Annual Quality Improvement Report: The Nursing Home Survey Process

REPORT TO THE MINNESOTA LEGISLATURE FOR FEDERAL FISCAL YEAR 2025

Annual Quality Improvement Report: The Nursing Home Survey Process

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Executive Summary

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

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

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

This report was prepared by staff of the Health Regulation Division (HRD). This report is the fifteenth annual report on the nursing home survey process and is based on analysis of data representing status of the program during Federal Fiscal Year 2025 (FFY25), which occurred from October 1, 2024, through September 30, 2025.

The development of this report allows the Department to reflect on both successes and areas for improvement. One area of success in FFY25 is improved consistency across the state between regional survey teams. In FFY25, a regional comparison within Minnesota reflects a difference of just under three deficiencies in the average number of health deficiencies issued per survey (2.83 deficiencies per survey), as compared to FFY24 with a regional comparison within Minnesota of 4.7 deficiencies per survey. This improvement reflects the department’s ongoing quality improvement and training efforts.

Introduction

Survey Process

General

The Licensing and Certification Program of the Health Regulation Division (HRD) at the Minnesota Department of Health (MDH) surveys nursing homes that are federally certified to provide care to Medicare and Medicaid residents using federal standards. MDH is under contract with the Center for Medicare and Medicaid Services (CMS) to conduct all federal certification inspections. There are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. MDH contracts with the Minnesota State Fire Marshall’s (SFM) office to conduct the LSC portion of the inspection, which must be completed within seven days of the health portion of the recertification survey. It is federally mandated that recertification surveys be conducted at least every 15.9 months, and that the statewide average interval between standard surveys of

skilled nursing facilities and nursing facilities not to exceed 12 months[1]. It is typical that a provider receives a recertification survey annually.

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

The LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The LSC, which is revised periodically, is a publication of the National Fire Protection Association (NFPA), which was founded in 1896 to promote the science and improve the methods of fire protection. The basic requirement for facilities participating in the Medicare and Medicaid programs is compliance with the 2012 edition of the LSC.

Surveys are unannounced and are conducted to make sure that the nursing home is meeting state licensing and federal certification standards. The survey review includes but is not limited to, quality of care and quality of life, whether residents' rights are observed, physician and nursing services, food and nutritional services, pharmacy services, infection control, freedom from abuse, and whether the facility meets environmental standards of cleanliness[2]. Facilities that do not meet all these standards must correct these deficiencies or they face a variety of federal and/or state sanctions. A deficiency indicates a provider's failure to meet a state licensure or federal certification requirement. Deficiencies range in scope and severity from isolated violations with no actual harm to residents to widespread violations that cause injuries or put residents in immediate jeopardy of harm.

When surveyors find a facility out of compliance with a federal regulatory requirement, the survey team issues a deficiency and corresponding state licensing order, and the facility is then required to correct the deficiency to come into compliance with regulatory requirements. A Statement of Deficiencies (CMS-2567) is provided to the nursing home, which contains the findings of the survey. A written Plan of Correction (PoC) is then required from the facility, and state surveyors conduct a revisit, either by desk review or onsite, to determine whether substantial compliance has been achieved.

The Revisit Process

Since the PoC serves as the facility's allegation of compliance, a post certification revisit (PCR) is conducted to determine whether substantial compliance has been achieved. Substantial compliance cannot be ascertained until facility compliance has been verified. Revisits may be conducted anytime for any level of noncompliance subject to the allowed number of revisits. Both paper/administrative reviews and onsite reviews are considered revisits. Two revisits are permitted at the State's discretion without prior approval from the regional office; a

[1] Medicare State Operations Manual Chapter 7 (pdf) (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c07pdf.pdf)

[2] For more information about nursing homes see the CMS web page: Nursing Homes - CMS (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes)

third revisit may be approved only by the CMS Regional Office[3]. See Appendix A for more information regarding the federal revisit policy and timing.

CMS Regulatory Updates

In fiscal year 2025, CMS directed two major changes for long-term care evaluations. The changes included implementation of regulatory updates and transitioning of the Long-Term Care (LTC) survey process platform from an application-based platform Aspen Central Office (ACO) to a web-based platform Quality Improvement & Evaluation system (iQIES).

Implementation of Regulatory Updates: In FFY25, CMS notified State Agencies of revised guidance for nursing home surveys. The revisions included changes to guidelines for admission, transfer and discharge, chemical restraints/unnecessary psychotropic medications, resident assessment nursing services, payroll-based journal, quality of life and quality of care, administration, quality assurance performance improvement, and infection prevention and control. In addition to updating the regulations, CMS also updated checklists, also known as the critical element pathways[4], for the survey staff to utilize while conducting investigations. The new guidance went into effect on April 28, 2025.

In response to the updated regulations, MDH provided education to all survey staff members, including formal training provided by the HRD Training and Quality team. In addition, supervisors reviewed and discussed changes with their survey team to ensure understanding. Survey staff also completed training provided by CMS. On January 21, 2025, MDH also provided education to nursing home providers via webinar to communicate the changes and encourage providers to review/revise their facility policies, provide education to their staff members, and implement change prior to the implementation of the regulations.

Platform Upgrade: The iQIES system replaced the older (legacy) reporting system and provided a single platform for the facility providers to submit information such as the Minimum Data Set, Payroll Based Journals, and other required reporting information. It aims to improve the provider experience by ensuring providers have secure, anytime access to their information with a single login. The transition to iQIES also enhanced the long-term care survey process (LTCSP) by allowing survey data provided to be merged instantly to improve communication, quality oversight and increase efficiency, which provides for better data and a more unified experience. CMS provided a training plan for State Agency staff in May 2025.

MDH developed a training plan by sending five staff members to a CMS “train-the-trainer” class. MDH also allowed time for all State Agency staff to view the CMS training and assigned each staff member a survey in the training/test environment to work through on their own or in a group. The HRD Training and Quality team provided support by live video trainings, attending individual team meetings, along with troubleshooting while staff members worked in the testing environment.

