GUIDE TO THE SURVEY PROCESS
FOR COMPREHENSIVE HOME CARE PROVIDERS

1. Purpose of the home care licensure survey process
The purpose of the survey is to evaluate and monitor the care and services provided to clients and to determine if the home care provider is in compliance with licensing requirements.

2. What are the primary areas of focus during a survey?
Any home care licensure requirements may be reviewed during the course of the survey; however, the focus is that care and services are provided to clients in accordance with accepted health care standards.

3. Types of Surveys

- **Full Survey**
  - Periodic inspection of Home Care Providers (HCPs) to assess ongoing compliance with regulations
  - Covers all core survey areas and all legal requirements of providers
  - For providers who:
    - Are temporary licensees
    - Do not meet requirements for a core survey
    - Surveyor has identified as having unacceptable client health or safety risks
  - May include additional review as deemed necessary by the Minnesota Department of Health (MDH)

- **Core Survey**
  - Focuses on essential health and safety requirements
  - Eligible HCPs will have:
    - Been licensed for at least 3 years
    - Been surveyed in last 3 years
    - No widespread violations beyond Level 1 on most recent survey
    - No substantiated licensing complaints in past 3 years
    - No complaints against the agency under the VAA or MMA in past 3 years
    - No enforcement action per 144A.475 in past 3 years

- **Follow-up Survey**
  - Conducted to determine if HCP has corrected deficient issues and systems
  - May be done by phone, e-mail, fax, mail or on-site reviews
4. Steps of the Survey Process

- **Entrance Conference**: MDH staff introduce themselves, provide an overview of the survey process, and request a list of clients who are receiving home care services. The home care provider may use the Current and the Discharged/Expired Client Rosters available on the MDH website or provide the requested information identified on the form in an alternate written format.

- **Observations**: Care and services provided to clients will be made throughout the survey and will vary depending on what services are offered by the home care provider. Observations may include medication administration and other tasks.

- **Interviews**: Interviews with staff, clients, and/or their representatives are conducted throughout the survey. Interviews provide an opportunity for MDH staff to verify the information obtained from other sources.

- **Tour**: If applicable, a tour of the Housing with Services (HWS) building where the Comprehensive Home Care provider is providing services is conducted to observe compliance with Comprehensive home care requirements, such as security/confidentiality of client information and storage of clients’ medication (if provided).

- **Home Visits**: Home visits are conducted during the survey to assist in evaluating the services provided by the home care provider. Consent for the home visit is obtained from the client or the client’s responsible person prior to the visit. Observations of the client and staff may occur during a home visit depending on what services are offered. At times it may be necessary to gather information by a telephone call to the client or the client’s responsible person in lieu of a home visit.

- **Documentation Review**: A review of the home care provider’s documentation, including but not limited to: policies and procedures, marketing materials, client admission/information packet, client records, and personnel records may be conducted.

- **Exit Conference**: When the survey tasks are completed, MDH staff will offer the home care provider an exit conference. The purpose of the exit is to outline and discuss the preliminary findings of the survey. MDH staff will explain the findings of the survey and provide information, as applicable.

5. Communication during the Survey

It is important for the home care provider to know that MDH and its staff are committed to having open communication during the survey process. The home care provider staff will be asked to provide information that reflects the current practices and policies of the licensee. If a question is not understood, ask for clarification. Additional information and/or clarification may be presented at any time during the survey. MDH staff members are expected to ask questions if they do not understand the licensee’s practices and policies as they pertain to the requirements in the statutes and rules. During the survey, MDH staff will provide education concerning issues that are identified. The home care provider should feel free to ask MDH staff questions. The
MDH supervisor may be contacted to help resolve any issues or concerns that may arise during the survey.

6. **Client Roster Forms**

The *Current and Discharged/Expired Client Roster* forms may be used during the course of the survey. These forms are available on the MDH website. If a licensee chooses, the forms may be filled out in advance and available at the onset of the survey.

7. **The length of a survey**

The survey will take one or more days. The length of the survey and the number of MDH staff assigned depends on the number of clients receiving services, the type of services the clients are receiving, issues identified during the survey, the number and location(s) of the Housing with Services establishments and the geographic location.

8. **Survey Completion**

The exit conference may be conducted onsite or by telephone. After the exit conference, MDH staff will submit the preliminary survey findings for final Department review. After review, any correction orders issued as a result of the survey and the final copy of any correction order(s) will be mailed or emailed to the provider within 30 days after the survey exit date. If the licensee believes any of the information to be inaccurate, they should contact MDH as soon as possible by calling (651) 201-5273 and ask to speak to the supervisor about the home care provider survey. The final correction order(s) will be posted on the MDH website to allow viewing by the public.

If the home care provider does not agree with the survey findings, the licensee may use the correction order reconsideration process to challenge the correction order issues, including the scope and level, and any fine assessed. Written information will be provided on the process for requesting a reconsideration of the survey results.

By the correction order date, the home care provider must document, in the provider’s records, any action taken to comply with the correction order. MDH may request a copy of this documentation on future surveys, upon complaint investigation, or as otherwise needed.

9. **Follow-up Survey**

If the home care provider receives correction orders, the licensee may be subject to a follow-up survey to determine if the violations cited have been corrected. It is not only important for the licensee to correct the problem(s) identified in the correction order; but it is also important for the licensee to correct system failures that led to the noncompliance.

For providers that have Level 3 or Level 4 violations, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey.

The information gathered during a follow-up survey will focus on the area(s) cited during the previous survey. New correction orders may be issued if new issues are identified. During the exit conference, MDH staff will present the preliminary findings of the follow-up visit, which will include the status of the correction orders.
10. **Fines**
Fines and enforcement actions may be assessed based on the level and scope of the violations as identified in MN statute 144A.474, subd. 11. Scope and Level are defined below:

**Scope**
- **Isolated** – when one or a limited number of clients are affected or one or a limited number of staff are involved or that situation has occurred only occasionally
- **Pattern** – when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive
- **Widespread** – when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients

**Level**
- **Level 1** – a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety
- **Level 2** – a violation that did not harm a client’s health or safety but had the potential to have harmed a client’s health or safety, but was not likely to cause serious injury, impairment, or death
- **Level 3** – a violation that harmed a client’s health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death
- **Level 4** – a violation that results in serious injury, impairment, or death

11. **Requesting a Hearing**
If a penalty assessment is issued at the initial survey or subsequent follow-up survey(s), the licensee may request a hearing as indicated in MN Statute 144A.475, subd. 7 to contest the fine (penalty assessment).

12. **Performance Incentive**
A licensee is eligible for a performance incentive if there are no violations identified in a core or full survey. The performance incentive is a ten percent discount on the licensee’s next home care renewal license fee.

13. **MDH Website**
The MDH website contains the rules and statutes as well as news and announcements pertinent to the home care provider. Documents used by MDH staff during the survey are available on this website along with other information that will assist providers in assuring compliance. Review the MDH website periodically for updates.

http://www.health.state.mn.us/divs/fpc/comphomecare/index.html
Comprehensive Home Care Provider
Entrance Conference Form

☐ Upon arriving at the Home Care Provider, the surveyor introduces self and asks to speak to the licensee or designee. The Introductory Letter and the surveyor’s business card are given to the person who greets the reviewer. An entrance conference is requested with the licensee or designee.

☐ During the Entrance Conference, explain the purpose of the survey. Give a brief overview of the survey process including estimated timeline for completion and the survey tasks that will be completed.

☐ Offer the licensee a copy of Guide to the Survey Process for Comprehensive Home Care Providers.

☐ Name of Administrator and Housing with Services Director:
________________________________________________________________________
________________________________________________________________________

☐ Name of registered nurse(s)/licensed practical nurse(s). What hours/days do the registered nurse(s)/licensed practical nurse(s) work? What is the registered nurses previous experience? What are the licensed practical nurses duties? Request evidence of current licensure for registered nurse(s) and licensed practical nurse(s) (144A.4795, subd. 2):
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☐ Name of PT/OT/Speech Therapist (if applicable). Provide evidence of licensure and/or Registration (144A.4795, subd. 2).

☐ Request that the Current Client Roster and Discharged/Expired Client Roster be completed and returned as soon as possible.

☐ If applicable: Provide a schedule of home visits during the survey.

☐ Discuss and obtain information regarding the following:
  o If applicable: Tell me where you provide services under this license (i.e. Housing with Services) and if there are any special care units at each site such as Memory Care?
________________________________________________________________________

  o If applicable: Do you have any Branch Offices? Is so, where are they located?
________________________________________________________________________
________________________________________________________________________

  o Tell me about the types of services that you provide.—(Review the provider’s “Statement of Services” provided to clients for accuracy (144A.4791, subd. 3).
o Do you provide any services by contracted staff? If so, what services (144A.4795, subd. 5):

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o Tell me about your medication administration system, medication administration times and medication storage (144A.4792):

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o Tell me what your procedure is for medication management for clients who will be away from home? (144A.4792, subd. 10)

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o Tell me about your system when prescriber’s orders are received by fax, how the order is communicated to the registered nurse (144A.4792, subd. 12-16):

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o How are unlicensed personnel trained to administer medications and who trains them? How are unlicensed personnel supervised for medication administration? (144A.4792, subd. 6-7, 144A.4795, 144A.4797, subd. 3)

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o How are unlicensed personnel and professional staff oriented and trained and who trains them (144A.4796)?

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o How do unlicensed personnel communicate to each other changes in client’s condition or events that occurred on their shift? How do they communicate this information to the registered nurse? (144A.4794, subd. 3)

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o How do nursing staff communicate to unlicensed personnel changes in client’s conditions, medications, etc?

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What is the procedure when an unusual occurrence occurs with a client, such as a client fall, medication error, elopement, etc.?

What are your staffing patterns?

What is your system of ensuring tuberculosis screening is conducted and current for your employees (144A.4798)?

Tell me about your Quality Management activities? (144A.479, subd. 3)

Do you utilize an electronic documentation system for the client record? If so, what parts of the record are electronic?

If the Home Care Provider utilizes accident/incident reports and medication error reports, request to review all incident/accident reports and medication error reports for the past six months.

Request to review abuse/neglect reports for the past six months. (144A.479, subd. 6)

Request to review any complaints for the past three to six months. (144A.4791, subd. 11)

Request to review policies and procedures related to ULP training and medication administration. (144A.4795)

If the Home Care Provider utilizes a 24 hour report book or communication book, request to review it.

Request to review the medication administration book/treatment book.

Review with the provider if they are conducting lab testing, the need for a CLIA waiver. (Give handout if are conducting lab testing and do not have a CLIA certificate of waiver).

Request to review admission information, including advertising material, complaint procedure and the Bill of Rights given to clients on admission. (144A.479, subd. 2, 144A.4791, subd. 11, 144A.44, 144A.4791, subd. 1)

Ask to review their Disaster and Emergency Plan (144A.4791, subd. 12)

Ask for a list of current employees and their hire dates.

Ask about annual training provided (144A.4796, subd. 6)
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Bill of Rights (right #2)
The right to be treated with accepted health care, medical or nursing standards of practice

Class A, Class F, and Comprehensive are all identical:

144A.44 Subd. 1 (2)
A person who receives home care services has these rights: The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services.
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Individualized Abuse Prevention Plans

Class A, and Class F are identical:

626.557 Subd. 14 (b) Reporting of Maltreatment of vulnerable adults

Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of:

(1) the person's susceptibility to abuse by other individuals, including other vulnerable adults;
(2) the person's risk of abusing other vulnerable adults; and
(3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

For the purposes of this paragraph, the term "abuse" includes self-abuse.

Comprehensive contains the same elements but is worded differently:

144A.479 Subd. 6 (b) Home Care Provider Responsibilities – Reporting maltreatment of vulnerable adults and minors.

Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Services Plans/Service Agreements

Class A:

4668.0140 Subp. 1-2 Service Agreement

No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

Contents of service agreement. The service agreement required must include:

A. a description of the services to be provided, and their frequency;
B. identification of the persons or categories of persons who are to provide the services;
C. the schedule or frequency of sessions of supervision or monitoring required, if any;
D. fees for services;
E. a plan for contingency action that includes:
   (1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;
   (2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;
   (3) who to contact in case of an emergency or significant adverse change in the client's condition;
   (4) the method for the licensee to contact a responsible person of the client, if any; and
   (5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.
Class F:

4668.0815 Subp. 1-4 Service Plan

Evaluation and documentation - No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

Reevaluation - A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

Modifications - A modification of the service plan must be in writing and agreed to by the client or the client's responsible person before the modification is initiated. A modification must be authenticated by the client or the client's responsible person and must be entered into the client's record no later than two weeks after the modification is initiated.

