

Partnership News & Best Practice

Partnership News

August 2018

Biannual Nursing Facility Regulation Report

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The July 2018 edition of the Biannual Nursing Facility Regulation Report was sent out through our Listserv.

The purpose of the report is to provide statistics and information regarding the regulation of South Dakota nursing facilities. The deficiency data includes all Long-Term Care health surveys (both standard and

complaint). The report is also posted on our website.

The information provided on the report is a snapshot which includes: data regarding the number of deficiencies cited compared to recent years, the number and type of surveys conducted, Informal Dispute Resolution's conducted, and Civil Money Penalties.

We continue to make every effort to ensure open communication with all providers.

As always, I welcome calls or emails from Administrators with comments and suggestions.

My phone is 605.773.3356 and email address is chris.qualm@state.sd.us.

Challenging Behavior Units

The Department of Human Services' Division of Long Term Services and Supports (LTSS), in partnership with the Department of Health's Office of Licensure and Certification (OLC), will be engaging with partners and stakeholders throughout the next several months to promote the success of the Challenging Behavior Unit (CBU) at Irene Sunset Manor. The goal of these efforts is to help promote education and awareness to nursing facilities across the state regarding how to successfully admit and retain individuals with challenging behaviors in community nursing facility settings. The efforts will

also educate on how incorporating Person-Centered Thinking (PCT) tools into the care planning process helps to achieve and maintain the best quality of life possible and can be particularly helpful for the individuals with challenging behaviors. LTSS and OLC will be participating in collaborative presentations at upcoming South Dakota Healthcare Association (SDHCA) and South Dakota Association for Healthcare Organizations (SDAHO) conferences to educate nursing facility providers about the Irene CBU program, how the CBU remains compliant

with nursing facility regulations, potential additional funding opportunities for individuals displaying challenging behaviors, and share success stories of individuals transitioning from the Human Services Center (HSC) to the CBU and sometimes even on to the general nursing facility population or an Assisted Living Center. If your facility is interested in learning more about how to successfully care for individuals with challenging behaviors, please contact **Beth Dokken** with LTSS at 605-773-3656 or **Diana Weiland** with DOH at 605-995-8057.

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Is it a Restraint or is it an Assistive Device/Enabler?

In **F604**, “Physical restraint” is defined as any manual method, physical or mechanical device, equipment, or material that meets all the following criteria:

- Is attached or adjacent to the resident’s body;
- Cannot be removed easily by the resident; and
- Restricts the resident’s freedom of movement or normal access to his or her body.

To clarify the examples found in Appendix PP of the State Operations Manual for F604, a bed rail that prevents a resident from voluntarily getting out of bed and the resident cannot lower the bed rail in the same manner as staff would be considered a physical restraint. The residents physical condition and his/her cognitive status may be contributing factors in determining whether the resident can lower the bed rail.

Conclusion – Not all bed rails are considered to be physical restraints; documented assessment of the individual resident either confirms or disproves the above criteria.

In **F700** Bed Rails, the intent of the regulation is to address the use of the bed rails. This means prior to installing rails for use, or using pre-installed rails, the provider will attempt to identify appropriate alternatives, ensure correct installation, use, and maintenance, that includes:

- Assessment for entrapment risk;
- Review of risks and benefits with the resident and/or representative;

- Obtaining informed consent prior to installation (or use);
- Ensuring appropriate bed dimensions for resident size and weight; and
- Following the manufacturers’ recommendations and specifications for installing, use and maintaining the bed rails.

CMS does not specify appropriate alternatives; the alternative attempted should be appropriate for the intended use of the bed rail. For example, a low bed or concave mattress would not be an appropriate alternative to an enabler for a resident receiving therapy for a hip-replacement. If there is no appropriate alternative suitable for the intended use of the bed rail, the resident record should reflect evidence of the following:

- Purpose of the bed rail and the notation no suitable alternative exists;
- Assessment of the resident, the bed and rail for entrapment risk (bed dimensions are appropriate for resident size and weight); and
- Risk versus benefits were reviewed with resident and/or representative, and informed consent is given.

