Winter 2012

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES

Long Term Care Highlights

A Short Q & A Regarding Significant Change in Status Assessments

By Joyce Johnson, Health Facilities Surveyor

The State Operations Manual, Appendix PP, 483.20(b)(2) states, "When required, a facility must conduct a comprehensive assessment of a resident as follows:. . .(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. . ."

When is a Significant Change in Status Assessment (SCSA) required? A SCSA must be completed when the Interdisciplinary Team (IDT) has determined a resident has experienced a decline or improvement in status that will not resolve itself without intervention, impacts more than one area of a resident's health, and requires review and/or revision of the care plan. A SCSA also is required when a resident enrolls in a hospice program or decides to discontinue hospice services. In all cases, the Assessment Reference Date (ARD) for the SCSA must be within 14 days of the determination by the IDT or 14 days from the effective date of hospice election or revocation.

What changes are considered significant? SCSAs are not required for temporary variations in status; when the resident's condition is expected to return to baseline within two weeks. The IDT should note the changes and document their rationale for not completing the SCSA in the resident's medical record. If the condition has not resolved within two weeks, staff should complete a SCSA. If there is only one change, a SCSA would not generally be required, but the IDT should monitor the resident's condition and document the plan for monitoring in the resident's medical record. Some changes may not be permanent, but may impact the resident's overall status for more than two weeks and require a comprehensive assessment and review/revision of the care plan. A SCSA is appropriate when there is a consistent pattern of change in two or more areas (either improvement or decline). The two areas may be within one domain, such as two areas of either decline or improvement in Activities of Daily Living (ADLs).

Inside this issue:

What changes are not considered significant? Changes not considered significant include easily reversible causes documented in the resident's record (such as medication side effects), short-term illnesses, predictable signs and symptoms associated with a previously diagnosed condition, steady progress under the current plan of care, and/or when a resident stabilizes and is expected to be discharged in the immediate future. For a resident making steady progress, a SCSA would be required once the IDT determines the resident has stabilized. For

(Continued on page 2)

(Continued from page 1) A Short Q&A Regarding Significant Change in Status Assessments

residents with a terminal condition, the determination is based on whether or not the change is an expected, well-defined part of the disease process and is being addressed in the resident's care plan.

When should a SCSA require a referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation? For a resident with a known or suspected mental illness (MI), mental retardation (MR), or a condition related to MR, referral for a possible PASRR Level II evaluation is required with a change in status. This referral must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act. This is not part of the Resident Assessment Instrument (RAI) process, but is an Omnibus Budget Reconciliation Act (OBRA) requirement.

A referral for a PASRR Level II evaluation is required when a resident previously identified by PASRR to have a MI/MR diagnosis experiences a decline or improvement in behavioral, psychiatric, or mood-related symptoms; when the resident indicates a preference to leave the facility; or when the resident's condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation.

A referral for a PASRR Level II evaluation also is required for residents who have not previously been identified to have MI, MR, or a condition related to MR when the resident experiences behavioral, psychiatric, or mood-related symptoms suggesting the presence of a diagnosis of MI, for a resident whose MR was not previously identified and evaluated through PASRR, or when the resident is transferred, admitted or readmitted to a facility following a inpatient psychiatric stay.

See the state PASRR program requirements for specific procedures.

References:

State Operations Manual Appendix PP - Guidance to surveyors for Long Term Care Facilities, Revised October 1, 2010

Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Revised May 2011, Chapter Two.

Surveying LTC Facilities That Use Electronic Health Records (EHR)

By Bruce Pritschet, Director, Health Facilities and Lucille Rostad, Manager, Health Facilities

The Centers for Medicare & Medicaid Services (CMS) recognizes the importance of the use of EHRs and the benefits for better resident care and reduced costs. Surveyors in North Dakota have not been issued portable computers, so it is important the facility provides each surveyor a computer to access the electronic record in your skilled nursing facility during your on-site survey.