Contents of service plan - The service plan must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the required individualized evaluation;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and
the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Comprehensive:

144A.4791 Subd. 9-10

Service Plan, Implementation, and Revisions to Service Plan

(a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service plan.

(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and

(5) a contingency plan that includes:

   (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

   (ii) information and a method for a client or client's representative to contact the home care provider;
names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and

the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Termination of Service Plan.

(a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

1. the effective date of termination;
2. the reason for termination;
3. a list of known licensed home care providers in the client's immediate geographic area;
4. a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);
5. the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and
6. if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.
Comprehensive Home Care Survey Self-Audit Tool

Topic: **Service Plans**

Audited by: ________________________________

Date of Audit: ____________________________

Task:

1. Make five blank copies of this form
2. Retrieve five random service plans from your current client caseload

Audit for compliance in the following areas.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Service plans are finalized within 14 days after the initiation of client services.</td>
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<td>Service plans and any revisions are signed by both the home care provider and by the client or client's representative.</td>
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<td>The service plans include information about how to contact the Office of Ombudsman for Long-Term Care.</td>
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<td>The service plan includes a description of the home care services provided to the client.</td>
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<td>The service plan includes the fees for home care services provided to the client.</td>
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<tr>
<td>The service plan includes the frequency of each home care service provided to the client.</td>
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<tr>
<td>The service plan includes the identification of the type or categories of staff for each home care service provided to the client.</td>
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<td>The service plan includes the schedule and methods of ongoing monitoring and reassessments.</td>
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<td>The service plan includes the frequency of supervision of staff and who will be supervising staff.</td>
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<tr>
<td>The service plan includes a description of any medication management services (if any) that are being provided to the client.</td>
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<td>The service plan includes a description of any prescribed treatments or therapies (if any) that are being provided to the client.</td>
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<tr>
<td>The service plan includes a contingency plan that identifies the actions to be taken by the home care provider if scheduled home care services cannot be provided.</td>
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<tr>
<td>The service plan includes a contingency plan that identifies the actions to be taken by the client or client's representative if scheduled home care cannot be provided.</td>
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<tr>
<td>Requirement</td>
<td>Met</td>
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<td>----------------------------------------------------------------------------</td>
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<td>services cannot be provided.</td>
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<tr>
<td>The service plan includes a contingency plan that includes information and methods for a home care client or client's representative to contact the home care provider.</td>
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<tr>
<td>The service plan includes a contingency plan that includes names and contact information of persons the client wishes to have notified in an emergency or if there is a significant change in the client's condition.</td>
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<td>The service plan includes a contingency plan that includes identification and contact information of who has authority to sign for the client in an emergency.</td>
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<tr>
<td>The service plan includes a contingency plan that includes identification of the circumstances in which emergency medical services are not to be summoned for the client, based on a client's completed advance directives, living will, and/or POLST forms.</td>
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<tr>
<td>The service plan has been <strong>revised, based on client needs</strong> as identified in ongoing monitoring or reassessment visits.</td>
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<tr>
<td>Services identified in the service plan are provided to the client as described in the service plan.</td>
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<tr>
<td>No home care services are being provided to the client that are not listed on the current service plan.</td>
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<tr>
<td>The service plan and the most recent revised service plan are included in the client record.</td>
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<tr>
<td>Staff providing home care services to a client are informed of the current service plan for that client.</td>
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<tr>
<td>Documentation indicates that the home care client was told in advance of any recommended changes by the provider to the service plan and the client was provided the opportunity to take an active part in any decisions about changes to the service plan.</td>
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If any applicable requirements are identified as "Not Met", correct the situation, audit other service plans to determine how widespread the problem is, correct all problems, and review policies, procedures, forms, software, and staff responsibilities to correct the problem going forward.

**References:** 144A.44 Subd. 1 (04), 144A.4791 Subd. 9 (a)-(f), 144A.4792 Subd. 5 (a), 144A.4793 Subd. 3
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Contents of Client Records

Class A:

4668.0160 Subp. 6 Content of Client Record

The client record must contain:

A. the following information about the client:
   (1) name;
   (2) address;
   (3) telephone number;
   (4) date of birth;
   (5) dates of the beginning and end of services; and
   (6) names, addresses, and telephone numbers of any responsible persons;

B. a service agreement as required;

C. medication and treatment orders, if any;

D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;

E. names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.
Class F:

4668.0810 Subp. 6 Content of Client Record

The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

A. the following information about the client:
   (1) name;
   (2) address;
   (3) telephone number;
   (4) date of birth;
   (5) dates of the beginning and end of services;
   (6) names, addresses, and telephone numbers of any responsible persons;
   (7) primary diagnosis and any other relevant current diagnoses;
   (8) allergies, if any; and
   (9) the client's advance directive, if any;

B. an evaluation and service plan as required;

C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;

D. medication and treatment orders, if any;

E. the client's current tuberculosis infection status, if known;

F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;

G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;

I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;
J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

Comprehensive:

144A.4794 Subd. 3 Contents of Client Record

Contents of a client record include the following for each client:

(1) identifying information, including the client's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified;

(3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known;

(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;

(5) client's advance directives, if any;

(6) the home care provider's current and previous assessments and service plans;

(7) all records of communications pertinent to the client's home care services;

(8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(10) documentation that services have been provided as identified in the service plan;

(11) documentation that the client has received and reviewed the home care bill of rights;

(12) documentation that the client has been provided the statement of disclosure on limitations of services;

(13) documentation of complaints received and resolution;
(14) discharge summary, including service termination notice and related documentation, when applicable; and

(15) other documentation required under this chapter and relevant to the client's services or status.
Comprehensive Home Care Provider
Client Review Form

Client Name: ______________________________

Client Identifier: __________________________  Diagnosis: _______________________

SOC:_____________                                      Service Plan Date:_________________

A Client Review includes observations of the client and the care and services they receive, client record review, client drug therapy review and client and/or family interview utilizing the Home Visit Client/Family Interview form.

NOTE: The surveyor will review the language in the MN Home Care Rules and Statutes when evaluating compliance.

Section A: Client Daily Life Review
Observations are made throughout the survey of the clients and the care and services they receive. Observations are made throughout the survey of the staff providing care and services to the clients. Interviews of staff and clients are conducted throughout the survey to evaluate and validate surveyor observations and findings.

- Staff knowledge and implementation of the client’s service plan and the client’s Individualized Vulnerable Adult or Minor Abuse Prevention Plan. 144A.479, subd. 6 (b)
- Client is free from physical and verbal abuse. 144A.44, subd. 1 (14)
- Client with care needs including but not limited to: tube feedings, pressure ulcers, blood glucose checks, insulin, oxygen, dialysis, hospice care and falls.
- Care and services are provided in accordance with accepted health care, medical or nursing standards. 144A.44, subd. 1 (2)
- Infection control practices to determine if staff are following current standards of practice, including but not limited to: appropriate hand hygiene; handling and transporting linen to prevent spread of infection and the use of protective gloves when appropriate.
- Client is treated with courtesy and respect and that client’s rights are not violated. 144A.44, subd.1 (13)
- Staff listens and are responsive to client requests. (Note staff interaction with both communicative and non-communicative clients)
- Medication administration and/or assistance with self administration of medications (if applicable).
- Client appears clean and neat.
- The use of physical and/or chemical restraints.
- Other observations/interviews as deemed necessary.

Client Daily Life Reviewed: (Initial) _____
The surveyor documents concerns and follow-up on Surveyor Notes sheets.
Section B: Client Record Review

The client records are reviewed to gather information regarding the evaluation/assessment and services the client is receiving.

- Client has an Individual Abuse Prevention Plan that is current and includes an individualized assessment of the client’s susceptibility to abuse by other individuals, the person’s risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors.
- Registered Nurse – initial assessment within 5 days, 144A.4791, subd 8.
- Reassessment within 14 days and ongoing client monitoring at least every 90 days or when a change.
- Service Plan within 14 days and revise as needed 144A.4791, subd. 9
- The services are provided as stated on the client’s Service Plan
- Client-specific written instructions are present for delegated nursing procedures.
- Client received the current MN Home Care Bill of Rights 144A.4791, subd. 1
- Home care provider’s complaint procedure. 144A4791, subd. 11
- Client records are kept confidential and are secure.
- Entries are entered in the client’s record in a timely manner and are legible.
- Statement of Services 144A.4791, subd. 3
- Notice of dementia training 144A.4791, subd. 2

Client Record Reviewed: (Initial) _____
The surveyor documents concerns and follow-up on Surveyor Notes sheets.

Section C: Medication Management – 144A.4792

Review the client’s record for requirements related to medication administration. Review all the herbal supplements, over-the-counter and prescribed medications taken by the client.

- Registered Nurse – develop and implement individual medication management plan (before service provided) and revised as needed. 144A.4792, subd. 5
- Individual Medication Management Plan – includes:
  - Medication management services to be provided
  - A description of storage of medications, based on client needs
  - Specific client instructions related to medication administration
  - Identification of person responsible for monitoring medication supplies and refills
  - Identify medication management tasks that may be delegated unlicensed personnel
  - Procedures for staff notifying a registered nurse when problems arise
  - Any client-specific requirements
- Delegation of medication administration/written instructions 144A.4791, subd. 7
• The client’s medication administration records are complete/medications are administered as ordered 144A.4791, subd.8
• Documentation of med set-up. 144A.4791, subd. 9
• Medication management. 144A.4791, subd. 10
• There are written prescriber’s orders for medication administered and orders are complete 144A.4791, subd. 13.
• Verbal orders are received only by a nurse or pharmacist entered into the record and recorded and forwarded for signature. 144A.4791, subd. 15
• Electronically transmitted orders are recorded, communicated to the registered nurse and placed in record 144A.4791, subd.16.
• Client’s medications and treatments are renewed. 144A.4791, subd. 14

**Client Drug Therapy Reviewed: (Initial) ____**
The surveyor documents concerns and follow-up on *Surveyor Notes* sheets.
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Tuberculosis

Class A, Class F, and Comprehensive all have the exact same requirement:

144A.4798 Subd. 1 Tuberculosis (TB) prevention and control.

A home care provider must establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's Web site.
Regulations for Tuberculosis Control in Minnesota Health Care Settings

A guide for implementing tuberculosis (TB) infection control regulations in your facility

Tuberculosis Prevention and Control Program
PO Box 64975
St. Paul, MN 55164-0975
Phone: 651-201-5414 or 1-877-676-5414
www.health.state.mn.us/tb

July 2013
Table of Contents

Introduction ......................................................................................................................... 1

Chapter 1. Background ........................................................................................................... 3
   Determining which regulations to follow ............................................................................ 3

Chapter 2. TB Infection Control Program .............................................................................. 5
   TB infection control team ................................................................................................. 5
   Facility TB risk assessment .............................................................................................. 5
   Written TB infection control procedures .......................................................................... 6
   HCW education .................................................................................................................. 7

Chapter 3. Screening Health Care Workers (HCWs) ............................................................... 9
   Definition of a HCW ............................................................................................................ 9
   General principles ............................................................................................................. 10
   Baseline TB screening ..................................................................................................... 10
   Serial TB screening ......................................................................................................... 11
   Special situations
      HCW with signs or symptoms of active TB disease ...................................................... 11
      HCW with a newly-identified positive TST or IGRA ...................................................... 12
      HCW with written documentation of a previous positive TST or IGRA ....................... 13
      HCW with verbal (undocumented) history of a previous positive TST or IGRA .......... 13
      Pregnant HCW ............................................................................................................. 13
      Conversions .................................................................................................................. 13
      HCW with TST results between 5 and 9 mm of induration ........................................... 14
      Students ......................................................................................................................... 14
      Volunteers ..................................................................................................................... 14
      HCW with previous history of severe adverse reaction to TST .................................... 14
      HCW refusal .................................................................................................................. 14
      HCW who travels outside of the United States .............................................................. 15
   Baseline TB Screening Tool for HCWs ............................................................................ 16
   Serial TB Screening Tool for HCWs ............................................................................... 18
   Exemption Form for Tuberculin Skin Testing of a Pregnant HCW ................................ 20
   Information for Health Care Workers with Tuberculin Skin Test (TST) Results between 5 and 9 mm ... 21

Chapter 4. Screening Residents .......................................................................................... 23
   General principles ............................................................................................................ 23
   Baseline TB screening of residents in boarding care homes and nursing homes ............ 23
   Baseline TB screening of residents in residential hospices .............................................. 24
   Special situations
      Resident with newly identified positive TST or IGRA ................................................ 24
      Resident with written documentation of previous positive TST or IGRA .................... 24
      Resident with verbal (undocumented) history of previous positive TST or IGRA ........ 25
      Residents with signs or symptoms of active TB disease ............................................. 25
      Residents with previous history of severe adverse reaction to TST .............................. 26
      Resident refusal ............................................................................................................ 26
   Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents ....... 27
   Baseline TB Screening Tool for Residents in Residential Hospice ................................. 29

Glossary ................................................................................................................................. 31
The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings.

