9.6	18
St. Cloud	5.5	4.8	4.8	9.6	102
Statewide	5.1	5.3	6.2	9.7	57%

<sup>a</sup>Percentage change refers to the change from the second most recent inspection to the most recent inspection.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

**In the last round of inspections, some teams more than doubled the number of deficiencies they issued.**

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.

The number of deficiencies issued per facility increased in all districts over the previous inspections. However, the increase was greatest in those districts that had been issuing the fewest deficiencies. The two districts that issued the most deficiencies in the previous inspections, Duluth and Bemidji, had increases of 16 and 35 percent, respectively, in the number of deficiencies per facility. In contrast, the two districts with the fewest deficiencies in the previous inspections, Mankato and Fergus Falls, had increases of 142 and 178 percent, respectively.

We talked with state inspection teams and their supervisors about recent changes in the number of deficiencies issued across the state. As we discussed in Chapter 2, there are a number of reasons why deficiency rates might vary, including factors related to nursing home characteristics, facility practices, and inspection practices. We learned that, in at least one respect, state inspection practices have changed considerably over the last year:

- **In 2003, MDH strongly “reminded” inspection teams to cite nursing homes for all deficient practices, including isolated practices that did not have a negative effect on residents.**

Prior to this, inspection teams in some parts of the state used their professional judgment to determine whether a specific violation represented an overriding problem or whether it was simply an isolated event. If the teams determined that a violation was simply an isolated event that did not have any negative consequences, they pointed it out to nursing home staff, but did not generally issue a deficiency. For example, some inspection teams may not have issued a

deficiency if they noticed that loaves of bread were stored too close to the kitchen ceiling, opting instead to just discuss the situation with staff.

In early 2003, however, MDH surveyed all of the state's nursing home administrators to learn more about their concerns regarding the inspection process. When a provider indicated that inspectors in his district did not issue as many deficiencies as they could have in its most recent inspection, the department immediately conducted another inspection of his facility, using program management staff from the central office rather than inspectors from that district. The re-inspection found several deficiencies that were missed in the earlier inspection, including a finding that the nursing home was providing substandard care to its residents. Concerned over the discrepancy between the re-inspection and the one conducted earlier, MDH took immediate corrective action. First, it temporarily reassigned the district supervisor in that area to job duties outside the district and assigned other district supervisors the responsibility of overseeing the work of that district's inspectors. Second, MDH summoned inspectors from that district to the department's main office and, in no uncertain terms, strongly "reminded" staff that they needed to comply with CMS' inspection protocols and requirements. Third, it required district supervisors to accompany those inspectors on all nursing home inspections for the remainder of the summer. Finally, it notified inspectors statewide of the need to adhere to CMS' inspection requirements.

Consequently:

- **Inspection teams, especially those in areas of the state that were issuing the fewest deficiencies, began issuing more deficiencies for "less serious" violations.**

As noted previously, inspectors assign each deficiency a letter code (A through L) to designate its scope (isolated, pattern, or widespread) and severity (potential for minimal discomfort, actual discomfort or the potential for harm, actual harm, or immediate jeopardy). As shown in Table 3.2, over the past two inspections, there was a 66 percent increase statewide in the number of deficiencies with a scope and severity level of "D" (isolated occurrences that resulted in minimal resident discomfort or have the potential for harm) and an 89 percent increase in level "E" deficiencies (a pattern of such violations). 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.

Another state policy that may affect the total number of deficiencies that inspection teams issue involves the practice of "cross-referencing," which refers to issuing multiple deficiencies for a single incident. For example, one of the facilities that we looked at received two deficiencies because a resident repeatedly walked away from the facility (also known as "elopement"). One of the deficiencies was for failing to reassess the resident for his elopement episodes and the other was for not providing proper supervision to prevent the elopements. Providers argue that issuing two or more deficiencies for the same incident is needless duplication because the action they take to correct both deficiencies is the same.

**Table 3.2: Number of Deficiencies Issued to Minnesota Nursing Homes by Scope and Severity and by District**

District	Most Recent Inspection						Total
	B	C	D	E	F	G and Above	
Bemidji	10	12	233	151	27	17	450
Duluth	12	17	293	129	19	18	488
Fergus Falls	38	22	248	158	14	9	489
Mankato	38	27	266	121	17	7	476
Metro A	11	19	204	107	12	3	356
Metro B	14	21	192	52	29	5	313
Metro C	23	32	245	97	20	16	433
Metro D	19	19	147	73	16	3	277
Rochester	7	5	230	140	12	19	413
St. Cloud	12	19	238	91	1,410	10	384
Statewide	184	193	2,296	1,119	180	107	4,079

  

District	Second Most Recent Inspection						Total
	B	C	D	E	F	G and Above	
Bemidji	1	3	161	83	20	50	318
Duluth	7	10	199	89	20	50	375
Fergus Falls	23	8	54	65	14	19	183
Mankato	17	22	97	47	10	10	203
Metro A	8	19	128	76	3	18	252
Metro B	16	25	142	24	14	18	239
Metro C	17	22	135	44	8	9	235
Metro D	10	12	126	57	13	6	224
Rochester	8	5	201	78	19	39	350
St. Cloud	3	14	141	30	5	21	214
Statewide	110	140	1,384	593	126	240	2,593

  

District	Percentage Change						Total
	B	C	D	E	F	G and Above	
Bemidji	900%	300%	45%	82%	35%	-66%	42%
Duluth	71	70	47	45	-5	-64	30
Fergus Falls	65	175	359	143	0	-53	167
Mankato	124	23	174	157	70	-30	134
Metro A	38	0	59	41	300	-83	41
Metro B	-13	-16	35	117	107	-72	31
Metro C	35	45	81	120	150	78	84
Metro D	90	58	17	28	23	-50	24
Rochester	-13	0	14	79	-37	-51	18
St. Cloud	300	36	69	203	180	-52	79
Statewide	67%	38%	66%	89%	43%	-55%	57%

NOTE: The Centers for Medicare and Medicaid Services does not record level "A" deficiencies in its inspection database.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

We examined how often inspection teams cited the same deficient practice to document two or more deficiencies across all 16 categories of standards. We found that:

- **Although inspection teams differed in the extent to which they issue multiple deficiencies based on the same incident, less than 10 percent of the total number of deficiencies issued were completely duplicated in other deficiencies.**

Of the 978 deficiencies that were issued to the 100 nursing homes in our sample, about 8 percent were completely cross-referenced to other deficiencies. To be counted as cross-referenced, all incidents supporting a violation had to be cited in another deficiency or deficiencies.<sup>9</sup> Because inspection teams frequently cite multiple instances of noncompliance in documenting deficiencies, eliminating those that also appeared elsewhere often had little effect on the overall number of deficiencies issued.