If surveyors are unable to access the electronic medical record directly, the length of the on-site survey time will be extended. If any certified facility is impeding the survey process by unnecessarily delaying or restricting access to the electronic medical records it may lead to the facility's termination from Medicare participation. The surveyor is allowed to see any portion of the medical record necessary to determine compliance. It makes no difference if the record is electronic or paper.

The state surveyors are required to provide safety, security and confidentiality for all information needed to conduct the skilled nursing facility survey. There is no need for surveyors to sign any facility HIPAA forms since they are held to strict confidentiality by the state and CMS. In addition, they are not employees of your facility and therefore not under your control.

Electronic access to records will not eliminate the need for a surveyor to print a copy or to request a paper copy of certain parts of certain records. The surveyor should print a paper copy of only those parts of records that are needed to support findings of noncompliance.

I hope this information is helpful and allows for a smooth survey the next time the team arrives at your facility. If you have questions related to surveyor access to electronic medical records, please contact our office.

Putting the Quality Back in Quality Assurance

By Rhonda Lowenstein, Health Facilities Surveyor

When most of us hear the term "quality" we equate it to an acceptable level or a high standard. In health care, quality refers to an acceptable standard of care given or received. The term "assurance" is defined by Webster's Dictionary as "the act or action of assuring as a pledge or guarantee." Quality Assurance (QA) plays an important role in our daily lives through the foods we eat, the stores where we shop, the vehicles we drive and particularly through the health care we seek. The Centers for Medicare and Medicaid Services (CMS) defines Quality Assurance as "the organizational structure, processes and procedures designed to ensure that care practices are consistently applied and the facility meets or exceeds an expected standard of quality." An effective QA program is the best way for health-care facilities to meet or exceed the expected standard of care.

An effective Quality Assurance program is essential for health care facilities to avoid continued problems with areas that affect the quality of the care they provide to their residents. An ineffective Quality Assurance program can lead to repeated and ongoing quality of care issues, poorly defined problem areas, a lack of effective monitoring and oversight and ineffective corrective action.

CMS requires facilities to maintain a quality assurance committee consisting of:

- The director of nursing services;
- A physician designated by the facility; and
- At least three other members of the facility's staff.

The Quality Assurance committee is required to meet at least quarterly, to identify issues that require Quality Assurance, and to develop and implement plans of action to correct the quality issues identified by the committee. In order for facilities to be able to effectively identify problem areas, their QA process must be ongoing and should take a multidisciplinary approach to identifying quality concerns. Dietary staff, direct care staff, activity staff, etc., can all provide valuable insight into quality of care issues, even if they are not directly involved in committee meetings. Effective monitoring and corrective action cannot take place without correctly identifying the quality of care areas, and taking a multidisciplinary approach to identification is vital.

In order for QA monitoring to be effective, facilities should assign designated staff who will be responsible for monitoring and oversight. Often times for nursing or direct care issues, the facility will designate the director of nursing, a nursing unit manager or other nursing staff to oversee the care provided. Facilities should designate an appropriate person to oversee the care provided based on his or her level of expertise and based on the quality of care concern identified.

The designated staff member should monitor as often as needed to ensure the facility will be able to attain compliance in the deficient area.

When facilities are cited for deficient practice by the State Survey and Certification agency, they are required to submit a Plan of Correction (PoC), which includes QA monitoring. It is vital that facilities monitor their corrective action frequently in order to ensure they will be able to attain and maintain compliance. A monitoring schedule of "monthly" or "quarterly" may not be the best approach for a facility that has already been cited for deficient practice. Effective and frequent Quality Assurance monitoring is vital in order to ensure that the corrective action is not only implemented, but is an appropriate solution to the deficient practice or quality of care concern.

Quality Assurance plays an important role in our daily lives and in our health-care services. Facilities play an important role as health-care providers and must ensure their Quality Assurance program enhances, rather than diminishes, the quality of care for their residents.

References:

State Operations Manual 483.75(0) Quality Assessment and Assurance www.websters-online-dictionary.org

What do Staff Members Need to Know about Dysphagia and Feeding Residents?