Minnesota laws governing tuberculosis (TB) prevention and control regulations in health care settings (including TB screening of health care workers and residents) have historically consisted of a variety of separate rules written for specific settings at various times. Many of them were based on national recommendations published in the 1990s or earlier.

In 2005, the U.S. Centers for Disease Control and Prevention (CDC) published revised guidelines* (www.cdc.gov/tb/publications/guidelines/infectioncontrol.htm). Since that time, the Minnesota Department of Health (MDH) has recognized that legal regulations and best practices for TB infection control in Minnesota needed to be revised to meet these guidelines and to incorporate current knowledge and technology.

The “TB waivers,” issued by MDH on March 9, 2009, were an interim step in this process to address the outdated TB laws for boarding care homes, home care providers, nursing homes, and supervised living facilities. The “TB waivers” stated that licensees were required to follow the 2005 CDC guidelines.

As a final step, MDH proposed new legislation in 2013, which was adopted by the Minnesota Legislature and takes effect on August 1, 2013. These laws are based on the 2005 national guidelines and replace the 2009 “TB waivers.” They apply to settings licensed by MDH, including boarding care homes, home care providers, hospices, nursing homes, outpatient surgical centers, and supervised living facilities.

*Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Facilities, 2005. From CDC, MMWR, December 30, 2005, 54(RR17);1-141.
Chapter 1

Background

Determining which regulations to follow

All state-licensed or federally-certified health care settings in Minnesota are required by law to follow certain measures to prevent and control TB in their facilities. In addition, facilities should follow the regulations of the Minnesota Occupational Safety and Health Administration (MN-OSHA). (see Resources)

There are three categories of regulations related to TB:

1. TB infection control program
2. Process for screening health care workers (HCWs)
3. Process for screening residents

This manual provides specific information about each type of regulation. To determine which of these regulations apply to your facility, see the table below. If you are unsure what type of license your facility has, you can look it up at www.health.state.mn.us/divs/fpc/directory/providerselect.cfm.

<table>
<thead>
<tr>
<th>Health care setting</th>
<th>TB infection control program (Chapter 2)</th>
<th>Screening HCWs (Chapter 3)</th>
<th>Screening residents (Chapter 4)</th>
<th>Regulatory authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted living facility</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Minnesota Statutes, section 144A.4798, Subd. 1¹</td>
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<tr>
<td>Boarding care home (MDH licensed)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Minnesota Statutes, section 144.56, Subd. 2c²</td>
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<tr>
<td>Home care provider (MDH licensed)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Minnesota Statutes, section 144A.4798, Subd. 1¹</td>
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<tr>
<td>Hospice (MDH licensed)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (residential hospice only)</td>
<td>Minnesota Statutes, section 144A.753, Subd. 4³</td>
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<tr>
<td>Nursing home (MDH licensed)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Minnesota Statutes, section 144A.04, Subd. 3b⁴</td>
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<td>Outpatient surgical center (MDH licensed)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Minnesota Statutes, section 144.55, Subd. 3c⁵</td>
</tr>
<tr>
<td>Health care setting</td>
<td>TB infection control program (Chapter 2)</td>
<td>Screening HCWs (Chapter 3)</td>
<td>Screening residents (Chapter 4)</td>
<td>Regulatory authority</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------</td>
<td>--------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Supervised living facility (MDH licensed)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Minnesota Statutes, section 144.50, Subd. 6a</td>
</tr>
<tr>
<td>Supplemental nursing services agency (MDH licensed)</td>
<td>Education program only</td>
<td>Yes</td>
<td>No</td>
<td>Minnesota Statutes, section 144A.72, Subd. 1</td>
</tr>
<tr>
<td>All other settings</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>MN-OSHA</td>
</tr>
</tbody>
</table>

1. [www.revisor.mn.gov/statutes/?id=144A.4798](http://www.revisor.mn.gov/statutes/?id=144A.4798)
2. [www.revisor.mn.gov/statutes/?id=144,56](http://www.revisor.mn.gov/statutes/?id=144,56)
3. [www.revisor.mn.gov/statutes/?id=144A.753](http://www.revisor.mn.gov/statutes/?id=144A.753)
4. [www.revisor.mn.gov/statutes/?id=144A.04](http://www.revisor.mn.gov/statutes/?id=144A.04)
5. [www.revisor.mn.gov/statutes/?id=144.55](http://www.revisor.mn.gov/statutes/?id=144.55)
6. [www.revisor.mn.gov/statutes/?id=144.50](http://www.revisor.mn.gov/statutes/?id=144.50)
7. [www.revisor.mn.gov/statutes/?id=144A.72](http://www.revisor.mn.gov/statutes/?id=144A.72)
TB Infection Control Program

All health care settings in Minnesota should have an up-to-date TB infection control program that includes:

- A team responsible for TB infection control
- A facility TB risk assessment
- Written TB infection control procedures
- Health care worker (HCW) education

TB infection control team

Identify a qualified person or a team of persons in your facility and assign them primary responsibility and authority for TB infection control. This person or team will conduct your setting’s facility TB risk assessment; develop, implement, and enforce TB infection control policies (including HCW and resident TB screening); and ensure that HCWs receive adequate TB-related training and education.

Facility TB risk assessment

The facility TB risk assessment is a structured evaluation of a health care facility or setting’s risk for transmission of *M. tuberculosis*. The infection control team determines the setting’s TB risk classification based on the results of the facility TB risk assessment.

All health care settings in Minnesota should perform an initial facility TB risk assessment. Medium-risk settings should update their assessment yearly; low-risk settings should update theirs every other year. Keep your facility’s completed TB risk assessment worksheets on file for future reference.

Your facility TB risk assessment should be conducted by your infection control team. In general, one-assessment encompasses an entire setting. However, in certain settings it may be appropriate to do separate assessments for specific areas within the setting.

Information on the number of TB cases by county for the previous year are posted on MDH’s web site in May of each year. Risk assessments conducted early in the calendar year (before new data are posted) should use data from the previous year. Please do not contact MDH before May to obtain TB data for the previous year.

Choose one of the following three methods to conduct your risk assessment(s):

1. Use the *Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH)*. This worksheet was developed by MDH and can be used by boarding care homes, home care providers, hospices, nursing homes, outpatient surgical centers, and supervised living facilities (see [www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.html#ch2](http://www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.html#ch2)).

2. Use the *Appendix B: Tuberculosis (TB) risk assessment worksheet* from the Centers for Disease Control and Prevention (CDC). (see [www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.html#ch2](http://www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.html#ch2)).

3. Create your own assessment tool using the criteria listed on pages 9-12 of CDC’s “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005.”
Use the results from your facility TB risk assessment to determine your TB risk classification.

The three risk classifications are:

- **Low risk**, in which persons with active TB disease are not expected to be encountered and exposure to TB is unlikely.
- **Medium risk**, in which HCWs will or might be exposed to persons with active TB disease or clinical specimens that might contain *M. tuberculosis*.
- **Potential ongoing transmission**, in which there is evidence of person-to-person transmission of *M. tuberculosis*. This is a temporary classification. If you determine that this classification applies to your setting, please consult with MDH’s TB Prevention and Control Program at 651-201-5414 for guidance.

If the infection control team is unsure whether to classify your setting as low or medium risk, the medium risk classification should be used.

When updating your facility TB risk assessment, you should confirm and document actions that were taken to address any problems identified during the previous risk assessment. In addition, you should conduct a problem evaluation to address any situations that may have occurred since your last risk assessment was done. Examples might include:

- A person with suspected or confirmed active TB disease was not promptly recognized and appropriate airborne precautions were not initiated,
- Certain administrative, environmental, or respiratory-protection controls failed, and
- Infection control lapses were identified (for example, HCWs were not adequately screened for TB; baseline TB screening of residents [if applicable] was not consistently done and documented; there were delays in transferring of patients with symptoms of active TB disease; or TB-related education and training of HCWs was not done or needs to be updated).

**Written TB infection control procedures**

Each facility should have written procedures to address TB infection control. Medium-risk settings should review their procedures annually and update, if necessary. Low-risk settings should review their procedures every other year and update, if necessary. Procedures should address:

- **Early recognition**: All HCWs should know the signs and symptoms of TB and their role in their facility’s TB infection control program.
- **Isolation**: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut.
- **Referral**: If your setting does not handle TB patients, transfer potentially infectious TB patients to a setting that is equipped to evaluate and treat TB patients.

The procedures should include information about working with the local or state public health department to conduct a TB contact investigation if health care-associated transmission of *M. tuberculosis* is suspected.
In addition, settings that expect to encounter (admit) patients with suspected or confirmed active TB disease are required to:

- Implement and maintain environmental controls, including AIR rooms,
- Develop a respiratory protection program, and
- Develop a plan for accepting patients with suspected or confirmed active TB disease.

**HCW education**

TB training is required at time of hire for all HCWs. The content of the training should be appropriate to the job responsibilities and educational or professional background of the HCW.

In medium-risk settings, TB training should be conducted annually. Low-risk settings should annually evaluate the need for TB training, and conduct training as needed.

Content should focus on basic information about:

- TB pathogenesis and transmission,
- Signs and symptoms of active TB disease, and
- Your health care setting’s infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing.
Chapter 3

Screening Health Care Workers (HCWs)

Definition of a HCW:

For purposes of TB infection control procedures, the following staff should be considered HCWs and should be included in your TB screening program:

- Administrators and managers
- Bronchoscopy
- Chaplains
- Clerical
- Computer programmers
- Construction
- Correctional officers
- Dental
- Dietician or dietary
- Educators
- Engineers
- Food service
- Health aides
- Health and safety
- Housekeeping or custodial
- Homeless shelter
- Infection control
- Janitorial, maintenance
- Laboratory
- Morgue
- Nurses
- Outreach
- Patient transport staff, including EMS
- Pharmacists
- Phlebotomists
- Physical and occupational therapists
- Physicians and other clinicians
- Public safety
- Radiology
- Respiratory therapists
- Social workers
- Students (e.g., medical, nursing, technicians, and allied health)
- Technicians (e.g., health, laboratory, radiology, and animal)
- Volunteers
In addition, HCWs who perform any of the following activities should also be included in your TB screening program:

- Entering patient rooms or treatment rooms whether or not a patient is present,
- Participating in aerosol-generating or aerosol-producing procedures (e.g., bronchoscopy, sputum induction, and administration of aerosolized medications),
- Participating in suspected or confirmed *M. tuberculosis* specimen processing, or
- Installing, maintaining, or replacing environmental controls in areas in which persons with active TB disease are encountered.

**General principles**

- There are two methods available to screen for TB infection: the tuberculin skin test (TST) and the Interferon Gamma Release Assay (IGRA). Information about these methods is available at [www.health.state.mn.us/divs/idepc/diseases/tb/tst.html](http://www.health.state.mn.us/divs/idepc/diseases/tb/tst.html) and [www.health.state.mn.us/divs/idepc/diseases/tb/bloodtests.html](http://www.health.state.mn.us/divs/idepc/diseases/tb/bloodtests.html).

- All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee’s record.

- TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document “0” mm) and interpretation (i.e., positive or negative).

- IGRA documentation should include the date of the test (i.e., month, day, year), the qualitative results (i.e., positive, negative, indeterminate or borderline) and the quantitative assay (i.e., Nil, TB and Mitogen concentrations or spot counts). Indeterminate or borderline results indicate an uncertain likelihood of *M. tuberculosis* infection and should be further evaluated by a physician.

- HCWs should be encouraged to keep copies of the results of their TB screening for future use.

- Disregard a HCW’s history of BCG vaccination when administering and interpreting a TST.

- It is the responsibility of the infection control team to ensure that written procedures are in place and are followed by staff to ensure that employees are free of infectious TB disease before beginning employment. Questions regarding the significance of an individual’s medical test results (e.g., chest X-ray reports) should be referred to the appropriate medical or nursing staff in your facility.

**Baseline TB screening**

Baseline TB screening is required for all HCWs (Table 3.1).

Baseline TB screening consists of three components:

1. Assessing for current symptoms of active TB disease,
2. Assessing TB history, and
3. Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a two-step TST or single IGRA.
An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients.

Available tool: *Baseline TB Screening Tool for HCWs Template* on pages 16-17.

**Serial TB screening**

Serial TB screening refers to TB screening performed at regular intervals following baseline TB screening. The frequency of serial TB testing is based on your facility’s TB risk classification (Table 3.1).