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[3] Medicare State Operations Manual Chapter 7 (pdf) (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c07pdf.pdf)

[4] Nursing Homes | CMS (https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes)

The full implementation from ACO to iQIES migration occurred on July 14, 2025. To support the survey staff members, a command center-style structure was developed in which each of the 10 individual teams were assigned to a staff member who had attended the train-the-trainer classes. As teams worked through the survey process, they each had a direct support staff to contact. As concerns were identified with the iQIES program, members of the HRD Training and Quality Team tracked all help desk tickets and communicated concerns and resolutions to staff members. Migration issues with survey processes between ACO and iQIES were identified and through consistent monitoring and communication with CMS and the website developers, all issues with migration were resolved.

Survey Techniques

There are varieties of techniques surveyors use to document, identify, and support deficiencies. In conducting the survey, surveyors use electronic worksheets or pathways, in conjunction with the Guidance to Surveyors. The Guidance to Surveyors assists in gathering information to determine whether the facility has met the requirements.[5]

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

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

Consistent training and surveyor competency is a priority for MDH. MDH has developed a full interdisciplinary team to ensure all aspects of patient/resident/client rights are maintained and upheld in each type of facility. MDH currently employees registered nurses, licensed nurses, occupational therapists, social workers, registered dieticians, and health care administrators to serve as evaluator staff.

CMS provides a mandatory annual Survey Skills Review (SSR) for each primary and secondary survey type. Most MDH surveyor staff members are required to test annually for LTC facilities as their primary survey type and Emergency Preparedness (EP) as their secondary survey type.

In addition to CMS required training, MDH has developed enhanced training for new and existing employees. All new staff members are guided through a 14-week training course, which includes a hybrid training model that offers both hands-on and computer-based skill building. The new survey staff members attend four weeks of lectures with the trainers, one week of technical training, one week of LTCSP training, two observation surveys, and three participatory surveys. The remaining weeks are scheduled training time to complete the required CMS training. MDH also provides ongoing training based on results of quality assurance monitoring and reviews of informal dispute resolution (IDR) and independent informal dispute resolutions (IIDR) outcomes. As

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[5] See Appendix PP: [Nursing Homes | CMS (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes)](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes)

inconsistences are identified, leadership will request support from the HRD Training and Quality team members and supervisors. In the past year, examples of additional investigation training provided to staff include falls from lifts, dialysis, kitchen procedures, infection control programs, protection of personal funds, cultural competency, and significant change nursing assessments.

MDH conducts quarterly video meetings along with annual in-person training for all survey staff members. During these meetings, education, facilitated group conversations, and guidance is provided to ensure understanding and interpretation of the Federal regulations as well as fostering professional growth and teamwork. In addition, the HRD training and quality team hosts weekly office hours for any staff member to have questions answered in real time.

Full transparency of our communication of CMS changes is also shared with the providers of Minnesota. This is obtained by hosting quarterly Nursing Home Regulatory Update calls with providers. During these meetings, the top ten frequently cited citations are reviewed followed by staff member presentations on topics to enhance the understanding of regulation implementation. In the past year education has been provided on topics such as falls from lifts, infection control, reporting abuse, and iQIES transitions.

Complaint Investigation Process

The Office of Health Facility Complaints (OHFC) was created by the Legislature in 1976 to review and investigate allegations of non-compliance with state regulations. Investigations of federal noncompliance were later added to OHFC's responsibilities to widen the safety net for vulnerable adults in Minnesota who reside in licensed facilities. For several years, complaint investigations were conducted which simultaneously addressed compliance with federal regulations and state statutes, as well as potential maltreatment as defined in the Minnesota vulnerable adult act. In December 2018, at CMS' direction, MDH made changes and aligned responsibility for the federal complaint program to be managed by the HRD Licensing and Certification (Federal) team. This created the current process for nursing home complaints, described below.

Minnesota state and federal laws authorize anyone to file a complaint about licensed health care facilities. Since July 2015, the Minnesota Adult Abuse Reporting Center (MAARC) has served as the centralized reporting system to file a complaint regarding a vulnerable adult in Minnesota. A complaint is an allegation of noncompliance with federal and/or state requirements. The complaint process must ensure that a person who has complained about the quality of care or other issues relating to a licensed or certified health care facility is not retaliated against for making the complaint. The complaint resolution process must include procedures to ensure accurate tracking of complaints received, including notification to the complainant that a complaint has been received, procedures to determine the likely severity of a complaint, and to ensure that the identity of the complainant will be kept confidential. All complaints are reviewed and triaged to achieve the best outcome for vulnerable adults.

Nursing homes are required to self-report incidents. The CMS State Operations Manual (SOM) Chapter 5[6] outlines the types of incidents a nursing home needs to self-report to the State Agency:

[6] 100-07 | CMS (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984)

- All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property;
- The results of all facility investigations involving alleged violations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property; and
- Reasonable suspicions of crimes against nursing home residents.

The CMS SOM also outlines the protocols to be followed by the state survey agency for investigations. Due to the similarities between the state and federal regulations for nursing homes, these federal protocols are utilized for nursing home investigations under both federal and state law. If an investigation substantiates noncompliance with state and/or federal regulations, deficiencies and/or state orders may be issued against the provider. The provider is responsible for correcting violations and assure compliance with applicable regulations within a specific timeframe to avoid further licensing sanctions and/or other penalties. If there were additional public protection needs from making a maltreatment determination under the Minnesota vulnerable adults act, the complaint is referred over to a separate team for additional investigation.

Vulnerable Adults Act

State law also mandates that allegations of maltreatment against a vulnerable adult be reported by the licensed health care entity. The Vulnerable Adults Act (VAA), first adopted in 1981, makes MDH a lead investigative agency for allegations of abuse, neglect, and financial exploitation of residents in licensed health care facilities.

The VAA requires the reporting of abuse, neglect, and financial exploitation which are defined in Minnesota Statutes, section 626.5572. Under federal regulations, Medicaid/Medicare certified facilities are also required to report alleged violations of abuse, neglect, mistreatment, and misappropriation of property. Reports made by providers are referred to as “Facility Self Reports” or “Facility Reported Incidents.”