By Bobbie Houn, Health Surveyor

The State Operations Manual (SOM) addresses "Quality of Care" issues under 483.25. The SOM states that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable level of function. The facility must provide the necessary care and services based on the findings of the comprehensive assessment and plan of care, and evaluate the resident's outcome and change the interventions if needed. Review of deficiency reports for the past three years revealed Health Facilities has issued citations directly relating to dysphagia issues on 20 occasions, based on an outcome or potential outcome to the resident(s).

Dysphagia, also known as a swallowing disorder, can cause food or drink to enter the airway. It is estimated that six million people have difficulty swallowing secondary to various diseases, conditions and/or surgical interventions. The prevalence of dysphagia increases with age and poses particular problems in the elderly. Approximately 30 to 75 percent of residents in nursing homes have a diagnosis of dysphagia.

As a result of having a swallowing disorder, residents may:

- Have poor nutrition.
- Become dehydrated.
- Have weight loss.
- Be a risk for aspiration, which can lead to pneumonia or chronic lung disease.
- Have less enjoyment at mealtime.
- Be embarrassed in social situations.
- Isolate themselves.

The incidence of malnutrition and/or dehydration in nursing homes has been shown to be as high as 50 percent. In addition, approximately 50 percent of residents in nursing homes require some form of eating assistance and report experiencing anxiety during mealtime, due to their fears, dependency and appearance. Dependence on facility staff to eat and/or drink also may increase the risk of respiratory infections. Acquired respiratory infections are the second most prevalent infection observed in nursing homes; secondary to urinary tract infections. It has been shown that residents who are dependent on facility staff to eat and/or drink are 20 times more likely to develop aspiration pneumonia than those who eat independently.

When a resident requires eating assistance, the speech language pathologist and/or occupational therapist typically are involved in the assessment process and the development of an individualized care plan. The care plan is designed to provide the resident with adequate nutrition in a safe, dignified manner. The success of the care plan, however, ultimately rests on how well it is implemented by facility staff.

Certified nursing assistants (CNAs) are the facility staff members who routinely feed residents and provide the majority of the resident's social interaction throughout the day. CNAs frequently feed more than one resident during a meal, and may feel pressure to complete this task in a timely manner. This may in turn lead to rushing the dining experience, which may lead to aspiration or inadequate nutritional intake.

CNA knowledge of dysphagia and feeding often is limited in terms of technical skills, safety and communication. Although CNAs are able to express knowledge of correct positioning for feeding, they inconsistently implement this knowledge. Residents are often observed tilted at the trunk or reclined in their wheelchair and/or bed while being fed by facility staff. CNAs should be encouraged to feed residents in an upright position and should sit at eye level to the resident when feeding to avoid giving the impression they are in a rush to feed. In addition, CNAs should use verbal or physical prompts when assisting residents, wipe food from the resident's face, and remove food from their clothing when necessary during the meal.

The most common symptom of dysphagia observed during meals is coughing. This symptom is often not acknowledged by CNAs during feeding, and is often not reported to the nursing supervisor. Large volumes and a fast rate of presentation using a full teaspoon or cup are commonly seen. CNAs are

(Continued on page 5)

(Continued from page 4) What do Staff Members Need to Know about Dysphagia and Feeding Residents?

often unaware that their presentation skills may exacerbate the dysphagia and increase the risk of aspiration. CNAs have reported they often learn how to manage difficult feeding problems from other CNAs rather than through formal in-service training. These feeding strategies that are learned on the job often focus on enhancing oral intake, sometimes at the expense of balanced nutrition or dignity.

CNAs are often observed conversing with other staff during meals. The focus of the conversation is often directed towards the task of eating rather than socializing with the residents. CNAs should greet each resident by name. They should make an effort to include all the residents at the table, even those that are unable to speak. In addition, they should avoid holding conversations with each other regarding personal topics. CNAs are often observed using short phrases such as "Open your mouth" or "Take a bite." They should decrease their use of command statements and use encouraging statements instead. They should also identify the modified foods and liquids served to the resident and give them a choice in the sequence in which they are fed during the meal.