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**In June 2004, MDH stopped issuing multiple deficiencies for some types of violations.**

Inspection teams varied in the extent to which they cross-referenced deficiencies. Teams in the Mankato district tended to cross-reference the least (less than 5 percent of deficiencies), while teams in the Metro D and Rochester districts cross-referenced the most (12 to 13 percent).

Concerned about the increase in the number of deficiencies issued statewide and the fact that Minnesota was issuing more deficiencies per facility than the national average, MDH recently directed inspection teams to stop cross-referencing certain types of deficiencies. Effective June 21, 2004, inspection teams discontinued issuing deficiencies related to assessing residents or developing their care plans if the incident supporting the deficiency also resulted in a quality of care or quality of life deficiency.<sup>10</sup> According to MDH, the department will examine the effect of this policy change on the total number of deficiencies in February 2005. Our data suggest that, if inspection practices do not change in other ways, discontinuing cross-referencing should have only a small effect on the number of deficiencies issued statewide. On the other hand, it may decrease inconsistencies in inspection practices throughout the state.

Because data in Chapter 2 showed a weak relationship statewide between the number of residents in a facility and the number of deficiencies it received, we also looked at the average size of the facilities in each district. We found that:

- **Overall, differences in the average size of nursing homes in each of the state's inspection districts do not explain differences in the number of deficiencies issued.**

Table 3.3 shows how districts rank on the average size of their nursing homes and the number of deficiencies issued during the most recent round of inspections. As these data show, the Metro A district ranks first in the size of its nursing homes and second in the average number of deficiencies issued while the Mankato

<sup>9</sup> To calculate the extent of cross-referencing, we did not eliminate quality of care or quality of life deficiencies that were totally cross-referenced to other deficiencies because deficiencies in these two categories may reflect substandard care problems in facilities.

<sup>10</sup> Minnesota Department of Health, *Information Bulletin 04-09* (St. Paul, June 2004).

**Table 3.3: Average Size of Minnesota Nursing Homes and Number of Deficiencies Issued by District**

<u>District</u>	<u>Average Number of Residents</u>	<u>Rank</u>	<u>Average Number of Deficiencies</u>	<u>Rank</u>
Bemidji	67	9	10.7	3
Duluth	87	5	13.2	1
Fergus Falls	75	7	10.2	4
Mankato	65	10	7.4	10
Metro A	110	1	11.1	2
Metro B	99	4	8.5	8
Metro C	108	2	10.1	5
Metro D	106	3	8.1	9
Rochester	73	8	9.6	6
St. Cloud	79	6	9.6	7
Statewide	87		9.7	

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

district ranks last on both measures. However, the Bemidji district ranks third in the number of deficiencies issued, but ninth in the size of its facilities. Conversely, Metro D ranks third in the size of its facilities, but ninth in the average number of deficiencies issued.

Finally, it is important to note that Minnesota is not the only state that is concerned about the consistency with which its inspection teams issue deficiencies. Recent studies of the inspection process in California, Kansas, Missouri, Montana, and Wisconsin have examined various consistency issues, such as differences in the average number of deficiencies issued by teams in different parts of those states.<sup>11</sup> However, none of the studies have pointed out the definitive reasons for inspection team variation. Likewise, the federal government is not immune to consistency problems. According to various reports by GAO and others, including our own analysis in Chapter 2, federal regions of the country differ significantly in the average number of deficiencies cited per nursing home.<sup>12</sup>

<sup>11</sup> California State Auditor, *Oversight of Long-Term Care Programs* (Sacramento, CA, April 2004); Kansas Legislative Division of Post Audit, *Kansas' Nursing Home Inspections: A K-Audit Determining Whether They're Carried Out in a Reasonable Manner* (Topeka, KA, December 2001); Missouri Office of State Auditor, *Review of the Division of Aging's Monitoring of Nursing Homes and Handling of Complaint Investigations* (Jefferson City, MO, March 1, 2000); Montana Legislative Audit Division, *Nursing Home Surveys* (Helena, MT, January 2003); and Wisconsin Legislative Audit Bureau, *Regulation of Nursing Homes and Assisted Living Facilities* (Madison, WI, December 2002).

<sup>12</sup> For example, see: GAO, *Nursing Home Quality*; U.S. Department of Health and Human Services, *Nursing Home Deficiency Trends and Survey and Certification Process Consistency* (Washington, DC, March 2003); and Appendix A of this report.

## Determining Scope and Severity

We also looked at whether inspection teams were consistent in how they classified the scope and severity of deficiencies once they were identified. We examined the most recent inspection reports for a sample of 100 nursing homes—10 facilities chosen at random in each of the state’s 10 geographic districts.<sup>13</sup> These inspections resulted in nursing homes receiving 978 deficiencies (excluding level “A” deficiencies).

### Classification Problems

We compared the deficiencies as written in the final inspection report with federal regulations and guidelines, paying special attention to each deficiency’s scope and severity rating and the federal regulation under which the deficiency was written. We found that:

- **While there were some inconsistencies among inspection teams in how they classified deficiencies, the problems were generally minor and did not threaten the overall integrity of the inspection process.**

Overall, inspection teams generally did a good job classifying the deficiencies that they identified and most of the deficiencies seemed reasonable. We questioned the scope, severity, or regulation under which deficiencies were written for about 9 percent of the deficiencies that we examined. The percentage that we questioned varied by district and ranged from about 5 percent for the Mankato and Metro B districts to 18 percent for Metro D. In general, inspection reports tended to understate the scope or severity of deficiencies more often than they overstated them.