Under the VAA, a preponderance of evidence is the legal standard of proof used in maltreatment investigations. To substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation. If an investigation of maltreatment is conducted, the state VAA allows for one of three determinations:

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

As mentioned earlier, a preponderance of evidence is a legal standard of proof used in maltreatment investigations. To substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation is true. Findings of maltreatment investigations are available on the MDH website.[7]

[7] HCP Evaluation and Investigation Results

If maltreatment is substantiated, MDH must make a further determination of whether the facility, an individual perpetrator, or both, are responsible for the maltreatment. When an individual is held responsible for maltreatment, this impacts their ability to work in regulated health care facilities in the future in several ways. First, the finding is reported to their licensing board, if applicable, such as the Board of Nursing (BON) for nurses or the Board of Executives for Long Term Services and Supports (BELTSS) for licensed nursing home administrators or licensed health services executives. Next, if the individual is on the nurse aide registry, the finding will be placed on the registry. Finally, the maltreatment finding is reported to the DHS background studies unit for possible disqualification under Minnesota Statutes 245C.

MN Survey Findings

Minnesota is part of the Center for Medicare and Medicaid Services (CMS) Chicago Region V, which is comprised of six states.[8] As mentioned in the previous section, there are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. The following section provides detailed information related to survey results and outcomes in FFY25 within our federal Chicago Region V and regional data within the state.

Number of Deficiencies – Chicago Region V

Health Deficiencies Issued

In FFY25, Minnesota issued an average of 7.0 deficiencies per health recertification survey, which is slightly higher than the FFY24 average of 6.6 deficiencies per survey.

Table 1 reflects the average number of health deficiencies per recertification survey in FFY25 for all states comprising CMS Chicago Region V. The average for Chicago Region V was 7.3 health deficiencies per survey.

TABLE 1: Average Number of Health Deficiencies by States within CMS Chicago Region V

State	Surveys	Deficiencies Issues	Average # of Deficiencies per Survey
Illinois	641	5045	7.87
Indiana	480	2976	6.20
Michigan	412	3135	7.60
Minnesota	318	2240	7.00

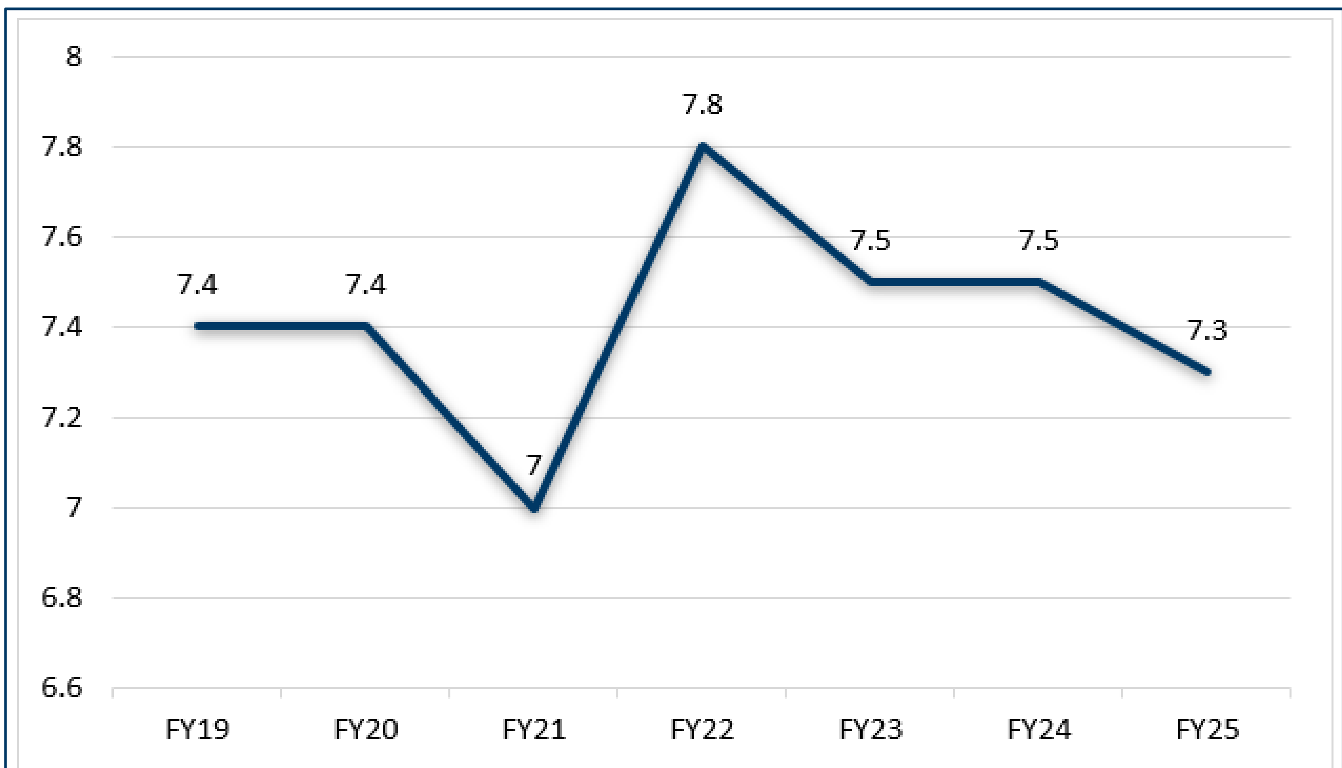
[8] Region V states include Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

State	Surveys	Deficiencies Issues	Average # of Deficiencies per Survey
Ohio	505	4540	8.99
Wisconsin	268	1895	6.35

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

Figure 1 reflects the trend of the average number of health deficiencies issued per health recertification survey over a seven-year period for CMS Region V. The average for Region V health deficiencies per survey is 7.3.

FIGURE 1: Average Number of Health Deficiencies Issued per Survey



Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

Life Safety Code Deficiencies Issued

The Life Safety Code (LSC) is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. A recertification survey for a nursing home contains both a health and an LSC portion of the survey.

Table 2 below shows the average number of LSC deficiencies per recertification survey in FFY25 for all states comprising CMS Chicago Region V. The average for CMS Chicago Region V is 5.69. Minnesota's average number of LSC deficiencies per survey is 4.93.