Summary of recommended CNA feeding practices:

- Body positioning
  - Sit the resident up straight
  - Don't recline or leave alone
  - Recline no lower than 45 degrees after meal
- Tray preparation
  - Take lids off and open cartons
  - Do not make bare hand contact with the food items on the tray
  - Confirm correct diet consistency
  - Offer condiments
  - Identify foods and ask what the resident wants to eat first
- Need for assistance/presentation
  - Make eye contact with resident
  - Use a slow rate
  - Use small volumes
  - Wipe mouth
  - Provide verbal and physical prompts when necessary
- Signs/Symptoms of dysphagia
  - Slow or absent swallow
  - Excessive or lack of chewing
  - Distressed facial expression
  - Drooling: food or liquid leaking out the front of the mouth
  - Pocketing: food in the mouth after the resident has finished eating
  - Throat clearing
  - Coughing or choking during or right after meals
  - Spitting
  - Vomiting
  - Avoidance of food or liquids
  - Wet, gurgly sounding voice during or right after meals
  - Chest congestion after meals
  - Recurring pneumonia
  - Weight loss
  - Dehydration
- After meal care
  - Perform mouth care after every meal
  - Perform mouth care during day if pocketing is suspected
  - Do not lie resident down immediately after meal

Knowledge of the appropriate feeding techniques to use with residents with dysphagia or residents who exhibit challenging feeding behavior is crucial. It is important for all nursing home personnel (nursing staff, CNAs, dietary staff and therapists) to collaborate regarding dysphagia issues. The speech language pathologist and/or occupational therapist can be important resources for information regarding dysphagia.

References:
State Operations Manual: Centers for Medicare and Medicaid Services
www.asha.org
Pelletier, Cathy A. (May 2004). What do certified nurse assistants actually know about dysphagia and feeding nursing home residents? *American Journal of Speech-Language Pathology*, Vol. 13, 99-114.

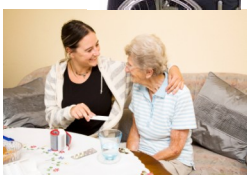
Nurse Aide Registry

By Bruce Pritschet, Director, Health Facilities and Cindy Kupfer, Nurse Aide Registry

Did you know the North Dakota Department of Health's nurse aide registry website renewal process is now available for the online renewal of the following types of registrants?

1. Certified Nurse Aides, (CNAs)
2. CNAs that are also Medication Assistants 1 (CNA/MA 1)
3. CNAs that are also Medication Assistants 2 (CNA/MA 2)
4. Nurse Aides, (NA)
5. Nurse Aides that are also Medication Assistants 1 (NA/MA1)
6. Home Health Aides (HHAs)

Follow this link to the nurse aide registry: http://www.ndhealth.gov/HF/North_Dakota_nurse_aide_registry.htm.



In addition to online renewals, fees can be paid using credit cards online for the following types of registrants that require payment of $25. Types of credit cards accepted include Visa, MasterCard and Discover. Debit cards are not accepted.

1. Nurse Aides - $25
2. Medication Assistants 1 - $25
3. Medication Assistants 2 - $25
4. Home Health Aides - $25
5. Nurse Aide and Medication Assistant 1 - $50
6. No charge for CNAs
7. Remember you cannot be registered as a Nurse Aide and Medication Assistant 2; you must be a CNA to be a Medication Assistant 2.

If you are applying for a certified nurse aide position in North Dakota and you are certified in another state, please contact the Nurse Aide Registry staff at 701.328.2353. After visiting with an applicant, the Department of Health can usually endorse your certification into the North Dakota Nurse Aide Registry for two years.

Just a reminder: When you are checking to see if an application has been renewed or an applicant has been placed on the Department of Health's registry after testing, please check the nurse aide registry website at http://www.ndhealth.gov/HF/North_Dakota_nurse_aide_registry.htm **before** calling the registry phone number. It is full of useful information.