For beds with rails that are incorporated or pre-installed, the provider must determine if disabling the bed rails poses a risk for the resident. CMS regulations do not specify bed rails must be removed or disabled when not in use. Please note, if bed rails are not appropriate for the resident and the provider

chooses to keep the bed rail on the bed, but in a down position, raising the rail even for episodic use during care would be considered noncompliance if all the requirements (assessment, consent, inspection, and maintenance) are not met prior to the episodic use for the resident.

Conclusion – Providers should have a process in place for determining whether beds and their bed rails are appropriate for the individual resident.

In **F909** Conduct regular inspection, CMS does not define a timeframe for the regular inspection for bed frames, mattresses, and bed rails. The provider should have a process to determine whether the bed and mattress is safe to use to prevent entrapment. They may consider the length of time the bed and/or mattress has been in use and its physical condition, changes in resident’s condition that may affect the use, or condition of the bed and mattress. A change of resident occupying the bed or mattress may call for an inspection of the bed and mattress to determine if any areas of possible entrapment are present based on the individual in and on the bed and mattress.

Is it a restraint or is it an assistive device/enabler? A well-documented assessment will go a long way in addressing the use.

Please feel free to contact **Diana Weiland** at **605-995-8057** if you have any questions.

Do you know how to respond when dementia causes unpredictable behaviors?

In March 2012, CMS introduced the National Partnership to Improve Dementia Care in Nursing Homes. A major component of the CMS initiative consisted of reducing the use of antipsychotic medications in long-term care residents with dementia nationwide by 15 percent by the end of 2012. Ultimately, the 15 percent reduction was met on a national basis, and by October 2017, it was announced that nursing homes nationwide had achieved a reduction of 35 percent! This astonishing success may be attributed to numerous factors including the adoption of the Hand-In-Hand Criteria, promotion of the concept of culture change, and acceptance of the position that behavioral interventions (aka non-drug approaches) constitute the therapy of choice when responding to adverse behaviors

associated with the various types of dementia.

For many years, long-term care regulations have mandated behavioral interventions be attempted or considered (unless clinically contraindicated) prior to utilizing antipsychotic medications to treat dementia-related behaviors. Following the great success of the CMS initiative and introduction of the new federal regulations in November 2017, the use of behavioral interventions is now mandated not just for antipsychotic use, but for all psychotropic medication classes, including antidepressants, anxiolytics, and sedative-hypnotics.

Several months ago, the Alzheimer's Association released an excellent, very well constructed article discussing the subject of dealing with dementia-related behaviors titled,

“BEHAVIORS: How to Respond When Dementia Causes Unpredictable Behaviors.” The article provides suggestions on properly dealing with a variety of dementia-related behaviors such as physical/verbal aggression, agitation, wandering, insomnia, etc. It serves as a concise, easy-to-use primer on methods for applying behavioral interventions and, thus, removing the need for psychotropic medications. The article should prove useful to both surveyors and caretakers alike.

[Alzheimer's Association](#)

Alz.org

Emergency Preparedness

Need help with planning? Need to know how to connect with a HealthCare Coalition in SD?

Go to <http://doh.sd.gov/providers/preparedness/hospital-preparedness/system/>

The **South Dakota Hospital Preparedness Program (HPP)** works with hospitals and other medical facilities to ensure that South Dakota's medical community is as prepared as we can be! For additional information about HPP, go to <http://doh.sd.gov/providers/Preparedness/Hospital-Preparedness/> or contact the HPP at 605-773-4412.

Use this link to find your **local Emergency Manager**: <https://dps.sd.gov/emergency-services/emergency-management>

CMS Emergency Preparedness Site:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>

The Assistant Secretary for Preparedness and Response (ASPR) **Technical Resources Assistance Center and Information Exchange (TRACIE)** is a resource for developing emergency plans and can be found at <https://www.asprtracie.hhs.gov>

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Interpretation on Home-Grown Produce

The South Dakota Department of Health Office of Healthcare Facilities Licensure and Certification (OLC) and Office of Health Protection (OHP) are in agreement of their position and interpretation on "Home-Grown Produce". Please see the following guidelines.

Interpretation by the South Dakota Health Department has determined home-grown or home-raised produce consisting of either fruit or vegetables may be used by a food service. Home-grown produce should only be used in a fresh form and cannot be canned, dried, or heat preserved for use at a later date. The only method of preservation that is approved is freezing of the raw product after preparing it for service as identified in 44:02:07:34. Where appropriate, certain vegetables may be subjected to blanching before freezing as recommended by USDA guidelines to improve quality and nutritional content.