TABLE 2: Average Number of LSC Deficiencies by States within CMS Chicago Region V

State	LSC Surveys	LSC Deficiencies Issues	Average # of LSC Deficiencies per Survey
Illinois	658	4886	7.42
Indiana	463	2482	5.36
Michigan	384	1780	4.63
Minnesota	321	1585	4.93
Ohio	546	2923	5.35
Wisconsin	273	1767	6.47

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

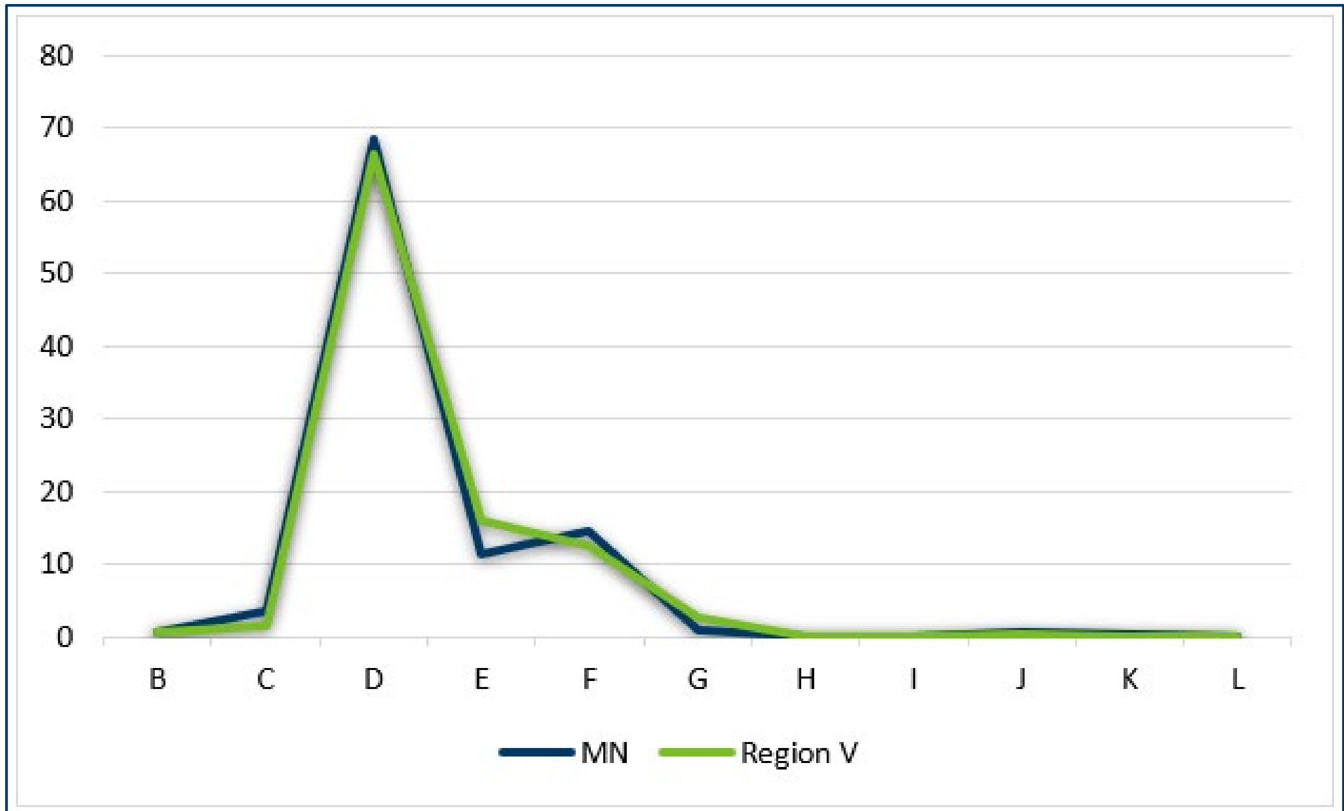
Scope and Severity of Citations – Chicago Region V

Scope and severity is a system of rating the seriousness of deficiencies. Every federal deficiency issued as a result of a survey or complaint investigation is assigned to a scope and severity level, ranging from A through L. A being the lowest and L being the highest. The highest scope and severity level of deficiencies found determine the overall scope and severity of the survey.[9]

[9] See Appendix B for the CMS grid used to determine scope and severity.

Figure 2 reflects the overall scope and severity percentages by health survey for Minnesota as compared to Chicago Region V.