We most often questioned whether inspection teams correctly classified the scope of a deficiency. For example, in one instance, the inspection team documented that a resident’s care plan failed to address the need for a lap buddy or anti-slip pad on the wheelchair. Instead of issuing a level “D” deficiency (isolated) because only one resident was affected, the inspection team issued a level “E” deficiency (pattern), a classification generally reserved for violations that affect three or more residents. In another case, the inspection team documented that a facility did not take action after residents complained about meals being served late in one of six units in the facility. As a result, the team issued two deficiencies: one for not resolving resident grievances and another for not accommodating resident preferences. However, the first deficiency was cited as an “E” (pattern), whereas the second was cited as a “D” (isolated).

We questioned fewer severity ratings that inspection teams assigned deficiencies. In one instance, a facility received a level “C” deficiency for having one of two emergency doors obstructed. Most inspection teams cite similar problems at a higher level because residents could be seriously harmed if they could not escape the facility during an emergency. In another instance, inspectors cited numerous examples of unsanitary kitchen conditions, including dust and dirt, dried food on

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**We questioned how inspection teams classified about 9 percent of the deficiencies we examined.**

<sup>13</sup> The inspections were done between December 2002 and March 2004. Our review was limited to examining only those deficiencies that were issued in the final inspection report; we do not know the extent to which inspection teams overlooked a violation.

equipment, and a refrigerator that was kept too warm. Instead of receiving an “F” level deficiency because of the potential for resident harm, the facility received a level “C” deficiency, which reflects the potential for resident discomfort.

In a few cases, inspection teams cited the wrong regulation in writing the inspection report, used the same incident to issue two mutually-exclusive deficiencies, or made some other error in completing the inspection report. For example, an inspection team cited one facility for placing a wet food processor lid under a plastic cover and for having a number of baking sheets and



To help prevent accidents, nursing homes must keep corridors free from obstructions.

pans darkened with food debris. Instead of citing the facility for not preparing, distributing, and serving food under sanitary conditions, the facility was cited for failing to obtain food from sources approved or considered satisfactory by state, federal, or local authorities.

As discussed in Chapter 2, CMS does not require that states report “A” level deficiencies to the federal government. Like most other states, MDH does not keep track of them, although inspectors record level “A” deficiencies during inspections and pass them on to nursing homes. We found that:

- **Most inspection teams did not issue level “A” deficiencies, which reflect isolated situations that have the potential for resident discomfort.**

Out of the nearly 1,000 deficiencies issued in our sample, inspection teams issued only 16 level “A” deficiencies. Of the ten districts, Metro C issued eight level “A” deficiencies and five districts (Bemidji, Metro A, Metro D, Rochester, and St. Cloud) did not issue any. Some of the inspectors that we talked with indicated that they could not think of an instance where they would issue one. We noted that most of the incidents cited as level “A” deficiencies were typically cited at the “D” level by other inspection teams. For example, one inspection team issued an “A” level deficiency when it observed staff failing to wash their hands when it was necessary; almost all other inspection teams issue such a finding as a “D” level deficiency. In another instance, a facility received a deficiency at the “A” level when it failed to have two of its residents visited by a physician at least once every 60 days. Other inspection teams cite non-timely physician visits at the “D” level.

## “Serious” Deficiencies

To better understand the circumstances surrounding the most serious types of deficiencies, we also reviewed the 11 inspection reports from the most recent inspections that involved substandard care or immediate jeopardy deficiencies. In examining these reports as well as the 100 inspection reports from our sample of nursing homes, we found that:

- **For the most part, state inspection teams were consistent in classifying the most “serious” deficiencies, those at levels “G” and above.**

In our review of inspection reports, we found a few instances where we thought that an inspection team understated the seriousness of a deficiency (that is, where we thought that the deficiency should have been issued at level “G” or above). In one instance, an inspection team issued a “D” level deficiency after a resident who suffered from depression and anxiety lost 45 pounds over a three-month period and the facility failed to address her need for psychological counseling. In another instance, a facility received a “D” level deficiency when a resident failed to receive regular pain medication for five months despite facility records indicating that the resident needed regular treatment to control chronic pain.

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**We found few problems with how inspectors classified the most “serious” deficiencies.**

Some of the instances where we thought that inspectors should have issued a level “G” or higher deficiency involved two or more deficiencies that were at least partially cross-referenced to one another. In these cases, inspection teams typically issued one deficiency at level “G” and the other at level “D.” According to the *State Operations Manual (SOM)* though, if the team’s findings for a particular requirement include examples at various severity or scope levels, the deficiency should be

classified at the highest level of severity, even if most of the evidence corresponds to a lower level of severity.<sup>14</sup> For example, in one facility a newly admitted resident, previously hospitalized for knee surgery, had to wait two hours before receiving pain medication. The nursing staff could not find the medication the resident had been receiving in its emergency kit and staff



Inspection teams must observe how nursing home staff administer medication to residents.

had to “borrow” medication from another resident. The facility received a “G” level deficiency for not providing services necessary to attain a resident’s highest practicable well being and a “D” level deficiency for not providing the necessary pharmacy services to meet the resident’s emergency needs.

<sup>14</sup> CMS, *State Operations Manual*, Appendix P, IV, D.

To supplement our random sample of 100 nursing homes, we also looked at the most recent inspection reports for facilities that were cited for providing residents with substandard care or placing them in immediate jeopardy.<sup>15</sup> We did not find any instances where inspection teams overstated resident harm (that is, where we thought that a level “G” or higher deficiency should have been issued at a lower level). The most common reason for issuing a finding of substandard resident care or immediate jeopardy was when a facility failed to provide adequate supervision or assistive devices to prevent accidents. For example, inspectors cited one facility for not supervising or implementing interventions for 5 of 6 cognitively-impaired residents who had repeatedly attempted to leave the facility, often successfully, even though the residents were identified as elopement risks.