Serial TB screening consists of three components:

1. Assessing for current symptoms of active TB disease,
2. Assessing TB history, and
3. Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a one-step TST or single IGRA.

HCWs who have positive TSTs or IGRAs and who work in medium-risk settings do not need additional TSTs or IGRAs but should be assessed for current TB symptoms on an annual basis and instructed to seek medical evaluation if TB symptoms develop at any time.

Available tool: *Serial TB Screening Tool for HCWs Template* on pages 18-19.

**Table 3.1: Baseline and serial TB screening regulations for HCWs**

<table>
<thead>
<tr>
<th>Risk classification</th>
<th>Baseline screening</th>
<th>Serial screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Medium</td>
<td>Required</td>
<td>Annual</td>
</tr>
<tr>
<td>Potential ongoing transmission (usually temporary)</td>
<td>Required</td>
<td>May require testing on a quarterly or twice-yearly basis. Consult with the MDH TB Prevention and Control Program at 651-201-5414 regarding the frequency of testing under these circumstances.</td>
</tr>
</tbody>
</table>

**Special Situations**

**HCW with signs or symptoms of active TB disease**

A HCW with infectious TB disease poses a special risk in the workplace because of the potential to spread the infection to vulnerable patients. TB is not commonly found in Minnesota HCWs, but it does occur. In 2011-2012, a total of 12 HCWs in Minnesota were diagnosed with active TB disease.

Do not wait for the results of a TST or IGRA before referring a person with TB symptoms for a medical evaluation. Approximately 25 percent of persons with active TB disease have a negative TST or IGRA because the body’s immune system is not strong enough to respond to the test.
Persons with active TB disease may have one or more of the following symptoms:

- Prolonged cough (≥ three weeks)
- Hemoptysis
- Weight loss
- Night sweats
- Fatigue
- Fever, chills
- Poor appetite
- Chest pain
- Other symptoms may be present, depending on the site of disease

Active TB disease most commonly affects the lungs (pulmonary). However, TB disease can occur in other parts of the body (most commonly, pleural or lymphatic).

**Any HCW with symptoms of active TB disease, regardless of the results of the TST or IGRA, should be promptly evaluated to exclude a diagnosis of active TB disease.** This should include a medical evaluation, a chest X-ray, and collection of sputum specimens for mycobacterial smear and culture or additional testing if indicated. If active TB disease is confirmed or suspected, the diagnosing clinician should notify MDH at 651-201-5414 within one working day.

HCWs with suspected or confirmed infectious TB disease or a draining TB skin lesion should be excluded from the workplace. They should be allowed to return to work only after a physician-knowledgeable and experienced in managing TB has determined that they are no longer infectious (this may be done in consultation with the health department).

HCWs with extrapulmonary TB disease usually do not need to be excluded from the workplace as long as the respiratory tract is not involved and the HCW has been cleared for work by a physician.

**HCW with a newly-identified positive TST or IGRA**

Before the HCW has direct patient contact, the following should be documented in their record:

1. Test result,
2. Assessment for current TB symptoms,
3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and
4. Medical evaluation to rule out a diagnosis of infectious TB disease.

After the negative baseline chest X-ray is done and the results are documented, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray. HCWs who work in medium-risk settings should be assessed for current TB symptoms on an annual basis and instructed to seek medical evaluation if TB symptoms develop at any time.
HCW with written documentation of a previous positive TST or IGRA

If the test is appropriately documented you do not need to repeat the test.

Before the HCW has direct patient contact, the following should be documented in their record:

1. Test result,
2. Assessment for current TB symptoms,
3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done. If infectious TB disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and
4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA.

HCWs who work in medium-risk settings should be assessed for current TB symptoms on an annual basis and instructed to seek medical evaluation if TB symptoms develop at any time.

HCW with a verbal (undocumented) history of a previous positive TST or IGRA

These HCWs should undergo the same screening procedures as HCWs without previous positive results. Results of the screening should be documented in the HCW’s record.

If the HCW has documentation of previous treatment for latent TB infection or active TB disease, that documentation may be substituted for documentation of previous positive TST or IGRA results.

Pregnant HCW

Pregnancy is not a contraindication for TB testing. Pregnant women should be included in the same baseline and serial TB screening programs as other HCWs. If a pregnant HCW declines a TST, offer an IGRA if it is available. If an IGRA is not available, consider having the HCW and her personal health care provider complete the Exemption Form for Tuberculin Skin Testing of a Pregnant HCW (see page 20).

A pregnant HCW with a newly identified positive TST or IGRA, or signs and symptoms of active TB disease, is at increased risk for active TB disease and should receive a chest X-ray, using an abdominal shield.

Conversions

A conversion is when a person’s TST or IGRA result is initially negative but changes to positive at a later date. For surveillance purposes, an increase in induration of >10 mm is defined as a TST conversion. Follow instructions for a HCW with newly positive TST or IGRA. Additional information is available on pages 13 and 32-34 of “Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005.”
Screening Health Care Workers (HCWs)  Chapter 3

HCW with TST results between 5 and 9 mm of induration

This result is considered negative for most HCWs but is positive for persons with certain risk factors, including:

- HIV positive,
- Recent close contact with someone with infectious TB disease,
- Organ transplant recipient,
- Immunosuppressed due to taking immunosuppressive drugs (equivalent to greater than 15 mg of prednisone a day for one month or longer) or TNF alpha inhibitor drugs such as Enbrel®, Humira®, or Remicade® for treatment of rheumatoid arthritis, Crohn’s disease, or other autoimmune disorders, or
- Have a current chest X-ray that shows “scarring” or “fibrosis” or “old, healed TB.”

Because employers cannot legally collect information about these personal health TB risk factors, it is recommended, but not required, that these HCWs be given MDH’s Information for Health Care Workers with Tuberculin Skin Test (TST) Results between 5 and 9 mm (see page 21) and encouraged to follow-up with their personal health care providers as necessary.

Students

Students who will be performing health care-related activities should receive the same screening as paid HCWs. Health care facilities where students are placed should ensure that the students’ school has performed the required testing. Students who will be in the clinical setting for less than two weeks require only a one-step (not the two-step) TST.

Volunteers

Volunteers who share airspace with patients for five to 10 hours or more per week should receive the same TB screening as paid HCWs.

HCW with previous history of severe adverse reaction to TST

Severe adverse reactions (i.e., necrosis, blistering, anaphylactic shock or ulceration) to TSTs are rare events. A HCW who provides a convincing verbal report of a severe adverse reaction to a prior TST, even if the reaction is not documented, should NOT receive a TST. Substitute an IGRA for the TST if it is available. If an IGRA is not available, document the severe reaction, conduct the TB symptom screen and review TB risk factors.

HCW refusal

HCWs who refuse a TST should be screened using an IGRA. HCWs who refuse an IGRA should be screened using a TST. HCWs who refuse both the TST and IGRA should receive a chest X-ray to rule out infectious TB disease.
HCW who travels outside of the United States

It is recommended, but not required, that HCWs who travel for more than four weeks to a country where TB is common and have close contact with residents of that country (e.g., visiting family, medical volunteer work) be tested with a single TST or IGRA eight to 10 weeks after returning to the United States. The *CDC Health Information for International Travel* (commonly called the Yellow Book) can provide more information. You can find it at:  
Baseline TB Screening Tool for Health Care Workers (HCWs)

Last name, first name, middle initial ____________________________ Date form completed ________/____/______

Date of birth ________/____/______ Work phone number (______)____________

Baseline TB screening includes three components:

(1) Assessing for current symptoms of active TB disease *and*
(2) Assessing HCW’s history *and*
(3) Testing for the presence of infection with Mycobacterium tuberculosis by administering either a single TB blood test or a two-step TST.

Symptoms of active TB disease (circle all that are present)

Coughing (>3 weeks) Chest pain Fatigue
Night sweats Coughing up blood
Weight loss/poor appetite Fever/chills

Note: If TB symptoms are present, promptly refer HCW for a chest X-ray and medical evaluation before starting work. Do not wait for the TST or TB blood test result.

HCW’s history (circle response)

Have you ever had a positive reaction to a TB skin test or TB blood test? Yes No
If yes: Date ________________ Number of millimeters of induration ______

Have you had a TB skin test in the past 12 months? Yes No
If yes: Date ________________ Number of millimeters of induration ______ Result ________________

Comments

Have you ever had the BCG vaccine? Yes No
Have you ever been treated for latent TB infection? Yes No
Have you ever been treated for active TB disease? Yes No
Have you ever had an adverse reaction to a TB skin test? Yes No
Have you received a live-virus vaccine within the past 6 weeks? Yes No

Tool address: www.health.state.mn.us/divs/idepc/diseases/tb/rules/basetbscrn.doc
### Baseline TB Screening Tool for HCWs Template

#### TB Blood Test

<table>
<thead>
<tr>
<th>Name of TB blood test (circle)</th>
<th>QuantiFERON TB-Gold</th>
<th>QuantiFERON-TB-Gold InTube</th>
<th>T-SPOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of blood draw</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation of reading</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(circle)</td>
<td>Positive*</td>
<td>Negative</td>
<td>Indeterminate</td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Refer HCW for a chest x-ray and medical examination to rule out active infectious TB disease*

#### Tuberculin skin testing (TST)

<table>
<thead>
<tr>
<th>Administration</th>
<th>TST – First Step</th>
<th>TST – Second Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person administering test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date and time administered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location (circle)</td>
<td>L forearm R forearm Other:________</td>
<td>L forearm R forearm Other:________</td>
</tr>
<tr>
<td>Tuberculin manufacturer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin expiration date and lot #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature of person who administered test</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(read between 48-72 hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date and time read:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of mm of induration:</td>
<td>____mm ____mm</td>
<td></td>
</tr>
<tr>
<td>(across forearm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation of reading* (circle)</td>
<td>Positive** Negative***</td>
<td>Positive** Negative</td>
</tr>
<tr>
<td>Reader’s signature</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Consult grid at [www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf](http://www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf)*

** Refer HCW for a chest x-ray to rule out active TB disease

*** If results are negative, perform the second step in one to three weeks

---

Adapted by the Minnesota Department of Health TB Prevention and Control Program from materials produced by the Global TB Institute and the Francis J. Curry National TB Center

Serial TB Screening Tool for Health Care Workers (HCWs)

Last name, first name, middle initial ____________ Date form completed __/__/____

Date of birth __/__/____ Work phone number (______)____________

Serial TB screening includes three components:

1) Assessing for current symptoms of active TB disease
   *and*
2) Assessing HCW’s history
   *and*
3) Testing for the presence of infection with Mycobacterium tuberculosis by administering either a single TB blood test or a single TST.

Symptoms of active TB disease (circle all that are present)

Coughing (>3 weeks)  Chest pain  Fatigue
Night sweats  Coughing up blood
Weight loss/poor appetite  Fever/chills

Note: If TB symptoms are present, promptly refer HCW for a chest X-ray and medical evaluation before starting work. Do not wait for the TST or TB blood test result.

HCW’s history (circle response)

Have you ever had a positive reaction to a TB skin test or TB blood test?  Yes  No
If yes: Date______________ Number of millimeters of induration _______

Have you had a TB skin test in the past 12 months?  Yes  No
If yes: Date______________ Number of millimeters of induration _______ Result ______________

Comments

Have you ever had the BCG vaccine?  Yes  No
Have you ever been treated for latent TB infection?  Yes  No
Have you ever been treated for active TB disease?  Yes  No
Have you ever had an adverse reaction to a TB skin test?  Yes  No
Have you received a live-virus vaccine within the past 6 weeks?  Yes  No

Tool address:  www.health.state.mn.us/divs/idepc/diseases/tb/rules/sertbscrn.doc
## Serial TB Screening Tool for HCWs Template (page 2)

### TB Blood Test

<table>
<thead>
<tr>
<th>Name of TB blood test (circle)</th>
<th>QuantiFERON TB-Gold</th>
<th>QuantiFERON-TB-Gold InTube</th>
<th>T-SPOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of blood draw</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation of reading (circle)</td>
<td>Positive*</td>
<td>Negative</td>
<td>Indeterminate</td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Refer HCW for a chest x-ray and medical examination to rule out active infectious TB disease

### Tuberculin Skin Testing (TST)

#### Administration

<table>
<thead>
<tr>
<th>Name of person administering test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and time administered</td>
<td></td>
</tr>
<tr>
<td>Location (circle)</td>
<td>L forearm  R forearm Other:________</td>
</tr>
<tr>
<td>Tuberculin manufacturer</td>
<td></td>
</tr>
<tr>
<td>Tuberculin expiration date and lot #</td>
<td></td>
</tr>
<tr>
<td>Signature of person who administered test</td>
<td></td>
</tr>
</tbody>
</table>

#### Results

(read between 48-72 hours)

<table>
<thead>
<tr>
<th>Date and time read:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of mm of induration: (across forearm)</td>
<td>____mm</td>
</tr>
<tr>
<td>Interpretation of reading* (circle)</td>
<td>Positive**  Negative</td>
</tr>
<tr>
<td>Reader’s signature</td>
<td></td>
</tr>
</tbody>
</table>

*Consult grid at [www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf](http://www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf)

** Refer HCW for a chest x-ray to rule out active TB disease

Adapted by the Minnesota Department of Health TB Prevention and Control Program from materials produced by the Global TB Institute and the Francis J. Curry National TB Center

Exemption Form for Tuberculin Skin Testing of a Pregnant HCW

Note: This is a suggested template developed by the Minnesota Department of Health (MDH) Tuberculosis Prevention and Control Program. It is designed to assist health care facilities who receive employee requests to be exempted from TB skin testing due to pregnancy. This is not an official MDH form. It may be adapted by individual health care facilities to create their own form. MDH does not recommend the practice of routinely exempting health care workers from TB skin testing due to pregnancy.