FIGURE 2: Percentage of Scope and Severity

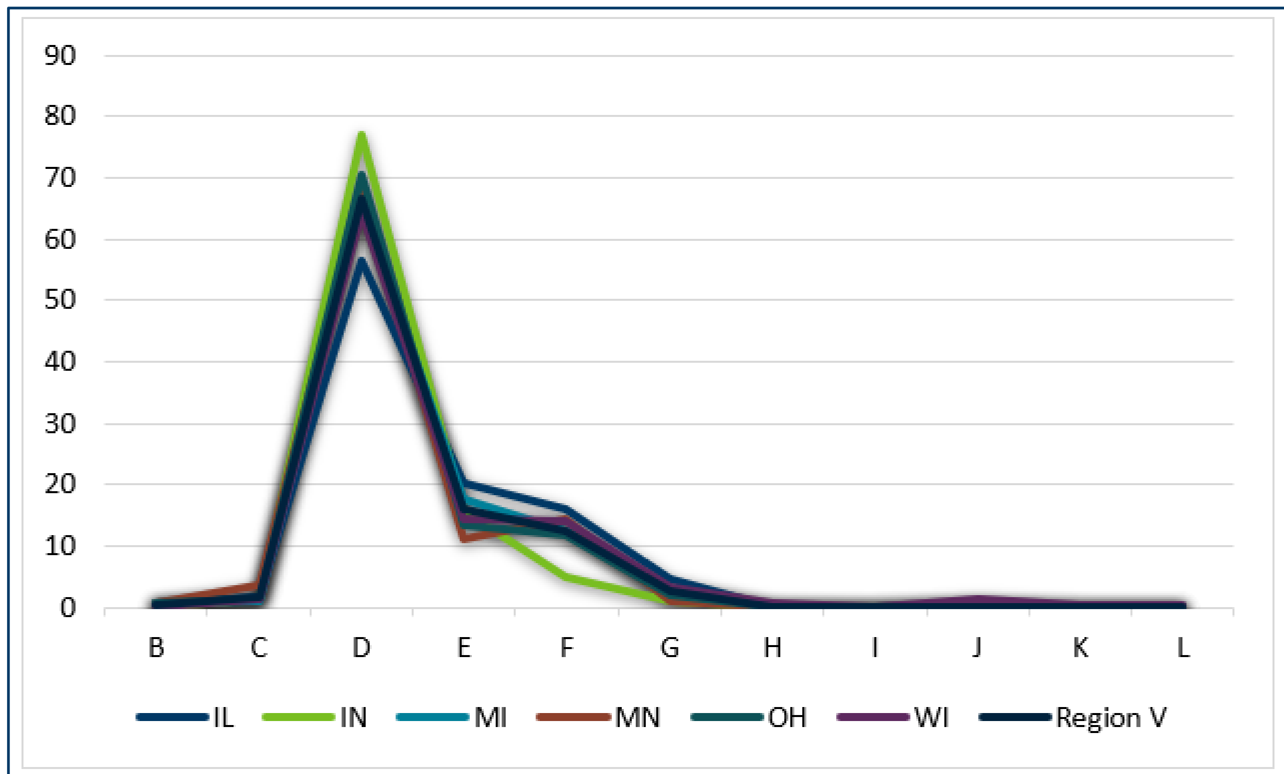


Area	B	C	D	E	F	G	H	I	J	K	L
MN	.69	3.53	68.31	11.22	14.51	.92	0.0	0.0	.69	.04	.09
Region V	.46	1.54	66.45	16.02	12.44	2.60	0.02	0.0	.40	0.07	0.06

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

The graph and table above reflected the overall scope and severity percentages by health survey for Minnesota as compared to Region V, and Figure 3 below contains a greater breakdown of the information found in Figure 2. The most common deficiencies are “D” level which means no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Figure 3 provides overall scope and severity percentages, but also includes this information for each state in Region V.

FIGURE 3: Scope and Severity Level by Percentage



State	B	C	D	E	F	G	H	I	J	K	L	Total
IL	.66	1.53	56.40	20.39	15.88	4.64	0.04	0	.34	0.04	0.08	100.%
IN	0.07	1.29	77.03	15.68	5.05	.88	0	0	0	0	0	100.%
MI	.51	.89	65.93	17.52	12.41	2.46	0.03	0	.22	0.03	0	100.%
MN	.69	3.53	68.31	11.22	14.51	.92	0	0	.69	.04	.09	100.%
OH	.51	1.31	70.62	13.27	11.83	2.09	0	0	.31	.0.04	0.02	100.%
WI	0.11	1.27	64.28	14.52	14.10	3.27	0.5	0	1.32	.42	.21	100.%
Region V	.46	1.54	66.45	16.02	12.44	2.60	0.02	.0	.40	0.07	.0.06	100.%

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

In addition to the highest overall scope and severity percentages by state, Table 3 reflects the total numbers of health surveys by the highest overall scope and severity level.

TABLE 3: Scope and Severity Level by Number

State	B	C	D	E	F	G	H	I	J	K	L	Total
IL	33	77	2831	1024	798	233	2	0	17	2	4	5021
IN	2	38	2274	463	149	26	0	0	0	0	0	2952
MI	16	28	2069	549	386	77	1	0	7	1	0	3134
MN	15	77	1492	245	317	20	0	0	15	1	2	2184
OH	23	59	3182	598	533	94	0	0	14	2	1	4506
WI	2	24	1227	275	267	61	1	0	25	8	4	1894
Region V	91	303	13075	3154	2450	511	4	0	78	14	11	19691

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

Survey Outcomes and Remedies

Survey Outcomes by Region Within the State – Number of Deficiencies

Minnesota Statutes, section 144A.10, subd. 17, requires the reporting of the number, scope, and severity of citations by region within the state. Minnesota has ten survey teams that cover the different areas across the state. To create regions within the state, these survey teams were grouped together to create North, Central, Metro and South regions.[10] The surveys completed within each region are compared for the purposes of regional analysis.

[10] Bemidji, Duluth, Fergus Falls teams comprise the North region, two St. Cloud teams comprise the Central region, two metro teams comprise the Metro region; and Marshall, Mankato and Rochester comprise the South region.

Table 4 reflects the number of surveys completed within each region, the number of deficiencies issued within each region, and the average number of deficiencies issued per health recertification survey by region in FFY25.

TABLE 4: Number of Health Recertification Surveys and Deficiencies Issued by Region

Region	Number of Surveys	Number of Deficiencies	Average Number of Deficiencies per Survey
North	90	531	5.90
Central	61	473	7.75
Metro	70	611	8.73
South	100	625	6.25

The largest regional difference of the average number of health deficiencies issued per recertification survey is almost three deficiencies, or 2.83 deficiencies per survey.

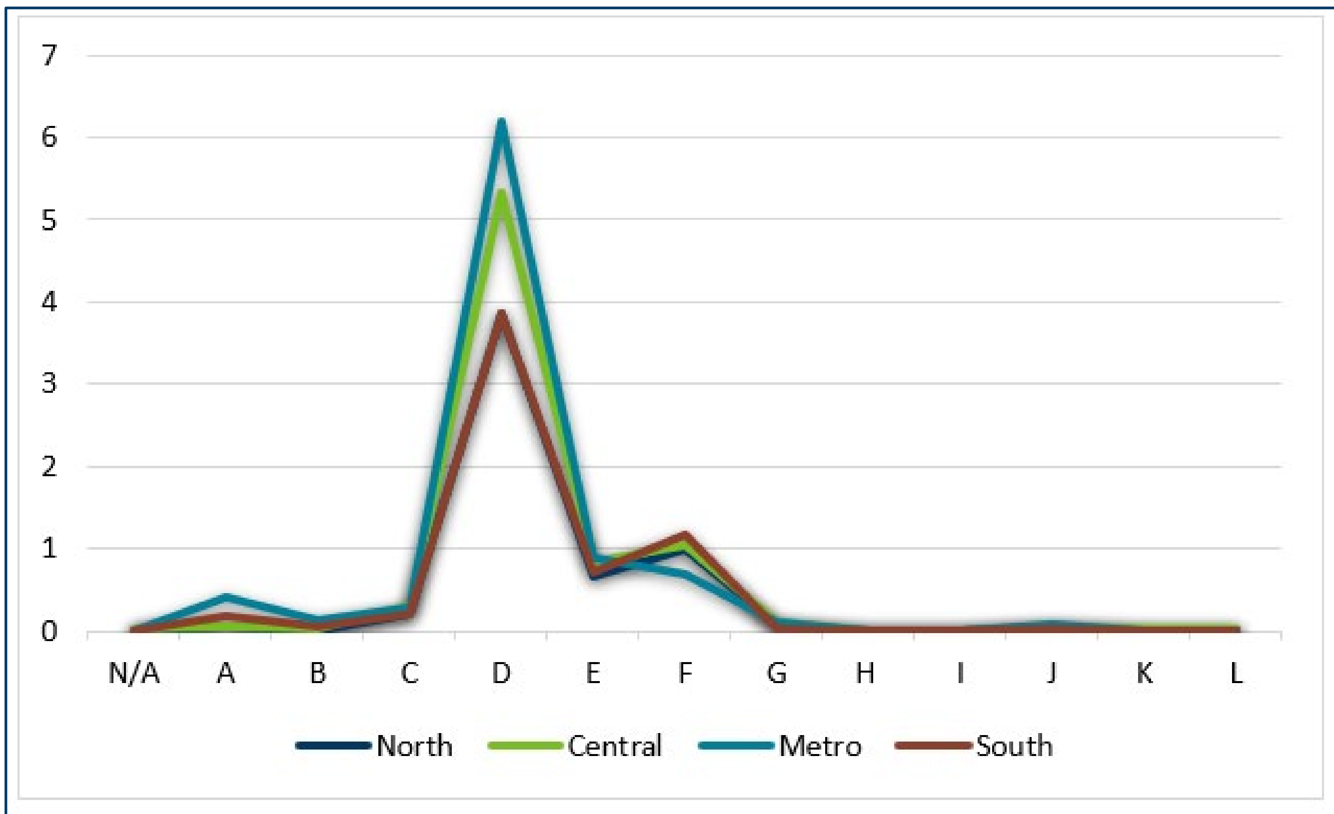
Survey Outcomes by Region Within the State – Scope and Severity