As we discussed earlier in Chapter 2, the number of deficiencies issued at level “G” or above decreased 54 percent over the last few rounds of inspections in Minnesota. According to MDH, part of the reason for the decline was in response to CMS’ concern that Minnesota was not interpreting resident harm the way that it should be—actual harm has to result in a lifestyle change for a resident or be of more than “limited consequence.” By this definition, it is difficult to issue a deficiency at level “G” or above. For example, if a resident fell, but was not seriously hurt, the resulting deficiency would be issued as a “D” rather than “G” level deficiency. As noted earlier, GAO has expressed concern to CMS over the definition of resident harm, indicating that the confusing definition has led to inconsistency problems in identifying level “G” and above deficiencies in a number of states.<sup>16</sup> At that time, CMS indicated that its definition of resident harm was not meant to be as restrictive as some states were interpreting it, but, as noted earlier, CMS has yet to clarify how it defines resident harm.

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**The federal Government Accountability Office (GAO) found that states vary in how they interpret resident harm.**

MDH requires that inspection teams consult with their district supervisors whenever teams think they might have a level “G” or higher deficiency or a finding of immediate jeopardy. District supervisors make the final decision whether inspection teams have collected enough evidence to document a level “G” or higher deficiency. For situations involving immediate jeopardy, the district supervisor consults with program administrators in the central office, who make the final determination.

### **Proliferation of “D” Level Deficiencies**

In keeping with how CMS defines the severity of deficiencies, our review of inspection reports showed that:

- **The seriousness of “D” level deficiencies varies widely, ranging from isolated minor violations with little potential for harm to practices that could lead to serious resident harm if left uncorrected.**

In our opinion, this mixing of seriousness blurs the significance of “D” level deficiencies. For example, we found one facility receiving a level “D” deficiency for not giving a resident who was on a calorie restricted diet a cookie the first time

<sup>15</sup> Most often, the same incidents resulted in a finding of substandard care as well as immediate jeopardy. Seven of the nine facilities that inspectors cited for substandard care in their most recent inspection were cited at levels high enough (“J” or above) to likewise trigger a situation of immediate jeopardy.

<sup>16</sup> GAO, *Nursing Home Quality*, 19-20, 45-46.

she asked for one. Another facility received a level “D” deficiency for failing to adequately supervise a cognitively impaired resident who was missing from the facility from 6:00 PM to 12:30 AM (when she returned to the facility disheveled and smelling of alcohol). The potential ramifications of both deficiencies differ drastically, yet both were classified at the same level of seriousness.

In a few instances, we thought that citing every instance of noncompliance with a regulation—though perhaps technically correct—was somewhat unreasonable. For example, a facility was cited with a level “D” deficiency because one of three employees interviewed did not know what to do in case of a fire. However, the employee in question had only started work the previous day and had not received orientation yet. The other two employees questioned answered satisfactorily. In another example, a facility received a deficiency because the floor covering in one lounge was dirty and frayed even though the nursing home administrator indicated that the flooring was scheduled to be replaced in an upcoming building project. In both of these instances, it may have been better if the team examined the totality of the facilities’ systems to ensure resident safety or the special circumstances of the finding before issuing the deficiency.

Moreover:

- **The large increase in deficiencies, especially isolated, low-level ones, has further strained the relationship between the Minnesota Department of Health and nursing home providers.**

Most nursing home administrators told us that issuing deficiencies for relatively minor violations that have little potential for harm has created staff morale problems for facilities. In addition, administrators were concerned that the public was not receiving enough information about the deficiencies cited (for example, the severity of the violation and the number of residents affected) to put them in proper context. Many of the inspection teams that we talked with agreed. Furthermore, they indicated that, in the last year, the department has taken away their ability to use their professional judgment in determining whether some deficient events are truly deficiencies or isolated lapses.

## ACTIVITIES TO ADDRESS INSPECTION CONSISTENCY

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**It is unreasonable to expect absolute consistency among inspection teams.**

Because nursing home inspection teams must use their professional judgment in determining whether residents are receiving appropriate care or how serious an incident may be, it is unrealistic to expect absolute consistency among inspectors. However, it is not unreasonable to expect that state and federal governments establish appropriate policies and procedures to ensure that regulations are applied in as consistent and meaningful manner as possible.

## State Oversight

As shown in Table 3.4, MDH has engaged in a variety of on-going activities and special, one-time projects to help promote consistent interpretation and application of nursing home regulations. We concluded, however, that:

- **MDH does not have an effective quality assurance program that routinely examines and measures how inspection teams are applying nursing home standards.**

Among other things, MDH relies on district supervisors to review the inspection reports issued by their staff.<sup>17</sup> As we pointed out earlier, numerous managers and supervisors review all higher-level deficiencies (level “G” and above) before inspection teams are permitted to cite them. In contrast, there is no such check on lower-level deficiencies (which comprise the vast majority of deficiencies and are among the fastest growing) other than that performed by district supervisors. However, most district supervisors told us that they do not have enough time to

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### Table 3.4: Minnesota Department of Health Activities to Oversee the Inspection Process

#### Ongoing Activities

- District Supervision: District supervisors are responsible for monitoring, evaluating, and mentoring inspectors and reviewing draft inspection reports.
- Supervisory Review of Higher-Level Deficiencies: Inspection teams must consult with their district supervisor before issuing a deficiency at level “G” or above or when they might have a finding of immediate jeopardy.
- District Supervisor Meetings: Supervisors attend monthly meetings in St. Paul and hold weekly telephone conference calls.
- Inspector Conferences Calls: All inspectors and supervisors participate in a two to three hour statewide telephone conference about four times a year.
- Mixed-Team Inspections: Inspectors periodically inspect nursing homes with inspectors from other districts.
- Statewide Inspectors: Four inspectors with specialized backgrounds accompany each inspection team at least once a year.

#### Special, One-Time Projects

- On-Site Mentoring and Coaching Surveys: From October 2003 through November 2004, all inspection teams were accompanied on-site by at least five different district supervisors.
- Environmental Deficiency Review: From March through July 2004, MDH management reviewed physical environment deficiencies prior to their issuance.
- Deficiency Review: In October 2003, MDH conducted training on deficiency writing and review.
- Re-Inspection: In early 2003, MDH management re-inspected a nursing home shortly after district inspectors completed their annual inspection.

SOURCES: Minnesota Department of Health, *Actions to Promote Integrity Through Consistent Implementation of the Survey Process* (St. Paul, 2004); and Office of the Legislative Auditor interviews with MDH staff.