To remove “Sample” watermark: On the “Format” menu, click on “Background,” then click “Printed Watermark,” then click “No watermark.”

Exemption from Tuberculin Skin Testing for a Pregnant Health Care Worker

I, __________ (physician’s name) recommend that my patient, __________, be exempted from tuberculin skin testing (TST) for the following reason: __________. I understand that the U.S. Centers for Disease Control and Prevention and the Minnesota Department of Health consider TST to be valid and safe during pregnancy and recommend that pregnant women with risk factors (e.g., health care workers) for exposure to tuberculosis (TB) should receive testing.

Check one:

____ I will arrange for my patient to receive a TB blood test (i.e., QuantiFERON, T-Spot) as a substitute for TST.

____ I have been unable to locate a laboratory that will perform a TB blood test (i.e., QuantiFERON, T-Spot) for my patient.

Signature: __________ (physician)
Clinic name and phone number: __________

I ___ (employee) have read the above information and understand that tuberculin skin testing is generally considered safe in pregnant women.

Signature: __________ (employee)

References:

Tool address: www.health.state.mn.us/divs/idepc/diseases/tb/rules/exmtpreghw.doc
Information for Health Care Workers with Tuberculin Skin Test (TST) Results between 5 and 9 mm

Note: This is a suggested template developed by the Minnesota Department of Health (MDH) Tuberculosis (TB) Prevention and Control Program. It is designed to assist health care facilities who have employees with tuberculin skin test (TST) results between 5 and 9 mm induration.

TST results between 5 and 9 mm of induration are negative for most health care workers but are positive for those with certain risk factors. The purpose of this form is to educate health care workers who have TST results between 5 and 9 mm and may have these risk factors. Employers cannot and should not collect information about these personal health TB risk factors. Employers are not required to follow-up with employees who have TST results between 5 and 9 mm unless the employee also has signs or symptoms of active TB disease.

This is not an official MDH form. It may be adapted by individual health care facilities to create their own form.

To remove “Sample” watermark: On the “Format” menu, click on “Background,” then click “Printed Watermark,” then click “No Watermark.”

SAMPLE

Dear employee:

You recently participated in tuberculin skin testing (TST). This is a test for latent tuberculosis (TB) infection. Your TST result, administered on ___/___/______ and read on ___/___/_______ was _____ mm induration. This test result is considered “negative” (normal) for most health care workers, but is considered “positive” for people with the following risk factors:

- Are HIV positive
- Have had recent close contact with someone with active TB disease of the lungs
- Have had an organ transplant
- Are immunosuppressed due to taking immunosuppressive drugs (equivalent to greater than 15 mg of prednisone a day for 1 month or longer) or TNF alpha inhibitor drugs such as Enbrel®, Humira®, or Remicade® for treatment of rheumatoid arthritis, Crohn’s disease, or other autoimmune disorders
- Have a current chest X-ray that shows “scarring” or “fibrosis” or “old, healed TB”

If you have one or more of these risk factors, we strongly encourage you to set up an appointment with your personal health care provider to discuss your test results. We recommend that you bring this form with you to your medical appointment.

Additional information about TB testing and latent TB infection is available at www.health.state.mn.us/divs/idepc/diseases/tb/factsheets/tst.html.

Tool address: www.health.state.mn.us/divs/idepc/diseases/tb/rules/hcwtsrslt.doc
Chapter 4

Screening Residents

Routine TB screening of residents (patients) is not required in Minnesota health care settings except for boarding care homes, nursing homes, and residential hospices. Residents in other facilities may be screened for TB at the discretion of their health care providers or the health care setting’s infection control team.

General principles

• Screening should be initiated within 72 hours of admission or within 90 days prior to admission.

• There are two methods available to screen for TB infection: the tuberculin skin test (TST) and the Interferon Gamma Release Assay (IGRA). Information about these methods is available at www.health.state.mn.us/divs/idepc/diseases/tb/tst.html and www.health.state.mn.us/divs/idepc/diseases/tb/bloodtests.html.

• It is the responsibility of the infection control team to ensure that written procedures are in place and are followed by staff to ensure that residents are free of infectious TB disease at time of admission. Questions regarding the significance of an individual’s medical test results (e.g., chest X-ray reports) should be referred to the appropriate medical or nursing staff in your facility.

• All reports or copies of the TST or IGRA and any chest X-rays and medical evaluations conducted should be maintained in the resident’s medical record.

• Residents who are temporarily transferred to other facilities (e.g., a hospital) do not need to be re-tested upon re-admission if that facility has a TB prevention and control program in place.

• Disregard a resident’s history of BCG vaccination when administering and interpreting a TST.

• TST documentation for residents should include the date (i.e., month, day, year), the number of millimeters of induration (if no induration, document “0” mm), and interpretation (i.e., positive or negative). If this information is not available, documentation of a history of infection with TB (e.g., a previous positive skin test or history of active TB disease) by a physician in the resident’s medical record is acceptable.

• IGRA documentation should include the date of the test (i.e., month, day, year), the qualitative results (i.e., positive, negative, indeterminate, or borderline) and the quantitative assay (i.e., Nil, TB and Mitogen concentrations or spot counts). Indeterminate or borderline results indicate an uncertain likelihood of *M. tuberculosis* infection and should be further evaluated by a physician.

Baseline TB screening of residents in boarding care homes and nursing homes

Baseline TB screening consists of three components:

1. Assessing for current symptoms of active TB disease,
2. Assessing for TB risk factors and TB history, and
3. Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a two-step TST or single IGRA.

Baseline TB screening of residents in residential hospices

Baseline TB screening consists of one component:

1. Assessing for current symptoms of active TB disease.

Screening for the presence of infection with Mycobacterium tuberculosis using a TST or IGRA is not necessary.

Available tool: Baseline TB Screening Tool for Residents in Residential Hospice Template on page 29.

Special Situations

Resident with a newly identified positive TST or IGRA

Documentation should include:

1. Test result,
2. Assessment for current TB symptoms,
3. Assessment of risk factors for progression to active TB disease,
4. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the resident has not been exposed to infectious TB disease since the chest X-ray was done. After a baseline chest X-ray is performed and infectious TB disease has been ruled out, the resident will not need additional chest X-rays unless they develop symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and
5. Medical evaluation to rule out a diagnosis of infectious TB disease.

Post the resident’s positive TST or IGRA status in a prominent place in their record to ensure that staff are aware of it in case the resident develops symptoms of active TB disease at a later date.

Resident with written documentation of a previous positive TST or IGRA

If the result is appropriately documented, an additional TST or IGRA is not needed.

Documentation should include:

1. Test result,
2. Assessment for current TB symptoms,
3. Assessment of risk factors for progression to active TB disease,
4. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the resident has not been exposed to infectious TB disease since the chest X-ray was done. After a baseline chest X-ray is performed and infectious TB disease has been ruled out, the resident will not need additional chest X-rays unless they develop symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and
5. Medical evaluation to rule out a diagnosis of infectious TB disease if resident didn’t have an appropriately documented chest X-ray and needed to get one. No medical evaluation is required if resident already has a chest X-ray dated after the documented positive TST or IGRA.
Post the resident’s positive TST or IGRA status in a prominent place in their record to ensure that staff are aware of it in case the resident develops symptoms of active TB disease at a later date.

**Resident with a verbal (undocumented) history of a previous positive TST or IGRA**

These residents should undergo the same screening process as residents without previous positive results. Results of the screening should be documented in the resident’s record.

If the resident has documentation of previous treatment for latent TB infection or active TB disease, that documentation may be substituted for documentation of previous positive TST or IGRA results.

**Resident with signs or symptoms of active TB disease**

Do not wait for the results of a TST or IGRA before referring a resident with TB symptoms for a medical evaluation. Approximately 25 percent of persons with active TB disease have a negative TST or IGRA because the body’s immune system is not strong enough to respond to the test.

Residents with active TB disease may have one or more of the following:

- Prolonged cough (≥ three weeks)
- Hemoptysis
- Weight loss
- Night sweats
- Fatigue
- Fever, chills
- Poor appetite
- Chest pain
- Other symptoms may be present, depending on the site of disease

Active TB disease most commonly affects the lungs (pulmonary), but approximately 40 percent of TB cases in Minnesota involve only an extrapulmonary site of disease (most commonly pleural or lymphatic). For infection control purposes, only pulmonary, pleural and laryngeal TB disease are considered potentially infectious; most extrapulmonary TB cannot be transmitted to others.

Any resident with symptoms of infectious TB disease, regardless of the results of the TST or IGRA, should be transferred to a facility with respiratory isolation rooms and promptly evaluated to exclude a diagnosis of active TB disease. This should include a medical evaluation and symptom screen, a chest X-ray, and collection of sputum specimens or additional testing if indicated.

If active TB disease is confirmed or suspected, the diagnosing clinician should notify MDH at 651-201-5414 within one working day. The resident should remain in respiratory isolation until TB is diagnosed and effective treatment is initiated, or TB is ruled out. The resident’s physician and the public health department should be consulted for guidance regarding when a resident with infectious TB disease can be removed from isolation.
Screening Residents

Resident with a previous history of severe adverse reaction to TST

Severe adverse reactions (i.e., necrosis, blistering, anaphylactic shock or ulceration) to TSTs are rare events. Residents who provide a convincing verbal report of a severe adverse reaction to a prior TST, even if the reaction is not documented, should NOT receive a TST. Substitute an IGRA for the TST if it is available. If an IGRA is not available, document the severe reaction, conduct the TB symptom screen and review TB history and TB risk factors.

Resident refusal

Residents who refuse a TST should be screened using an IGRA. Residents who refuse an IGRA should be screened using a TST. Residents who refuse both the TST and IGRA should receive a chest X-ray to rule out infectious TB disease.
Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents

Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents

<table>
<thead>
<tr>
<th>Last name, first name, middle initial</th>
<th>Date of birth</th>
<th>Date form completed</th>
</tr>
</thead>
</table>

Baseline TB screening includes three components:

1. Assessing for current symptoms of active TB disease
2. Assessing the resident’s TB risk factors and TB history
3. Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a single TB blood test or a two-step TST.

### Symptoms of active TB disease (circle all that are present)

- Coughing (>3 weeks)
- Night sweats
- Weight loss/poor appetite
- Chest pain
- Coughing up blood
- Fever/chills
- Fatigue

*Note:* If TB symptoms are present, promptly refer patient for a chest X-ray and medical evaluation. Do not wait for the TST or TB blood test result.

### Resident’s history and risk factors (circle response)

- Ever had a positive reaction to a TB skin test or TB blood test?  Yes  No
- If yes: Date______________ Number of millimeters of induration ______
- Had a TB skin test in the past 12 months?  Yes  No
- If yes: Date______________ Number of millimeters of induration ______ Result_________________

<table>
<thead>
<tr>
<th>BCG vaccine?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated for latent TB infection?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Treated for active TB disease?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Had a known exposure to TB &lt; 2 years ago?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Born outside of the U.S.?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Traveled or lived outside of the U.S. in the past 2 years?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>HIV-infected?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Immune suppressed*?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>History of substance abuse?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>End stage renal disease, diabetes, or silicosis?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Scarring/fibrosis on chest X-ray?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Undernourished or underweight (&lt; 90% of ideal)</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Live-virus vaccine within the past 6 weeks?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Severe adverse reaction to a TB skin test?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

* *i.e., taking immunosuppressive drugs (equivalent to greater than 15 mg of prednisone a day for 1 month or longer) or TNF alpha inhibitor drugs such as Enbrel®, Humira®, or Remicade® for treatment of rheumatoid arthritis, Crohn’s disease, or other autoimmune disorders

# Baseline TB Screening Tool for Residents Template (page 2)

## TB Blood Test

<table>
<thead>
<tr>
<th>Name of TB blood test (circle)</th>
<th>QuantiFERON TB-Gold</th>
<th>QuantiFERON-TB-Gold InTube</th>
<th>T-SPOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of blood draw</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Results

<table>
<thead>
<tr>
<th>Interpretation of reading (circle)</th>
<th>Positive*</th>
<th>Negative</th>
<th>Indeterminate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Refer HCW for a chest x-ray and medical examination to rule out active infectious TB disease.