As mentioned previously, every federal deficiency issued is assigned a scope and severity level ranging from A through L. Scope and severity is a system of rating the seriousness of deficiencies. Scope ranges from isolated findings to widespread findings of a deficient practice. Severity ranges from a potential for minimal harm if the deficient practice is not corrected, to immediate jeopardy to resident health or safety.[11] The highest scope and severity levels of deficiencies found determine the overall scope and severity of the survey. See Appendix B for the CMS grid used to determine scope and severity.

Figure 4 reflects the overall scope and severity percentages per health recertification survey by region in FFY25.

[11] Scope/severity levels of “G”, “H” and “I” or above represent deficiencies of actual harm. Scope/severity of “J”, “K” and “L” represent deficiencies that are an immediate jeopardy to resident health or safety.

FIGURE 4: Scope and Severity per Health Recertification by Percentage



Region	N/A	A	B	C	D	E	F	G	H	I	J	K	L
North	0%	0.05%	0.01%	0.2%	3.86%	0.67%	0.98%	0.07%	0%	0%	0.04%	0%	0.01%
Central	0.02%	0.05%	0.02%	0.30%	5.32%	0.84%	1.03%	0.10%	0%	0%	0.05%	0.02%	0.02%
Metro	0%	0.4%	0.13%	0.29%	6.19%	0.88%	0.69%	0.09%	0%	0%	0.07%	0%	0%
South	0%	0.19%	0.04%	0.21%	3.86%	0.72%	1.18%	0.02%	0%	0%	0.03%	0%	0%

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

Table 5 below reflects the counts of the overall health scope and severity level per recertification survey, by region in FFY25. Figure 4 contains percentages based on the total number of overall scope and severity level of the survey divided by the total number of surveys conducted in that region, whereas Table 5 simply contains raw counts. Please note that while similar, the number of surveys conducted within each region varies slightly, making percentages a better tool for comparisons.

TABLE 5: Health Scope and Severity Level per Recertification by Region by Number

Region	N/A	A	B	C	D	E	F	G	H	I	J	K	L
North	0	5	1	18	348	60	88	6	0	0	4	0	1
Central	1	3	1	18	325	51	63	6	0	0	3	1	1
Metro	0	28	9	20	433	62	48	6	0	0	5	0	0
South	0	19	4	21	386	72	118	2	0	0	3	0	0

Remedies

As explained in the previous section, the highest levels of deficiencies of the survey determine the overall scope and severity of the survey. If the scope and severity of the survey met the criteria for no opportunity to correct, then immediate sanctions (or remedies) are required to be imposed. If sanctions are imposed, it is in accordance with the scope and severity matrix in Appendix B.[12]

A complete listing of remedy categories follows. Many factors are used to determine which and how many remedies to impose within the available remedy categories for levels of noncompliance.

TABLE 6: Remedy Categories

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

[12] CMS makes the final determination on the imposition of all Category 2 and Category 3 remedies.

While the overall scope and severity level of a survey may result in immediate remedies, there are other situations where remedies may be triggered during the survey process. One example of this would include a facility not correcting previously issued deficiencies at the time of an onsite revisit, which would result in finding the facility in continued non-compliance. The survey in this example may have started out without remedies, but now has remedies imposed due to the uncorrected revisit.

In FFY25 a total of 217 remedies were imposed for recertification or complaint surveys. It is important to note that multiple kinds of remedies may be imposed during one survey process or enforcement case. For example, a survey resulting in remedies imposed may involve two civil money penalties (CMP), one for each “G” or above deficiency, and directed plan of correction. This would be reflected in Table 7 as one count of imposed (CMP) and as one count of imposed directed plan of correction.

Table 7 below illustrates the total types of all remedies imposed in Minnesota for all enforcement cases (both recertification and complaint surveys) over a three-year period FFY23- FFY25.

TABLE 7: Total Number of Remedies Imposed

Type of Remedy	FFY23	FFY24	FFY25
Imposed Directed Plan of Correction	51	4	4
Imposed CMPs	176	134	192
Imposed DOPNA	40	27	21
Total Remedies Imposed	267	165	217

Source: Federal Internet Quality Improvement and Evaluation System (iQIES) FFY25

Timelines in Relation to Imposed Remedies

Survey Revisits

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

During FFY25, there were 56 surveys[13] where CMS imposed federal Category 2 or 3 remedies. Fifty-two of these 56 cases received on site revisits within the 15-calendar day requirement. Therefore, on site revisits were conducted within the 15-day requirement for 93% of the applicable surveys, up from 92% in 2024.