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<sup>17</sup> After their review, district supervisors send the final inspection reports to facilities and CMS. They also review and approve facilities’ plans of correction.

routinely review all deficiencies before inspection reports are finalized. Furthermore, their review does not help identify differences that may exist among inspection teams in different parts of the state.

The department holds a variety of routine meetings to help address inspection related problems and concerns. It conducts a two to three hour statewide telephone conference call with all inspectors and supervisors about four times a year to provide clinical updates, interpretive guidance, and inspection process clarifications. The department also holds monthly district supervisor meetings in St. Paul to discuss inspection findings, identify areas that need clarification, review workload, and resolve consistency-related issues. To provide for more frequent communication, the department also conducts “Monday morning” telephone conferences calls with all district supervisors. District supervisors are expected to share whatever they learn at the monthly and weekly conferences with their respective staff.

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**MDH has used a variety of ongoing activities and special projects to oversee the inspection process.**

Most of the inspection teams that we talked with, though, were skeptical about the value of the quarterly conference calls, citing many technical-related problems as well as little follow-up by central management in terms of providing written clarification or guidance about problems discussed. Many district supervisors were likewise skeptical about the value of the monthly meetings that they attended in St. Paul. They noted that, while many important issues were discussed, department management generally failed to follow through by developing a written position on issues of concern in the field. A common refrain that we heard from many district supervisors and inspectors was that “nothing ever happens” as a result of the meetings that they attend.

In the absence of an effective ongoing quality assurance program, MDH has had to undertake various one-time activities to respond to recent legislative and provider concerns about inspection consistency. These one-time activities, which included (1) on-site mentoring and coaching by supervisors, (2) an environmental deficiency review, (3) quality assurance review, and (4) one nursing home re-inspection, have yielded some useful information. For example, in March 2004, MDH began reviewing all deficiencies related to the physical environment of nursing homes prior to issuing them.<sup>18</sup> The department reviewed 195 deficiencies and found that inspectors accurately assigned scope and severity ratings 91 percent of the time. As discussed earlier, the one nursing home re-inspection that the department performed led to a major change in inspection practices. However, these projects have been undertaken sporadically and generally as a reaction to criticism from others—largely because MDH does not have an ongoing, centralized quality assurance program that it can rely on to both anticipate and respond to outside criticism and to help direct its own activities.

MDH staff told us that it was a management decision to forgo more ongoing activities in favor of one-time projects. In light of the seriousness of the issues being raised, the department wanted to better focus its resources. At the same time, department management recognized that some of the projects would decrease the amount of time district supervisors had available to routinely monitor their staff.

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<sup>18</sup> Minnesota Department of Health, *Dietary, Sanitation, and Environmental Tags Review Summary* (St. Paul, undated).

## Federal Oversight

The federal government engages in three activities to help ensure that inspection teams across the country are implementing the nursing home inspection program consistently. These include: (1) Federal Oversight/Support Surveys (FOSS) where one or more federal inspectors observe and evaluate how well state teams conduct individual inspections; (2) comparative inspections (also called “look-behinds”) where federal inspectors essentially replicate an inspection done a few weeks earlier by a state team; and (3) an annual state performance standard report, which measures how well individual states perform on a number of comparative measures. District supervisors routinely receive copies of all FOSS reports and comparative inspections. They distribute the reports that are related to facilities in their district to their staff.

In reviewing available documents over federal fiscal years 2003 and 2004, we found that:

- **The federal government has generally given Minnesota satisfactory or higher marks for how it implements and conducts nursing home inspections statewide—slightly higher ratings than it has given other states in the Chicago region.**

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**As part of the oversight program, federal staff accompany state inspectors on about 5 percent of inspections.**

FOSS reports use a scale from one (much less than satisfactory) to five (extremely effective) to grade state inspection teams in six different categories (identification of inspection concerns, sample selection, general investigation, kitchen/food service investigation, medications investigation, and deficiency determination). State inspection teams rarely received a rating below 3 (satisfactory). During federal fiscal year 2004, federal investigators observed Minnesota inspection teams on 16 nursing home inspections. Minnesota inspectors received an average rating of 4.57; average ratings by category ranged from 4.07 (deficiency determination) to 4.93 (kitchen and food service investigation).<sup>19</sup> Ratings were slightly lower in 2003 when federal investigators observed 20 inspections in Minnesota. Average ratings for federal fiscal year 2003 were 4.45 overall, with individual ratings ranging from 3.95 (general investigation) to 4.80 (sample selection).<sup>20</sup>

For the last two federal fiscal years, CMS has issued a *State Performance Standard Review Report*, which is based partially on the FOSS reports.<sup>21</sup> The performance report measures Minnesota’s performance against seven standards: (1) inspections are planned, scheduled, and conducted in a timely fashion; (2) findings are supportable; (3) certifications are fully documented and consistent with applicable law, regulations, and general instructions; (4) adherence to proper procedures when certifying noncompliance; (5) proper expenditures and charges; (6) accurate and timely complaint investigations; and (7) accurate and timely data

<sup>19</sup> Office of the Legislative Auditor analysis of 16 FOSS reports for federal fiscal year 2004.

<sup>20</sup> Office of the Legislative Auditor analysis of 20 FOSS reports for federal fiscal year 2003.

<sup>21</sup> Centers for Medicare and Medicaid Services, *Final FY 2003 State Performance Standard Review Report* (Washington, DC, March 15, 2004) and *Final FY 2002 State Performance Standard Review Report* (Washington, DC, March 14, 2003).

entry. For federal fiscal year 2003, Minnesota fully met five of the performance standards and partially met the remaining two (timely and accurate complaint investigation and data entry).

In Minnesota's 2003 report, CMS also looked at how state inspection teams determined deficiencies for 21 nursing home inspections (18 FOSS inspections and 3 comparative inspections), which represent 5 percent of the inspections done in Minnesota. The federal government rated state teams on 103 measures for the FOSS inspections. Minnesota was rated at or above the satisfactory level on 99 measures (96 percent) and "less than satisfactory" on 4 measures (4 percent). Overall, the states in the Chicago region (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin) had 95 percent of the measures rated satisfactory or above.