## Tuberculin skin testing (TST)

### Administration

<table>
<thead>
<tr>
<th>TST – First Step</th>
<th>TST – Second Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person administering test</td>
<td></td>
</tr>
<tr>
<td>Date and time administered</td>
<td></td>
</tr>
<tr>
<td>Location (circle)</td>
<td>L forearm   R forearm  Other:________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location (circle)</th>
<th>L forearm   R forearm  Other:________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculin manufacturer</td>
<td></td>
</tr>
<tr>
<td>Tuberculin expiration date and lot #</td>
<td></td>
</tr>
<tr>
<td>Signature of person who administered test</td>
<td></td>
</tr>
</tbody>
</table>

### Results

(read between 48-72 hours)

<table>
<thead>
<tr>
<th>Date and time read:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of mm of induration: (across forearm)</td>
<td>____mm   ____mm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpretation of reading* (circle)</th>
<th>Positive**</th>
<th>Negative***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reader’s signature</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Consult grid at [www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf](http://www.health.state.mn.us/divs/idepc/diseases/tb/candidates.pdf)

** Refer HCW for a chest x-ray to rule out active TB disease

*** If results are negative, perform the second step in one to three weeks

---

*Adapted by the Minnesota Department of Health TB Prevention and Control Program from materials produced by the Global TB Institute and the Francis J. Curry National TB Center*

**Tool address:** [www.health.state.mn.us/divs/idepc/diseases/tb/rules/tbscrmbchnh.doc](http://www.health.state.mn.us/divs/idepc/diseases/tb/rules/tbscrmbchnh.doc)
Baseline TB Screening Tool for Residents in Residential Hospice

Last name, first name, middle initial               Date of birth               Date form completed

Symptoms of active TB disease (circle all that are present)

- Coughing (>3 weeks)
- Night sweats
- Weight loss/poor appetite
- Chest pain
- Coughing up blood
- Fever/chills
- Fatigue

Note: If TB symptoms are present, promptly refer patient for a chest X-ray and full medical evaluation. Do not wait for the TST or IGRA result.

Tool address: www.health.state.mn.us/divs/idepc/diseases/tb/rules/tbscrnrh.doc
<table>
<thead>
<tr>
<th>Term</th>
<th>Defined as</th>
</tr>
</thead>
<tbody>
<tr>
<td>active tuberculosis (TB) disease</td>
<td>Condition caused by Mycobacterium tuberculosis that has progressed to causing clinical or subclinical disease. TB disease usually affects the lungs, but it can also affect other parts of the body, such as the lymph nodes, bone, or brain. If TB is treated properly, most people can be cured. If TB is NOT treated properly, the disease can be fatal or develop into drug-resistant forms of TB. Compare to latent TB infection (LTBI). See also extrapulmonary TB and pulmonary TB.</td>
</tr>
<tr>
<td>airborne infection isolation (AII)</td>
<td>Isolation of patients infected with organisms that are spread via airborne droplet nuclei smaller than five microns in diameter (e.g., M. tuberculosis).</td>
</tr>
<tr>
<td>Bacille Calmette-Guérin (BCG) vaccine</td>
<td>A vaccine for TB used in many countries where active TB disease is endemic. It is not used in the United States. BCG vaccine helps prevent disseminated and meningeal TB disease in infants and young children, but offers much less protection for adults.</td>
</tr>
<tr>
<td>baseline TB screening</td>
<td>The initial screening for TB performed at the time that HCWs begin work or residents are admitted to a health care facility. Baseline screening identifies individuals with LTBI or active TB disease and is also used to compare with any future screening results. See also TB screening.</td>
</tr>
<tr>
<td>boosting</td>
<td>A phenomenon in which people who are skin tested many years after becoming infected with <em>M. tuberculosis</em> may have a negative reaction to an initial TST, followed by a positive reaction to a TST given up to a year later; this happens because the first TST boosts the immune response. Two-step testing is used in TB screening programs to tell the difference between boosted reactions and reactions caused by recent infection (see two-step TST). Boosting does not pertain to interferon gamma release assays (IGRAs).</td>
</tr>
<tr>
<td>conversion</td>
<td>A change in the result of a test for <em>M. tuberculosis</em> infection (TST or IGRA) which is interpreted as having progressed from uninfected to infected. An increase of ≥10 mm in induration during a maximum of two years is defined as a TST conversion for the purposes of employee surveillance programs. A conversion indicates that a new <em>M. tuberculosis</em> infection has likely occurred; this poses an increased risk for progression to active TB disease.</td>
</tr>
<tr>
<td>exposure</td>
<td>Being subjected to something (e.g., an infectious agent) that could have an adverse health effect. A person exposed to <em>M. tuberculosis</em> does not necessarily become infected. See also transmission.</td>
</tr>
<tr>
<td>Term</td>
<td>Defined as</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>extrapulmonary TB</td>
<td>Active TB disease in any part of the body other than the lungs (e.g., lymph nodes, bone). An individual can have both pulmonary and extrapulmonary TB disease at the same time. Extrapulmonary TB is typically not considered infectious.</td>
</tr>
<tr>
<td>facility</td>
<td>A physical building or set of buildings.</td>
</tr>
<tr>
<td>facility TB risk assessment</td>
<td>An initial and ongoing evaluation of the risk for transmission of <em>M. tuberculosis</em> in a particular health care setting. To perform a risk assessment, the following factors should be considered: the community rate of TB, number of TB patients encountered in the setting, and the speed at which patients with active TB disease are suspected, isolated, and evaluated. The TB risk assessment determines the types of administrative and environmental controls and respiratory protection needed for a setting.</td>
</tr>
<tr>
<td>health care setting</td>
<td>A place where health care is delivered.</td>
</tr>
<tr>
<td>health care workers (HCWs)</td>
<td>Paid or unpaid person working in a health care setting.</td>
</tr>
<tr>
<td>hemoptysis</td>
<td>Coughing up of blood or blood-tinged sputum; one of the possible symptoms of pulmonary TB disease. Hemoptysis can also be observed in other pulmonary conditions (e.g., lung cancer).</td>
</tr>
<tr>
<td>induration</td>
<td>A palpable, raised, hardened area that may develop in response to the injection of tuberculin antigen. Induration is measured in only one direction (across the forearm), and the result is recorded in millimeters. The measurement is compared with guidelines to determine whether the test result is classified as positive or negative.</td>
</tr>
<tr>
<td>infectious</td>
<td>The ability of an individual with active TB disease to transmit (spread) TB bacteria to other persons. Directly related to the number of TB bacteria that the individual expels into the air. Persons who expel many bacilli are more infectious than those who expel few or no bacilli.</td>
</tr>
<tr>
<td>interferon gamma release assay (IGRA)</td>
<td>A test that detects the presence of <em>M. tuberculosis</em> infection by measuring the immune response to the TB bacteria in the blood. There are two commercially available IGRAs: QuantiFERON-TB and T-Spot.</td>
</tr>
<tr>
<td>Term</td>
<td>Defined as</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>latent TB infection (LTBI)</td>
<td>Persons with latent TB infection have <em>M. tuberculosis</em> organisms in their bodies but do not have active TB disease, have no symptoms, and are noninfectious. Such persons usually have a positive reaction to a TST or IGRA.</td>
</tr>
<tr>
<td>Mantoux tuberculin skin test</td>
<td>see tuberculin skin test</td>
</tr>
<tr>
<td>medical evaluation</td>
<td>A process for diagnosing active TB disease or LTBI, selecting treatment, and assessing response to therapy. A medical evaluation can include medical history and TB symptom screen, clinical or physical examination, screening and diagnostic tests (e.g., TSTs, IGRAs, chest X-rays, bacteriologic examination, and HIV testing), counseling, and treatment referrals.</td>
</tr>
<tr>
<td><em>Mycobacterium tuberculosis</em> (<em>M. tuberculosis or M. tb</em>)</td>
<td>A type of tuberculous mycobacteria; a gram-positive bacterium that causes tuberculosis. Sometimes called the tubercle bacillus.</td>
</tr>
<tr>
<td>potential ongoing transmission</td>
<td>A risk classification for TB screening, including testing for <em>M. tuberculosis</em> infection when evidence of ongoing transmission of <em>M. tuberculosis</em> is apparent in the setting. Testing might need to be performed every 8–10 weeks until lapses in infection controls have been corrected, and no further evidence of ongoing transmission is apparent. Use potential ongoing transmission as a temporary risk classification only. After corrective steps are taken and conversion rates stabilize, reclassify the setting as medium risk for a period of at least one year.</td>
</tr>
<tr>
<td>pulmonary TB</td>
<td>Active TB disease that occurs in the lung, usually producing a cough that lasts ≥ 3 weeks.</td>
</tr>
<tr>
<td>purified protein derivative (PPD) (tuberculin)</td>
<td>A material used in the tuberculin skin test for detecting infection with <em>M. tuberculosis</em>. In the United States, PPD solution is approved for administration as an intradermal injection (5 TU per 0.1 mL), a diagnostic aid for LTBI (see tuberculin skin test).</td>
</tr>
<tr>
<td>respiratory protection</td>
<td>The use of N-95 or other respirators to protect a HCW from inhaling droplet nuclei containing <em>M. tuberculosis</em>.</td>
</tr>
<tr>
<td>serial TB screening</td>
<td>TB screening performed at regular intervals following initial baseline TB screening.</td>
</tr>
<tr>
<td>Term</td>
<td>Defined as</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>symptom screen</td>
<td>A procedure used during a clinical evaluation in which patients are asked if they have experienced any of the common symptoms of active TB disease (e.g., cough, weight loss, night sweats).</td>
</tr>
<tr>
<td>TB blood test</td>
<td>see IGRA</td>
</tr>
<tr>
<td>TB screening</td>
<td>Methods used to identify persons who have active TB disease or LTBI. May include one or more of the following: TST, IGRA, chest x-ray, symptom screening.</td>
</tr>
<tr>
<td>transmission</td>
<td>Transmission occurs when a person inhales droplet nuclei containing <em>M. tuberculosis</em>, and the droplet nuclei transverse the mouth or nasal passages, upper respiratory tract, and bronchi to reach the alveoli of the lungs, resulting in infection.</td>
</tr>
<tr>
<td>tuberculin skin test</td>
<td>Skin test used to detect TB infection. Sometimes referred to as “PPD” or “Mantoux.”</td>
</tr>
<tr>
<td>(TST)</td>
<td></td>
</tr>
<tr>
<td>two-step TST</td>
<td>Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1–3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected.</td>
</tr>
</tbody>
</table>
Tuberculosis Prevention and Control- MDH Surveyor Checklist

Home Care, Hospice, Supervised Living Facility, Nursing Home, Boarding Care Home, Outpatient Surgical Center

Resource for all items on checklist:

“Regulations for Tuberculosis Control in Minnesota Health Care Settings: A Guide for Implementing Tuberculosis (TB) Infection Control Regulations in Your Facility”

___ Provider has documentation of supervisory responsibility for the TB infection control program. [page 5]

___ Provider has a current written TB risk assessment that is reviewed and updated periodically. [pages 5-6]
   Date of most recent risk assessment ____________

___ Provider has a written infection control plan that includes: (1) procedures for handling persons with active TB disease and (2) documentation of initial and ongoing TB-related training and education for all health care workers. [pages 6-7] Date of most recent review of plan ______________

___ Results of baseline TB screening of all paid and unpaid health care workers are documented. All reports or copies of tuberculin skin tests (TSTs), IGRAs/TB blood tests for *M. tuberculosis*, medical evaluation, TB symptom screen, and chest radiograph results are maintained in the health care worker’s employee file. [pages 10-14]

___ Baseline screening includes two-step skin testing (unless the TB blood test is used). [pages 10-11]

___ If the setting is classified as “medium risk” or higher, results of serial TB screening of all paid and unpaid health care workers are documented. All reports or copies of tuberculin skin tests (TSTs), IGRAs/TB blood tests for *M. tuberculosis*, medical evaluation, TB symptom screen, and chest radiograph results are maintained in the health care worker’s employee file. [page 11]

Residents (for Boarding Care Homes and Nursing Homes only)