[13] 26 surveys were recertification surveys and 30 were complaint investigations

Time Requirements for Statement of Deficiencies

15 Working Day Requirement

Completed statements of deficiencies are then electronically provided to the facility after the survey exit. The statute requires that facilities be provided with a completed Statement of Deficiencies within 15 working days of the exit conference.

In FFY25, there were a total of 318 recertification surveys completed for nursing facilities. Of those 318 surveys, the average working days to meet the requirement for delivering final Statement of Deficiencies within 15 days of exit was 10.12 days.

Appeals, IDRs and IIDRs

Federal Level: Appeals

Facilities have the right to formally appeal any Civil Money Penalties (CMP's) imposed by CMS. The appeal process is a federal process, where facilities communicate directly with the CMS Region V Office in Chicago. In FFY25, Minnesota was not informed of any appeals at the federal level. This is down from one appeal in FFY24 and seven in FFY23.

State Level: IDR and IIRDs

The federal regulations require each state to develop and offer informal dispute resolution (IDR) and independent informal dispute resolution (IIDR) process to facilities wishing to dispute survey findings.[14] Minnesota Statutes, Section 144A.10, subdivisions 15 and 16, are the statutory provisions governing the two processes. Legislation was passed in 2024 to align state statutes with the federal regulations that require the IIDR process only following the issuance of a CMP.[15]

The purpose of the informal process is to give providers an opportunity to refute cited deficiencies after a survey. The IDR process entails a review of the challenged deficiencies by the reconsideration team that was not involved in the original survey or complaint investigation. Depending on the desire of the facility, the reconsideration team may facilitate a meeting where they receive the facility's challenges verbally. The reconsideration team will also review any written submissions and the survey or investigation record.

The IIDR process involves the facility's challenge being heard by an Administrative Law Judge (ALJ) from the Minnesota Office of Administrative Hearings (OAH). In an IIDR, both the facility and MDH present their positions to the ALJ in a proceeding resembling a court hearing. Following the proceeding, the ALJ makes an advisory recommendation to the Commissioner of Health. The Commissioner's MDH designee reviews the

[14] 42 C.F.R. §§ 488.331 and 488.431. Code of Federal Regulations (https://www.ecfr.gov/)

[15] These Minnesota Statutes governing IDR and IIDR were amended in the 2024 legislative session to mirror the scope of the federal regulations. The changes took effect on October 3, 2024, and will be effective for all IDRs and IIDRs in the FFY2025 report.

recommendation and makes the final agency recommendation to CMS. CMS reviews the record and issues the final decision on the challenged deficiency.

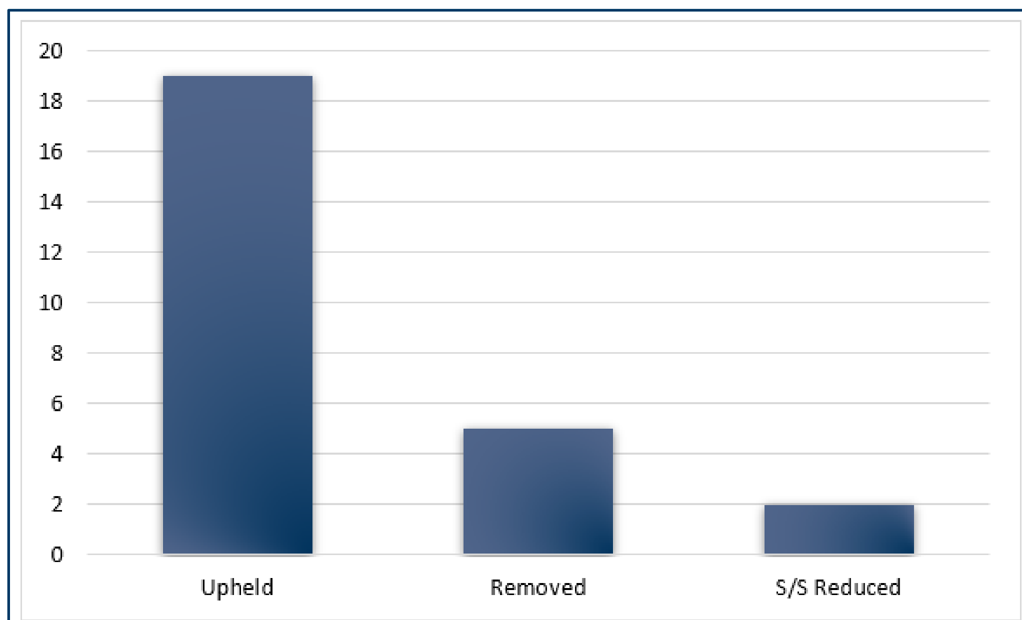
As a result of the review, a variety of outcomes may occur. If found fully supported, the deficiency will be upheld as written. If the findings are found unsupported, the deficiency will be removed. The deficiency may be found supported, but not at the issued scope and severity. In that case, the scope and severity will be reduced. In some cases, it may be found that MDH issued the deficiency at the wrong citation. This results in the tag being modified to the correct citation. Finally, if the deficiency was issued at an immediate jeopardy, the review may find that the period MDH found the facility placed residents in immediate jeopardy for a shorter period than cited in the deficiency. In such cases, the length of the immediate jeopardy will be reduced.

IDR Outcomes

During FFY25, MDH received IDR requests on 28 deficiencies.

Of the challenged deficiencies, 19 were upheld as written with no modifications, two were upheld in substance with modifications to the underlying text, five were removed, and two had the scope and severity reduced following the MDH review.