The report also reviewed the scope and severity ratings of the 155 deficiencies that state inspectors initially cited during the 18 FOSS reviews. Federal investigators compared those ratings to what appeared in the final inspection report filed with the federal government. For 19 deficiencies (12.3 percent), federal investigators felt that state inspectors had insufficient evidence to document the discrepancy between what was cited in the draft inspection report and the final report.<sup>22</sup> The discrepancy rate for the Chicago region was also 12.3 percent.

In addition, CMS analyzed the extent to which it agreed with the 153 deficiencies cited in the final inspection reports. For 2003, CMS agreed with the scope and severity ratings MDH inspection teams assigned to 98 percent of the deficiencies issued; the comparable figure for the Chicago region was 93 percent.<sup>23</sup>

## OTHER ISSUES

Overall we think that the nursing home inspection process has many strong points: (1) inspections are team-based, (2) inspection teams rely heavily on observation, interviews, and resident outcomes, and (3) inspections are unannounced and occur at diverse times of the day and week. In addition, state inspectors and their supervisors are well trained and experienced. As of July 2004, 73 of the 77 inspectors (95 percent) were registered nurses. There were also two social workers that specialized in facility programs, one nutritionist, and one medical records specialist.<sup>24</sup> About one-third of the inspectors were hired

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<sup>22</sup> The federal government defines satisfactory performance as an unjustified discrepancy rate of 20 percent or less.

<sup>23</sup> MDH inspectors either did not write a deficiency or changed its scope or severity rating for 10 of the 19 deficiencies that the federal government disagreed with at the time of the inspection. If federal officials had not been at the inspection, it is likely that the deficiencies would have appeared in the final inspection report. Adding the ten deficiencies not cited because of "federal involvement" and the three deficiencies that federal inspectors did not agree with in the final report yields an 8 percent "error" rate for MDH inspectors—comparable to the 9 percent that we found.

<sup>24</sup> At the beginning of our study, MDH also employed a sanitation specialist. He died during the course of our study and, to date, has not been replaced. The department has recently hired more inspectors from other disciplines, including occupational therapy and physical therapy, and plans to add staff with other professional backgrounds, such as pharmacy.

within the last two years, and about one-fifth had over ten years experience as an inspector, for an overall median tenure of about six years. Most of the inspectors had prior nursing home experience, and about one-fifth were directors of nursing at some point before becoming an inspector. To supplement their professional background, newly hired inspectors receive extensive state sponsored training in addition to the week-long training program and written exam that the federal government requires.<sup>25</sup>

District supervisors also have extensive long term care backgrounds. On average, they have been with the department for eight years—five of those years as a supervisor. About one-half previously worked as inspectors for the department, and all have had other long term care experience.

The inspection process, though, has a few problems that have contributed to low morale among inspectors and, at times, high turnover.<sup>26</sup> Specifically:

- **Different travel policies, expanded evening observation requirements, and poor communication have contributed to low morale among nursing home inspectors.**

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**Travel-related concerns are sensitive issues for nursing home inspectors.**

First, some travel policies for nursing home inspectors are different from those for other state employees. Several MDH policy statements and Memoranda of Understanding with the Minnesota Nurses Association (the bargaining unit that represents nursing home inspectors, among others) govern how inspectors are reimbursed for travel expenses and how they are compensated for their travel time.<sup>27</sup> Travel-related issues are sensitive issues for inspectors because they spend very little time in their office, especially those based outside the Twin Cities metropolitan area. Most inspection teams that we talked with are “on-the-road” four days a week. Because their jobs entail considerable travel to and from facilities as well as unconventional work hours, inspectors generally leave for work from their home.

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<sup>25</sup> Before inspectors attend the mandatory federal training, the department requires that newly hired inspectors complete a two-month training program consisting of classroom instruction. This is followed by a supervised on-site inspection component in which they accompany teams on actual inspections. Most newly hired inspectors spend several more months participating in inspections under the supervision of an experienced inspector. When we talked with inspection teams from around the state, almost all were very satisfied with the inspection-related training that they received to do their jobs. At the same time, many noted that additional computer training would be helpful, including more training specifically related to filling out expense reports, time sheets, and other department reports.

<sup>26</sup> The department experienced significant turnover among its licensing and certification staff in 2002 when it adopted new travel and scheduling requirements for inspectors. Turnover (including retirements) was 15 percent in 2002 compared with 7 percent in 2001 and 8 percent in 2003. Cecelia Jackson, Information and Compliance Monitoring Division, Minnesota Department of Health, interview by author, In person, St. Paul, Minnesota, August 1, 2004.

<sup>27</sup> Minnesota Department of Health, *Compensated Travel Time Policy* (St. Paul, September 30, 2002); Minnesota Department of Health, *Overnight Stay Policy* (St. Paul, September 30, 2002); Minnesota Department of Health, *Policies and Procedures: Vehicle Use* (St. Paul, May 2004); and *Memorandum of Understanding Between the State of Minnesota and Minnesota Nurses Association Regarding Compensated Travel Time* (St. Paul, September 4, 2002).

Like many other state employees who use their own vehicles to commute directly from home to a temporary worksite, state inspectors are reimbursed for the actual mileage from their home or office, whichever is less. However, inspectors in the four Twin Cities district offices are usually reimbursed at a lower rate than other inspectors (and some other state employees) because MDH generally has state vehicles available that staff could use. Inspectors told us, though, that it is not always convenient or easy to pick up or drop off a state vehicle, especially outside of “normal” office hours. Also, to ensure that inspectors are not being compensated for routine commuting time, nursing home inspectors who travel directly to a facility from home (or vice versa) are compensated only for the time that it takes to drive to a facility in excess of 20 miles from their office. The department calculates compensated travel time at 2 minutes per mile for inspectors in the four Twin Cities districts and 1.5 minutes per mile for inspectors in the six remaining districts. Finally, inspectors are reimbursed for hotel expenses if their compensated travel time one way exceeds one hour and the inspection lasts more than one day.