___ Results of baseline TB screening of all residents within 72 hours of admission or within 3 months prior to admission are documented. All reports or copies of tuberculin skin tests (TSTs), IGRAs/TB blood tests for *M. tuberculosis*, medical evaluation, TB symptom screen, and chest radiograph results are maintained in the patient’s medical record. [pages 23-26]

___ Baseline screening includes two-step skin testing (unless the TB blood test is used). [page 23]

Residents (Residential Hospice only)

___ Results of baseline TB screening of all residents within 72 hours of admission or within 3 months prior to admission are documented. TB symptom screen only. [page 24]
Comprehensive Home Care Survey Self-Audit Tool

Topic: **Tuberculosis**

Audited by: _______________________________

Date of Audit: ___________________________

Task:

1. Make five copies of this blank form
2. Retrieve five employee personnel files
3. If you keep employee medical information in files other than personnel files (recommended) also retrieve five of those files, and the file for at least one regularly scheduled volunteer
4. Retrieve your home care infection control policies and procedures
5. Retrieve the job description of the staff person identified as being responsible for supervision of the TB infection control program
6. Retrieve the staff orientation topics checklist
7. Retrieve you community TB risk assessment document

Review the items for compliance with the following requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>The home care provider has identified a nurse that has been given supervisory responsibility of the TB program – this responsibility is identified in the person’s job description.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An interview with the person responsible for supervision of the home care provider’s TB program indicates the person has good knowledge of the organization’s TB protocols as well as CDC and MDH expectations regarding TB.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The home care provider has a current Community TB Risk Assessment document completed and on file. The assessment contains the most current community TB rates and identifies if the community is considered low, medium, or high risk for TB transmission.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| The home care provider’s written infection control plan includes:  
  1. Procedures for handling persons with active TB disease  
  2. Documentation of initial and ongoing TB-related education for all health care workers |     |         |     |
<p>| Documentation is maintained that all home care workers and all regularly scheduled volunteers who share airspace with clients were screened for symptoms of TB prior to the TST or blood test. |     |         |     |
| All home care workers and all regularly scheduled volunteers who share |     |         |     |</p>
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air space with clients have documentation indicating the first step of a two-step tuberculin skin test (TST) was conducted and read, with a negative result, prior to the home care worker or volunteer sharing direct air space with home care clients. Alternative test would be a negative IGRA blood test.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The results of the second-step of the two-step tuberculin skin test is on file.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation records indicate that infection control training and infection control practices was part of required orientation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual home care staff required training (part of the required 8 hours of annual training) includes a review of infection control techniques and reporting of communicable diseases.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verify that any agreements with supplemental staffing agencies (nursing pools) indicate that any staff sent to your home care agency will have been pre-screened for TB.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If any applicable requirements are identified as “Not Met”, correct the situation, audit other personnel and volunteer records, and other sources of information to determine how widespread the problem is, correct all problems, and review policies, procedures, forms, and staff responsibilities to correct the problem going forward.

**Resources:**

- MDH TB Screening – information about the Tuberculin Skin Test and the TB Blood Tests
- MDH Regulations for Tuberculosis Control in Minnesota Health Care Settings – this excellent resource contains a sample employee TB health screening form, sample TST documentation form, and a sample TST exemption form for pregnant health care workers
- Community TB Risk Assessment Worksheet for Health Care Settings
- Directions regarding how to complete the TB Risk Assessment Worksheet, including County TB case counts
- Centers for Disease Control (CDC)
- Minnesota Department of Health TB Website
  - [http://www.health.state.mn.us/tb](http://www.health.state.mn.us/tb)

**Reference:** 144A.4798 Subd. 1
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Quality Assurance and Quality Management

Class A:

4668.0180 Subp. 9 Quality Assurance

The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

A. monitor and evaluate two or more selected components of its services at least once every 12 months; and

B. document the collection and analysis of data and the action taken as a result.

Class F:

No requirement

Comprehensive:

144A.479 Subd. 3 Quality management

The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.
Comprehensive Home Care Survey Self-Audit Tool

Topic: **Quality Management/Performance Improvement Requirement**

Audited by: ____________________________

Date of Audit: _________________________

Task:

1. Make a one blank copy of this form
2. Retrieve your current Quality Management project
3. Retrieve your previous Quality Management project
4. Retrieve your complaint Log
5. Retrieve your most recent MDH survey (regular or OHFC investigation)

Review the items for compliance with the following requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current Quality Management project is able to be located quickly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The previous Quality Management project is able to be located quickly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Quality Management projects would be easily retrievable for a surveyor or investigator during an unannounced survey.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation about Quality Management activity is available for 2 years.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are the two Quality Management projects organized in a manner that a surveyor would understand what issue was the focus of the Quality Management activity or plan? **Recommended** (not required in statute) documentation might include:

1. The topic or focus of the Quality Management project
2. The source of any data used
3. Any comparable data (if available)
4. The process used for the performance improvement process (e.g. PDCA, Root Cause Analysis, etc.)
5. The beginning date of the project
6. The timeline for the project
7. Persons assigned to participate in the performance improvement project
8. The resolution or changes made resulting from the project (if any)
9. An evaluation of the project
10. The end date of the project (if it has ended)

While not required, the home care provider has considered using previous survey outcomes or OHFC investigations as a source of a Quality
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management project.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While not required, the home care provider has considered using data from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the required complaint log as a source of a Quality Management project.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The documented Quality Management activities/projects must evaluate some</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>portion of at least one of the following broad topic areas:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. A review of client services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A review of client complaints received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A review of other issues that have occurred</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The outcome of the Quality Management activity/project should focus on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>determining whether changes in services, staffing, or other procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>need to be made in order to ensure safe and competent services to clients.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If any applicable requirements are identified as “Not Met”, correct the situation.

Hints:

- It is unclear how MDH will survey for compliance with this requirement.
- It is suggested that at least one Quality Improvement project be in place at all times.
- It is suggested the home care provider pick topics for Quality Improvement projects that are closely aligned to the success of the organization and satisfaction of its clients.
- You may want to consider a log of Quality Improvement projects to document the various projects you have worked on over time.

Reference: 144A.479 Subd. 3
Supervision of Unlicensed Staff

Class A:

4668.011 Subp. 9 Periodic supervision of home health aide tasks

After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

A. within 14 days after initiation of home health aide tasks; and
B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4 (medications and delegated nursing or therapy services); or
C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse.

Class F:

4668.0845 Subp. 2-3 Services that do and do not require supervision by a RN

A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by a registered nurse at the housing with services establishment, to
verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. Supervision or monitoring must be provided no less often than the following schedule:

(1) within 14 days after initiation of assisted living home care services that require supervision by a registered nurse; and

(2) at least every 62 days thereafter, or more frequently if indicated by a nursing assessment and the client's individualized service plan.

B. If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

Services that do not require supervision by a registered nurse. After the orientation required under part 4668.0835, subpart 5, unlicensed persons who perform services listed under part 4668.0830, subpart 2, or other assisted living home care services that do not require supervision by a registered nurse must be supervised at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. The service plan developed under part 4668.0815 must address the frequency of the supervision of each service and the appropriate person to perform the supervision.

Comprehensive:

144A.4797 Subd. 3 Supervision of staff providing delegated nursing or therapy home care tasks

(a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Performance of Routine Procedures/Competency Testing

Class A:

4668.0100 Subp. 4 Home Health Aide Tasks – Performance of Routine Procedures

A person who is qualified to perform home health aide tasks may perform delegated medical or nursing and assigned therapy procedures, if:

A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client;

B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client;

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person’s ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients’ records.

Class F:

4668.0825 Subp. 4 Delegated Nursing Services – Performance of Routine Procedures

A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person’s ability to competently follow the procedures;
D. the procedures for each client are documented in the client's record; and
E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

4668.0855 Subp. 7 Delegated Medication Assistance and Administration – Performance of Routine Procedures

A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
D. the procedures for each client are documented in the client's records; and
E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Comprehensive:

144A.4795 Subd. 4 Delegation of Home Care Tasks

A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The comprehensive home care provider must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual client needs and preferences.

144A.4792 Subd. 7 Delegation of Medication Administration

When administration of medications is delegated to unlicensed personnel, the comprehensive home care provider must ensure that the registered nurse has:

(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
144A.4793 Subd. 4 Delegation of Treatments and Therapy

Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has:

1. instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures;

2. specified, in writing, specific instructions for each client and documented those instructions in the client's record; and

3. communicated with the unlicensed personnel about the individual needs of the client.
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Medication Administration Documentation

Class A:

There is no really good matching requirement. Closest matches include:

4668.0160 Subp. 6 (D)

The client record must contain notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact.

4668.0003 Subp. 21a Medication administration.

"Medication administration" means performing a task to ensure a client takes a medication, and includes the following tasks, performed in the following order:

A. checking the client's medication record;
B. preparing the medication for administration;
C. administering the medication to the client;
D. documenting after administration, or the reason for not administering the medication as ordered; and
E. reporting information to a nurse regarding concerns about the medication or the client's refusal to take the medication.

Class F:

4668.0855 Subp. 9 Medication Records

The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of
medication or medication administration. If assistance with self-administration of medication or
medication administration was not completed as prescribed, documentation must include the
reason why it was not completed and any follow up procedures that were provided.

Comprehensive:

144A.4792 Subd.1 (c) Medication Management

The written policies and procedures must address requesting and receiving prescriptions for
medications; preparing and giving medications; verifying that prescription drugs are
administered as prescribed; documenting medication management activities; controlling and
storing medications; monitoring and evaluating medication use; resolving medication errors;
communicating with the prescriber, pharmacist, and client and client representative, if any;
disposing of unused medications; and educating clients and client representatives about
medications. When controlled substances are being managed, the policies and procedures must
also identify how the provider will ensure security and accountability for the overall
management, control, and disposition of those substances in compliance with state and federal
regulations and with subdivision 22.

144A.4792 Subd. 4 Medication Management – Client Refusal

The home care provider must document in the client's record any refusal for an assessment for
medication management by the client. The provider must discuss with the client the possible
consequences of the client's refusal and document the discussion in the client's record.

144A.4792 Subd. 8-9 Medication Management – Documentation (Administration and Set-up)

Each medication administered by comprehensive home care provider staff must be documented
in the client's record. The documentation must include the signature and title of the person who
administered the medication. The documentation must include the medication name, dosage,
date and time administered, and method and route of administration. The staff must document
the reason why medication administration was not completed as prescribed and document any
follow-up procedures that were provided to meet the client's needs when medication was not
administered as prescribed and in compliance with the client's medication management plan.

Documentation of dates of medication setup, name of medication, quantity of dose, times to be
administered, route of administration, and name of person completing medication setup must
be done at the time of setup.
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Required Annual Infection Control Training

Class A, F, and Comprehensive are identical, except Comprehensive adds the reporting of communicable diseases to the required components of annual infection control staff training.

Class A:

6668.0100 Subp. 6 (A) In-service Training
4668.0065 Subp. 3 Infection Control In-service Training

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. The training must include:

A. hand washing techniques;
B. the need for and use of protective gloves, gowns, and masks;
C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;
D. disinfecting reusable equipment; and
E. disinfecting environmental surfaces.

Class F:

6668.0835 Subp. 3 (A) In-service Training
4668.0065 Subp. 3 Infection Control In-service Training

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the
provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. The training must include:

A. hand washing techniques;
B. the need for and use of protective gloves, gowns, and masks;
C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;
D. disinfecting reusable equipment; and
E. disinfecting environmental surfaces.

Comprehensive:

144A.4796 Subd. 6 (3) Annual Infection Control Training

All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include:

A review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of communicable diseases
Comprehensive Home Care Survey Self-Audit Tool

Topic: **Staff Training - Annual**

Audited by: ____________________________

Date of Audit: ________________________

Task:

1. Make five copies of this blank form
2. Retrieve five random employee personnel files

Review the files for compliance with the following requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel files indicate that 8 hours of annual training have been completed and documented within the last 12 months of employment.</td>
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<tr>
<td>Within the 8 hours of annual training each year, the following 4 topics have been addressed:</td>
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<tr>
<td>(1) Training on the reporting of maltreatment of vulnerable adults under the Minnesota Vulnerable Adults Act, including:</td>
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<tr>
<td>• Status of home care staff as mandated reporters</td>
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<tr>
<td>• Training regarding what constitutes suspected maltreatment, abuse, neglect, financial exploitation, unexplained physical injuries, accidents, and errors in the provision of therapeutic conduct.</td>
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<tr>
<td>• Reporting internally</td>
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<tr>
<td>• Immediate (not to exceed 24 hours) reporting to the Common Entry Point (CEP)</td>
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<tr>
<td>(2) A review of the Home Care Bill of Rights</td>
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<tr>
<td>(3) A review of infection control techniques used and implementation of infection control standards, including:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Review of hand-washing techniques</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The need for and use of protective gloves</td>
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<td></td>
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<tr>
<td>• The need for and use gowns and masks</td>
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<td></td>
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<tr>
<td>• Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades</td>
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<tr>
<td>• Disinfecting reusable equipment (particular focus on shared Glucometers)</td>
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<td></td>
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<tr>
<td>• Disinfecting environmental surfaces</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Reporting of communicable diseases</td>
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</tr>
<tr>
<td>• Signs and symptoms of Tuberculosis</td>
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<tr>
<td>Requirement</td>
<td>Met</td>
<td>Not Met</td>
<td>N/A</td>
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<tr>
<td>Other infection control processes that are in alignment with current practices and the types of services provided by the home care agency.</td>
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<tr>
<td>(4) A review of the home care provider’s policies and procedures relating to the provision of services and how to implement those policies and procedures.</td>
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<tr>
<td>Using random staff interviews, staff should be able to tell you how they would access the home care agency policies and procedures. This should be a focus of the annual training requirement noted above.</td>
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</tbody>
</table>

If any applicable requirements are identified as “Not Met”, correct the situation, audit other personnel records to determine how widespread the problem is, correct all problems, and review policies, procedures, forms, software, and staff responsibilities to correct the problem going forward.