FIGURE 5: IDR Outcomes – FFY25

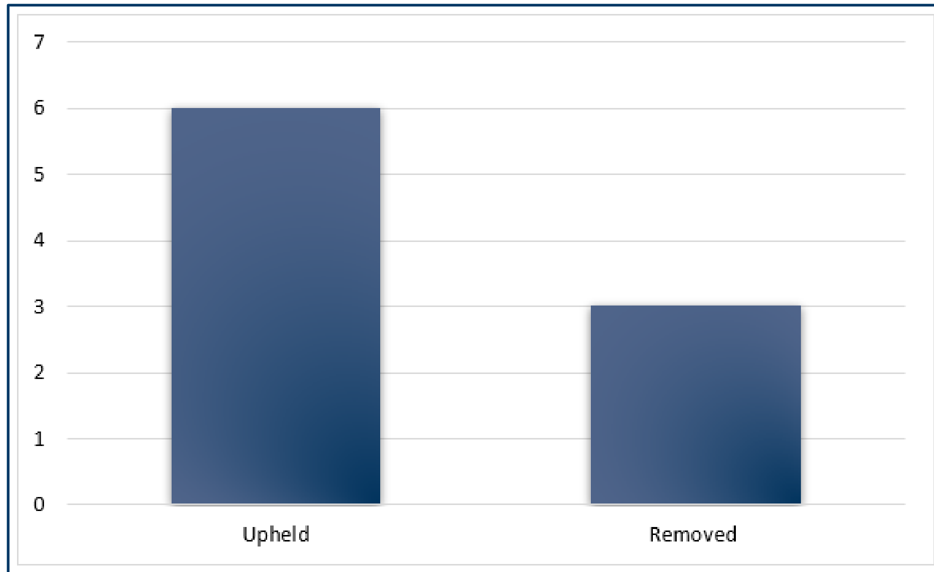


IIDR Outcomes

During FFY25, MDH conducted IIDR proceedings challenging nine deficiencies.

In total, six of the nine reviewed deficiencies were upheld as written and three deficiencies were removed.

FIGURE 6: IIDR Outcomes – FFY25



Areas of Special Focus

MDH strives to continuously improve both internal and external processes. Below are some areas of focus and highlights from FFY25.

Collaborative Systems Change

Collaborative Systems Change is a program within the HRD designed to understand barriers to regulatory compliance and create collaborative solutions alongside providers, partners, and advocates.

HRD invites providers, partners, and advocates, to study recurring issues and trends, identify systemic influences that impact compliance, analyze qualitative and quantitative data, and recommend solutions. The aim of this program is to foster a culture of open dialogue by establishing a space outside the regulatory environment for collaborative learning and improved compliance.

HRD used the collaborative systems change process to understand and document barriers providers face when complying with tuberculosis prevention and control screening requirements and the impact this has on hiring direct care staff and delaying resident care. As a result of our efforts, HRD designed and published a set of resources, in four languages, for direct care staff and regulated providers:

- Your Tuberculosis (TB) Test Results: Why are your test results important to keep?
- Tuberculosis (TB) Test Results Frequently Asked Questions

In addition, HRD used the collaborative systems change process to understand the complexities of developing an Individual Abuse Prevention Plan and mitigation strategies for residents in assisted living and clients receiving home care. Our collective efforts resulted in the design and publication of a set of recourses, in four languages and customized for home care and assisted living providers, their staff, and residents or clients of assisted living facilities and home care.

- Developing the Individual Abuse Prevent Plan.
- Who is required to have an IAPP?
- Welcome to your new services.

HRD continues to collaborate with providers, partners, and advocates to identify trends we want to study, and to expand opportunities for providers, partners, and advocates to participate in the collaborative systems change program.

HRD Feedback Questionnaire

HRD developed a feedback questionnaire to give to providers at the beginning and end of a recertification survey and complaint investigation. The feedback from the providers is anonymous unless a provider would like to share their name. The feedback provides information to HRD on customer service and survey/investigation areas that can be improved. This questionnaire supports HRD's culture of learning and collaborative safety by providing opportunities for facilities and providers to give their perspectives about survey and complaint procedures, how representatives of HRD communicated and whether the facilities and providers felt heard during the survey or complaint process. The responses have been positive, and providers have been very open to share about their experiences. Any critical feedback is given immediately to the supervisor. If a provider shares an HRD staff name, that is shared with the supervisor as well.

This feedback questionnaire has been in place for over two years and providers continue to share their experiences with the recertification survey and complaint investigation process. Providers have been very honest with the feedback and HRD has used the feedback to focus on customer service and ways to improve the survey/investigation process. Currently the feedback questionnaire is given to nursing home providers, assisted living facilities, and licensed-only home care providers. HRD will continue to use the feedback questionnaire with these providers and will look to expand to additional provider types in the near future.

Appendices

APPENDIX A: CMS Revisit/Date of Compliance Policy

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

Appendix A: CMS Revisit/Date of Compliance Policy

Revisit #	Substantial Compliance	Old deficiencies corrected but continuing noncompliance at F (no SQC) or below	Old deficiencies corrected but continuing noncompliance at F (SQC), harm or IJ	Noncompliance continues	Any noncompliance
1st Revisit	Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the 1st onsite revisit, or correction occurred sooner than the latest correction date on the PoC.	1. A 2nd onsite revisit is discretionary if acceptable evidence is provided. When evidence is accepted with no 2nd onsite revisit, compliance is certified as of the date confirmed by the evidence. 2. When a 2nd onsite revisit is conducted, acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.	1. A 2nd onsite revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.	1. A 2nd onsite revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered as the compliance date.	
2nd Revisit	Compliance is certified as of the date of the 2nd onsite revisit or the date				1. A remedy must be imposed if not already imposed. 2. Either conduct a

Revisit #	Substantial Compliance	Old deficiencies corrected but continuing noncompliance at F (no SQC) or below	Old deficiencies corrected but continuing noncompliance at F (SQC), harm or IJ	Noncompliance continues	Any noncompliance
	confirmed by the acceptable evidence, whichever is sooner.				3rd onsite revisit or proceed to termination.
3rd Revisit (A 3rd revisit is not assured and must be approved by the RO)	Compliance is certified as of the date of the 3rd onsite revisit.				Proceed to termination.

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

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-services training.
- Interviews with more than 1 training participant about training.
- Contact with resident council, e.g., when dignity issues are involved.

Givens:

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

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

Scope	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J = **SQC,** PoC Required	K = **SQC,** PoC Required	L = **SQC,** PoC Required
Actual harm that is not immediate	G= PoC Required	H = **SQC,** PoC Required	I = **SQC,** PoC Required
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D= PoC Required	E= PoC Required	F = **SQC,** PoC Required
No actual harm with potential for minimal harm	A = **Substantial Compliance,** No PoC	B = **Substantial Compliance**, PoC Required	C = **Substantial Compliance**, PoC Required

Substandard Quality of Care (SQC) is defined in 42 C.F.R. §488.301 as one or more deficiencies which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, related to certain participation requirements.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements (42 C.F.R. §488.301).