Second, federal nursing inspection regulations require that inspectors observe resident care and services at different times of the day, including early morning and evening (“off-hours”). The regulations do not, however, specifically quantify how much off-hour time inspectors must spend at a facility. Concerned over the wide variation in the amount of off-hour time inspectors in different parts of the state spent in facilities and the vagueness of the federal regulations, MDH entered into a Memorandum of Understanding with the Minnesota Nurses Association that requires inspection teams to spend at least two hours observing residents between 6:00 PM and 9:00 PM for every 36 hours of inspection time at each facility.<sup>28</sup> In addition, inspection teams must conduct evening observations on more than one day of the inspection in two facilities each month. The memorandum requires that the department determine in advance of the inspection which facilities inspectors will stay “late” in, subject to the approval of the district supervisor. Nursing home inspectors told us that they used to be able to use their professional judgment regarding when to stay late, depending on the conditions they encountered during an inspection. They indicated that there are times when facilities do not need to have additional late observations, but they must stay anyway, resulting in an inefficient use of staff time.

Third, communication between inspectors and central management in MDH could be improved. The majority of the inspectors that we talked with felt “unappreciated” or “betrayed” by central office management. Many inspectors believe that MDH did not “defend” staff at the day-long hearing held by the Health and Human Services Policy Committee of the Minnesota House of Representatives in February 2004 or in the days thereafter.<sup>29</sup> Instead, they said that central management “assumed” that inspectors were not doing their jobs correctly throughout the state. In addition, some felt “betrayed” in the aftermath

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<sup>28</sup> *Memorandum of Understanding Between the State of Minnesota and Minnesota Nurses Association Regarding Scheduling of Work* (St. Paul, September 4, 2002), 1.

<sup>29</sup> Minnesota House of Representatives, House Health and Human Services Policy Committee, February 25, 2004.

of the department's re-inspection of one nursing home using central office staff rather than district inspectors. Most inspection teams reported that their ability to use their professional discretion was taken away.

Despite low morale, all of the inspection teams that we talked with found much satisfaction in the work they did. They believed their work improved the lives or care of the elderly throughout the state. They enjoyed working as part of a team and looked forward to meeting and talking with nursing home staff and residents.

Minnesota Department of Health management is aware of the problems that inspectors have with their travel and work schedules. At the request of the Minnesota Nurses Association, the department is meeting with association representatives to discuss inspectors' concerns. Until such time as changes are made to the negotiated agreements, however, MDH indicates that it has little recourse but to abide by them.

## RECOMMENDATIONS

Our report makes three recommendations that we think will help address some of the concerns that legislators, MDH staff, providers, advocacy groups, and other stakeholders have about the nursing home inspection program. The recommendations also should help improve the adversarial relationship that exists between MDH and providers. We agree with the Commissioner of Health's recent decision to retain the Long Term Care Issues Ad Hoc Committee that she created in 2003 so that the committee can continue to work on communication problems among various stakeholders. The group consists of nursing home providers, representatives from provider, advocacy, and professional organizations, and various state agency and legislative staff. In addition, the department is working on improving communication between state inspectors and providers during the inspection process. It has obtained federal funds to hire a provider liaison that will, among other things, develop consistent standards of behavior that inspection teams and facility staff can use during the inspection process.

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**MDH is working on improving communication among various nursing home stakeholders.**

## Quality Assurance

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### RECOMMENDATION

*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.*

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Our major concern about MDH's nursing home inspection program has to do with the department's inability to systematically identify inspection-related problems before they become major issues. This makes it difficult to respond to the concerns of providers, legislators, and advocacy groups in a timely manner. The

department should implement an ongoing quality assurance program that routinely examines inspection reports statewide, and should rely less on special one-time projects developed largely to respond to outside criticisms. Currently, MDH does not centrally review inspection reports or the vast majority of deficiencies issued, thereby neglecting the largest and some of the fastest growing categories of deficiencies—those at levels “D” and “E.” Such reviews would allow the department to identify and address problems or concerns, such as the growth of “D” level deficiencies, issuing level “A” deficiencies, or discrepancies among districts in issuing certain types of deficiencies.

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**MDH needs to have a more centralized review process for lower-level deficiencies.**

A recent report from the Office of Inspector General in the U.S. Department of Health and Human Services found that 31 states had formal internal quality assurance programs to review draft inspection reports.<sup>30</sup> For example, Indiana has nurses who do nothing but review inspection reports from across the state before they are issued. In addition to meeting monthly to review problems or issues, staff “run the book” once a year, a process whereby they discuss problems or concerns regarding how Indiana inspection teams use each deficiency. Ohio has one program manager that routinely monitors, on a statewide basis, the deficiencies issued by each district, looking for outliers or areas that might need more clarification.

In 2003, GAO recommended that CMS require states to have a quality assurance process that includes, at a minimum, a review of a sample of inspection reports below the level of actual harm to help reduce instances of inspectors understating quality of care problems.<sup>31</sup> In its comments to the GAO, New York stated that it had implemented such a process and was experiencing positive results. New York uses these reviews to provide inspector feedback and expects that instances where deficiencies may be understated will decline. Although we did not detect major problems with state inspection teams understating the seriousness of deficiencies, routinely reviewing all lower-level deficiencies on a statewide basis might help the state deal with the large increase in “D” level deficiencies and the subsequent “blurring” of their significance that we discussed earlier.

It should be noted that MDH has already embarked on an improved quality assurance program as a result of the reports issued by the Department of Administration in mid-2004.<sup>32</sup> For example, the department has created a quality assurance position that it hopes to fill in the near future. This person’s responsibilities will include implementing routine monitoring procedures regarding the inspection process.

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<sup>30</sup> U.S. Department of Health and Human Services, *Deficiency Trends*, 18.

<sup>31</sup> GAO, *Nursing Home Quality*, 42.

<sup>32</sup> Minnesota Department of Administration, *Communications for Survey Improvement (CSI-MN)* (St. Paul, June 30, 2004); Minnesota Department of Administration, *Nursing Home Licensing and Certification* (St. Paul, June 30, 2004); and Minnesota Department of Health, *Survey Findings/Review Subcommittee Final Report* (St. Paul, July 2004).