Hints:

- Additional required annual dementia training requirements go into effect on 1-1-16. See the HWS Dementia Training audit tool.
- Only four topics are required in the annual training requirements. Other topics that the home care provider may want to consider including in the 8 hours of annual training include (but are not limited to):
  - Client Confidentiality/HIPAA
  - A Workplace Accident and Injury Reduction Program (AWAIR)
  - Employee Right to Know Training (AWAIR)
  - Chemical Hazard Labeling and Safety Data Sheets
  - Restraints (clients must be free from any physical or chemical restraints imposed for purposes of discipline or convenience)
  - Siderails in the home care setting
  - Use of the term “Assisted Living”
  - Proper Body Mechanics – Lifting/Transfers
  - Medications Procedures and Update
  - Hydration and Dietary Issues of the elderly
  - Communication Skills
  - Customer Service training
  - Skin breakdown and pressure ulcers
  - New medical technology and equipment
  - Disease specific information (Strokes, Parkinson’s disease, Diabetes, etc.)
  - Review and demonstration of job competencies
  - Individual areas of weakness as identified in staff performance reviews
  - Advance Directives and the Patient Self Determination Act
  - Recognizing symptoms of abuse or neglect
- Emergency Procedures – Fire, Tornado, Loss of Power, Missing Clients, and other emergencies
- Safe Medical Devices Act – including medical device reporting requirements
- CPR certification and recertification (if appropriate for your setting)
- Blood borne Pathogens
- Survey Process and Regulations – Common Deficiencies
- Skills Refresher/Competency Update/Skills Fair
- Sexual Harassment and Discrimination
- Other issues relevant to the home care’s clientele or service specialties

References: 144A.4796 Subd. 6-7
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Reporting of Suspected Maltreatment

Class A, F, and Comprehensive are identical:

626.557 Reporting of maltreatment of vulnerable adults

Subdivision 1. Public policy.

The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated.

In addition, it is the policy of this state to require the reporting of suspected maltreatment of vulnerable adults, to provide for the voluntary reporting of maltreatment of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases.

Subd. 2. [Repealed, 1995 c 229 art 1 s 24]

Subd. 3. Timing of report.

(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

Subd. 3a. Report not required.

The following events are not required to be reported under this section:

(1) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report.

(2) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.
(3) Accidents as defined in section 626.5572, subdivision 3.

(4) Events occurring in a facility that result from an individual’s error in the provision of therapeutic conduct to a vulnerable adult, as provided in section 626.5572, subdivision 17, paragraph (c), clause (4).

(5) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

Subd. 4. Reporting.

(a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a Web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

Subd. 4a. Internal reporting of maltreatment.

(a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the
facility remains responsible for complying with the immediate reporting requirements of this section.

(b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter.

(c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally.

(d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally.
Comprehensive Home Care Survey Self-Audit Tool

Topic: Reporting of Suspected Maltreatment

Audited by: ____________________________

Date of Audit: _________________________

Task:

1. Make ten copies of this blank form
2. Retrieve ten random resident incident reports
3. Retrieve five random client files
4. Retrieve five random personnel files
5. Retrieve five sources of documentation indicating the Common Entry Point was contacted
6. Retrieve the complaint log

Review the files for compliance with the following requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff orientation records indicate that all new staff have been educated on the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. As a home care employee, home care staff are mandated reporters under the Minnesota Vulnerable Adults Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Procedure for internally reporting suspected situations of client maltreatment.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. Requirement to externally report suspected situations of client maltreatment to the Common Entry Point (CEP) immediately (immediately is defined as not to exceed 24 hours).</td>
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<td></td>
</tr>
<tr>
<td>5. Exceptions for external reporting – error in therapeutic contact, accidents.</td>
<td></td>
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</tr>
<tr>
<td>Requirement</td>
<td>Met</td>
<td>Not Met</td>
<td>N/A</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Annual staff training (not to exceed a time period of 12 months) records indicate that all staff have been educated on the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. As a home care employee, home care staff are mandated reporters under the Minnesota Vulnerable Adults Act.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Procedure for internally reporting suspected situations of client maltreatment.</td>
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</tr>
<tr>
<td>3. Requirement to externally report suspected situations of client maltreatment to the Common Entry Point (CEP) immediately (immediately as defined as not to exceed 24 hours).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Exceptions for external reporting – error in therapeutic contact, accidents.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A review of incident reports indicates that any suspected maltreatment identified in the report was reported to the Common Entry Point in a timely manner.</td>
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</tr>
<tr>
<td>A review of client records indicates that documentation indicating suspected maltreatment (e.g.: unexplained bruising, suspicious injuries, behaviors indicating unusual fear of particular staff, etc.) was reported to the Common Entry Point in a timely manner.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A review of previous reports made to the Common Entry Point were made to the CEP in a timely manner (immediately after awareness of the suspected maltreatment – but not to exceed 24 hours).</td>
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</tr>
<tr>
<td>A review of previous reports made to the Common Entry Point indicate the issues were investigated and properly handled to minimize future reoccurrence with the individual or other home care clients.</td>
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</tr>
<tr>
<td>A review of the complaint log indicates that any complaints that that may be related to suspected maltreatment (complaints of rough treatment, fear of a staff person, etc.) were reported to the common entry point in a timely manner.</td>
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</tr>
</tbody>
</table>

If any applicable requirements are identified as “Not Met”, correct the situation, audit other records to determine how widespread the problem is, correct all problems, and review policies, procedures, forms, software, staff education, and staff responsibilities to correct the problem going forward.

References: MN Statutes 144A.479 Subd. 6 (a), 144A.479 Subd. 6 (a), 626.557
Common Home Care Deficiencies in Minnesota
Transition/Comparison of Class A, Class F, and Comprehensive Requirements

Informing Clients of Complaint Procedure

Class A and F:

4668.0040 Subp. 1-3 Informing Clients of Complaint Procedure

A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Clients must provide written notice that includes:

A. the client's right to complain to the licensee about the services received;
B. the name or title of the person or persons to contact with complaints;
C. the method of submitting a complaint to the licensee;
D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and
E. a statement that the provider will in no way retaliate because of a complaint.

Prohibition against retaliation. A licensee must not take any action that negatively affects a client in retaliation for a complaint made by the client.

Comprehensive:

144A.4791 Subd. 11 (c) Client Complaint and Investigative Process

The required complaint system must provide for written notice to each client or client's representative that includes:

(1) the client's right to complain to the home care provider about the services received;
(2) the name or title of the person or persons with the home care provider to contact with complaints;
(3) the method of submitting a complaint to the home care provider; and

(4) a statement that the provider is prohibited against retaliation according to paragraph

A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client’s representative.
Comprehensive Home Care Survey Self-Audit Tool

Topic: Complaints (Home Care)

Audited by: ____________________________

Date of Audit: ________________________

Task:

1. Make five copies of this blank form
2. Retrieve your complaint log or complaint binder
3. Retrieve your policies and procedures regarding complaints
4. Retrieve the document you give new clients regarding your complaint process
5. Retrieve your staff orientation topics checklist or a sample of personnel files
6. Retrieve the Home Care Bill of Rights provided to clients
7. Retrieve five client records of clients who have expressed a complaint
8. Retrieve random employee personnel/education files

Review the items for compliance with the following requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>The home care Bill of Rights provided to clients contains the right “to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.”</td>
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<tr>
<td>In addition to the text of the home care bill of rights, a notice shall be provided to the client or the client’s representative that contains the following statement describing how to file a complaint with certain external agencies: &quot;If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities.&quot; The statement should also contain additional elements noted below.</td>
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<td>The statement should include the telephone number, web site address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities.</td>
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<td>The statement should also include the home care provider’s name, address, e-mail, telephone number.</td>
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<tr>
<td>Requirement</td>
<td>Met</td>
<td>Not Met</td>
<td>N/A</td>
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<td>The statement should also include the name or title of the person at the provider to whom problems or complaints may be directed.</td>
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<td>The statement should also include a statement that the home care provider will not retaliate because of a complaint.</td>
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<td>The home care provider has a written acknowledgment of the client’s receipt of the home care bill of rights or has documentation why an acknowledgment could not be obtained. The acknowledgment may be obtained from the client or the client's representative.</td>
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<tr>
<td>The home care provider’s written acknowledgment of the client’s or the client’s representative receipt of the home care bill of rights is retained in the client’s record.</td>
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<tr>
<td>Documentation of home care complaints received and resolutions are in the client’s records.</td>
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<td>Staff orientation documents indicate the topics of handling of client complaints, reporting of complaints, and where to report complaints including information about the Office of Health Facility Complaints (OHFC) and the Common Entry Point (CEP) were included in orientation.</td>
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<td>The home care provider has policies and procedures describing a system for: 1. Receiving complaints 2. Investigating complaints 3. Reporting complaints 4. Attempts to resolve complaints</td>
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<td>The home care provider’s complaint policies and procedures clearly identifies the process by which clients may file a complaint or concern about home care services.</td>
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<td>The home care provider’s complaint policies and procedures contain an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints.</td>
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<tr>
<td>The home care provider’s complaint policies and procedures contains a process to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights.</td>
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<td>The home care provider’s complaint system provides for reasonable accommodations for any special needs of the client or client’s representative if requested.</td>
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<td>The home care provider’s complaint system contains documentation of at least the following for each complaint received: 1. The complaint received 2. The date the complaint was received 3. The name of the client 4. The investigation of the complaint</td>
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</table>
### Requirement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Met</th>
<th>Not Met</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. The resolution of the complaint</td>
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<td>A record, log, or binder of complaints received shall be kept by the home care provider. The complaint records must be kept at least two years after the date a complaint was received.</td>
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<td>The provider has documentation that it has provided each client or client’s representative with the home care provider’s system for handling complaints. The written notice must include:</td>
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<tr>
<td>1. The client's right to complain to the home care provider about the services received</td>
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<tr>
<td>2. The name or title of the person or persons with the home care provider to contact with complaints</td>
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<td>3. The method of submitting a complaint to the home care provider</td>
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<td>4. A statement that the provider is prohibited against retaliation</td>
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<tr>
<td>Home care records or interviews do not indicate that the home care provider took any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or client’s representative.</td>
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<td>The provider’s “Quality Management” program, which is available for surveyors to review, focuses on at least one of the following topics: a review of client services, complaints received, or other issues that have occurred to help determine whether changes in services, staffing, or other procedures should be considered.</td>
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</tbody>
</table>

If any applicable requirements are identified as “Not Met”, correct the situation, audit other client records, complaint forms, and other sources of information to determine how widespread the problem is, correct all problems, and review policies, procedures, forms, software, and staff responsibilities to correct the problem going forward.

**Hints:**

- A home care provider may want to have a guideline outlining what a “complaint” is compared to a concern or issue that gets immediately handled and resolved.
- Complaints from clients or clients’ representatives regarding the building or grounds of the Housing with Services establishment are NOT the same as complaints against the home care provider. Consider separating out complaints regarding home care services from complaints for issues or concerns that are not home care related (e.g. parking, heat, food, snow on sidewalk, activities, etc.).
- If you have a resident/tenant council that keeps minutes, also verify that complaints documented in such minutes have been investigated and resolved.

**References:** 144A.44 Subd. 1 (19), 144A.44 Subd. 1 (20), 144A.4791 Subd. 11 (a), 144A.4791 Subd. 11 (b), 144A.4791 Subd. 11 (c) 1-4, 144A.4791 Subd. 11 (d)