Please note:

- When renewing your certified nurse aide (CNA) status on the Department of Health's website or your nurse aide (NA) status, the "Employers contact name" should be a unit manager's name, director of nursing's name, or another manager or supervisor's name. This is **NOT** meant to be an emergency contact name of a parent or spouse or the name of the facility where you are employed.
- Online renewals: "Employer Information," please type in **City Only**, the state is not required.
- A person is eligible to renew **up to but not including** his or her expiration date. If a
- person renews on his or her expiration date, a message will come up saying he or she is not eligible to renew, please contact the North Dakota Department of Health.

Remember:

- The Nurse Aide Training, Competency Evaluation and Registry Rules (Article 33-43) addresses expiration dates beyond six months as follows:

  4. (c)
  If an individual on the department's nurse aide registry is identified as performing nursing related services for pay with an expired registration of more than six months, the department will notify the state survey agency, the employer, and the individual that the individual must immediately cease to work. The individual's registry status will no longer be recognized by the department. To obtain current registry status again, the individual must follow the process for initial application for registry status.

  This applies to nurse aides, certified nurse aides, home health aides and medication assistants 1 and 2.

New Dining Practice Standards in Long Term Care Facilities

By Bobbie Houn, Health Facilities Surveyor

Residents who resist care are often labeled "non-compliant" or "difficult." The Pioneer Network is an organization that is committed to changing the culture in long term care facilities. They recently brought together a variety of organizations and agencies to develop food and dining practice standards that focus on personal choice while supporting safety and quality of care.

A majority of residents leave food uneaten, resulting in weight loss and/or other nutritional concerns. Many of those same residents often receive, but do not consume, supplements throughout the day. Therapeutic (diabetic, low salt, low fat) and altered (mechanical soft, pureed) diets are a major contributing factor to poor intake. These diets are often unattractive and unpalatable.

The new dining practice standards include the following:

- Inform the resident of his/her choices. Determine the diet based on his/her goals and preferences. Do not focus exclusively on diagnoses.
- Assess for quality of life issues such as level of independence, meal time, and satisfaction with food.
- Begin with a regular diet and close monitoring, unless the resident's medical condition warrants a restricted diet.
- Individualize the plan of care.
- Ensure that the physician and pharmacist are aware of the resident's dining preferences so that medical issues (timing of medications and impact on appetite) can be addressed appropriately.
- Monitor the resident's nutritional status.
- Allow the resident to make dining choices, as able.
- Revise the plan of care whenever/if the resident makes "risky" decisions. Show they have made an informed decision and risks have been mitigated.
- All decisions default to the resident.

There is often no clear right answer when caring for residents. Health-care providers must explain the risks and benefits to the resident, his or her family, and the interdisciplinary team caring for him or her. The resident does have the right to make an informed choice, including disregarding medical advice. The team should attempt to mitigate risks and should monitor his/her plan of care.

References:
www.asha.org
http://www.pioneernetwork.net

Wedding Announcement

Health Facilities is happy to announce the marriage of Lucille Torpen and Arlen Rostad. Lucille and Arlen were married on Saturday, November 26, 2011.

Lucille's new contact information is as follows:

Lucille Rostad, Manager
North Dakota Department of Health
Division of Health Facilities
600 E. Blvd. Ave., Dept 301
Bismarck, N.D. 58505-0200
Phone: (701) 328.2352
Fax: (701) 328.1890
E-mail: lrostad@nd.gov

Long Term Care Highlights is published by:
Division of Health Facilities
North Dakota Department of Health
600 E. Boulevard Ave., Dept. 301
Bismarck, N.D. 58505-0200
Phone: 701.328.2352
Fax: 701.328.1890
Web: www.ndhealth.gov

Terry Dwelle, M.D., M.P.H.T.M., State Health Officer
Darleen Bartz, Ph.D, Chief, Health Resources Section
Bruce Pritschet, Director, Health Facilities
Lucille Rostad, LTC Program Manager
Rocksanne Peterson, Newsletter Design