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## Written Guidance

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### RECOMMENDATION

*The Minnesota Department of Health should provide more timely assistance to inspectors in interpreting federal regulations and guidelines, especially in the area of one-time events with no negative outcomes.*

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**Although nursing home inspections are significantly controlled by federal requirements, MDH needs to assume more ownership over the program in Minnesota.**

We also concluded that state inspectors need more written guidance from MDH to help them apply CMS' regulations consistently and meaningfully. In meeting with MDH staff throughout the state, we were struck by how strongly staff emphasized that the nursing home inspection program was a federal rather than a state program. We think that the department must assume more ownership over the inspection program. Until very recently, the department's approach has been to seek clarification from the federal government when regulations and guidelines are not clear, which can be a slow and fruitless approach. In the meantime, state inspection teams work with little state direction in key areas. We think that the department should be providing more guidance to inspectors, especially in areas where the federal regulations are not clear, such as one-time events with no negative outcomes.

We also noted that inspectors are not always informed about the results of appeals regarding deficiencies that they issued or about changes to inspection reports once they submit their draft reports to their supervisor. Inspectors indicated that knowing why a report was changed or why a deficiency did not withstand the appeal process would be a good training exercise. In addition, inspectors in one part of the state told of learning about a significant policy change in how inspections were to be conducted from the facility they were inspecting rather than from their district supervisor.

While an ongoing, centralized quality assurance program should enhance the department's ability to identify issues that need clarification before they become major problems, MDH also needs to respond to issues raised by supervisors and inspectors in a timely manner. District supervisors need to routinely bring district concerns to their monthly meetings where they should be discussed and resolved by the entire group of supervisors. This would help ensure a more consistent interpretation of unclear or confusing nursing home regulations statewide. Resolution of issues should be communicated to inspectors, both verbally and in writing (through the department's website), as well as to nursing home providers.

To some extent, MDH has become more proactive in the last year in terms of clarifying federal regulations that are unclear or problematic. For example, in June 2004, the department directed inspection teams to stop issuing multiple deficiencies for selected types of violations based on the same negative finding. According to the department, this would bring Minnesota inspection practices more in line with those of other states. The department had brought the issue to the attention of federal officials earlier, but CMS had not acted on the problem. Also, the department has aggressively pursued federal interpretations and guidance regarding the life safety standards that State Fire Marshall inspectors apply.

## Deficiency-Related Information

### RECOMMENDATION

*To supplement on-line inspection reports, the Minnesota Department of Health should develop a more user-friendly way to summarize and report on the seriousness of inspection deficiencies.*

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**MDH's on-line reporting of inspection results places too much emphasis on the number of deficiencies rather than their seriousness.**

In March 2004, MDH made nursing home inspection reports and nursing homes' plans of correction available on-line. However, the department failed to provide any summary information that would help consumers put the overall number of deficiencies in perspective. For example, it is difficult for consumers to distinguish between administrative deficiencies and quality of care or quality of life deficiencies. We think that the manner in which the state reports nursing home inspection results places too much emphasis on the number rather than the type or seriousness of deficiencies, which can be misleading to the public. The total number of deficiencies that a facility receives may be less important to consumers and policy makers than the seriousness of the deficiencies.

The state could provide summary information about deficiencies resulting in immediate jeopardy situations or findings of substandard care, or group deficiencies into categories of most interest to consumers, such as quality of care, quality of life, or resident rights. Another measure that may be of interest to the public is the extent to which inspectors cite a facility for the same deficiencies over time. Also, MDH could weight deficiencies by their scope and severity to better help consumers understand their seriousness. Not all states publish actual inspection reports on-line, but many states provide more summary information about the results of nursing home inspections. The summary information can help consumers distinguish among the seriousness of various deficiencies and rate one facility relative to the statewide average or to others in its geographic region.

For example, Florida computes an overall inspection score based on the number, scope, and severity of a facility's deficiencies and then assigns the facility anywhere from one to five "stars" based on whether it had fewer or less serious deficiencies relative to other facilities in its geographical region. A "five star" nursing home means that it ranks in the top 20th percentile of facilities in the region; a "one star" star facility ranks in the bottom 20th percentile. The overall score (which includes all possible deficiencies) is also broken down into three categories: administration, quality of care, and quality of life. Facilities are also assigned stars for selected inspection components, including dignity, nutrition and hydration, pressure sores, resident decline, and restraints and abuse. In addition, a panel of state agencies and provider associations in Florida awards "gold seals" to nursing homes with exceptionally high standards in managing care and quality of life for their residents. Performance criteria include: high quality of care ranking relative to other nursing homes in the region; no conditional licenses or nursing home watch list appearances in the previous 30 months; and an excellent record

with the state long-term care ombudsman. Implemented in 2002, the panel recently awarded 13 homes a gold seal for outstanding performance.<sup>33</sup>

In Indiana, each facility is scored against 45 standards related to administration, care and services, dietary, environment, and resident rights that the state believes are most indicative of quality care. Deficiencies in these areas are assigned a point value based on their scope and severity; facilities cited for substandard care or immediate jeopardy get additional points. Facilities receive a weighted score based on their scores from each of their last three inspections, although the most recent inspection is weighted the most heavily. The best score that a facility can receive is zero—which means that the facility did not receive any deficiencies in the 45 requirements used for scoring in its last three inspections, and there were no findings of substandard care or immediate jeopardy. As of November 24, 2004, the average score statewide in Indiana was 110, with 64 percent of the facilities scoring better than average and 36 percent scoring below average.<sup>34</sup>

To some extent, Minnesota is moving toward providing consumers easier access to information about nursing homes. At the direction of the Governor, MDH is developing a nursing home report card that will contain a variety of measures, including one related to inspection results. The department hopes that the report card will be available on-line in 2005.

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<sup>33</sup> Tampa Bay Business Journal, “Four Bay Area Nursing Homes Receive State Honors” (2004); [http://tampabay.bizjournals.com/tampabay/stories/2004/11/229/daily9.html?jst=b\\_1n\\_h1](http://tampabay.bizjournals.com/tampabay/stories/2004/11/229/daily9.html?jst=b_1n_h1); accessed November 30, 2004.

<sup>34</sup> Indiana State Department of Health, “Nursing Home Report Cards (2004); <http://www.state.in.us/isdh/regsvcs/lrc/repcard/rcgrp.htm>; accessed January 11, 2005.