The Administrative Rules of South Dakota Health Department section 44:02:07:34 states raw fruits and raw vegetables shall be thoroughly washed with potable water before cooking or serving. Any sink used to wash, prepare, store, or soak food shall be indirectly connected to the sewer through an air break. These rules must be followed. Also, produce, being perishable foods, should be stored under refrigeration of 41°F or less after harvesting and throughout their shelf-life.

Attention should be given to the possible contamination of

these products via the use of herbicides and insecticides. One of the latest concerns to surface is the use of wind-fallen fruit that may have been gathered in pastures or grazing areas where livestock have been present. Fruit such as apples gathered under these conditions have been implicated in E. coli 0157:H7 illness due to incidental contamination with fecal bacteria. When it is determined fresh fruits and vegetables are being used, additional questions should be asked by the inspector concerning the source and if chemicals may have been used.

Did you know?

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a free Opioid Overdose Prevention Toolkit - 2018 which equips health care providers, communities, and local governments with material to develop practices

and policies to help prevent opioid-related overdoses and deaths.

The Toolkit addresses issues for health care providers, first responders, treatment providers, and those recovering from opioid overdose.

Download the electronic kit: <https://www.samhsa.gov/capt/tools-learning-resources/opioid-overdose-prevention-toolkit>

Additional South Dakota-specific information is available at <https://www.avoidopioidsd.com>.

Online Reporting

The online reporting system is providing us an efficient and effective method to review and triage the numerous incident reports we receive in our office each and every day. Thank you to all of you using the system to report incidents occurring in your facility.

Unfortunately, we have been receiving a lot of incomplete reports as final reports. The root cause needs to be determined. If it was a fall, was the walkway clear of clutter, was it wet? Was the resident wearing appropriate footwear? Has the resident had a recent medication change? Were their ears examined to determine if they were full of wax? Was the lighting in the room adequate? Was the resident wearing their glasses? These are just a few examples of determining the root cause.

The following is an example of a thorough report that was recently submitted:

At approximately 6:37pm, staff reported an alarm sounding in the Alzheimer's Care Unit. When it was determined it was a door alarm, staff called an elopement code specific for this building and completed a count of all residents and found that resident name was not in the building. Staff immediately searched building and facility grounds and did not locate resident. Staff in the facility had last seen resident at 6:30

pm, when he requested to go out to smoke. A staff member that was off duty called the facility and reported seeing the resident walking approximately 2.5 blocks from the facility. A staff member immediately went to find resident and resident willingly came with staff back to facility. Resident was back in the facility at approximately 6:47 pm. A full head-to-toe assessment was completed with no injury noted BP: 121/52, T: 98.2, R: 16, O2: 94%, P: 61 and resident has no c/o pain and was placed on 15 minute checks. Resident stated to the Administrator that he was going to "buy chips, dip, and soda," but told the staff member who went to pick him up that he was going to "buy smokes." The outside temperature at the time of the incident was 70 degrees and sunny. Resident was dressed appropriately for the weather. Family and physician notified. Wife understanding and states she will come visit resident tomorrow. Maintenance came to facility and changed the door alarm code on 5/18/18 at 8:59 pm. All residents with a risk for elopement have the potential to be affected. Resident admitted to Alzheimer's Care Unit on 5/28/13. Resident diagnoses include (diagnoses were listed). Resident BIMs score is 15. No previous elopement attempts noted. Resident care plan reviewed and was being followed. New intervention: A new physician's order was received for OT to complete a full cognitive

assessment. Assessment to be completed by OT on 5/19/18 related to placement and elopement risk, care plan updated to reflect OT evaluation 5/19/18. Elopement book reviewed and updated all resident's elopement risk assessment scores and care plan reviewed for all residents who are at risk for elopement. Care conference held on 5/19/18 with resident's wife to review event on 5/18/18 and new interventions. IDT team will visit with resident to discuss activities that are meaningful to him and update his plan of care accordingly. Accident Critical Element Pathway reviewed to ensure environment is free from accident hazards, to specifically include elopement. Through interviews with staff, it was identified that some staff were unsure whether the flashing light in the Alzheimer's Care Unit was a fire alarm or door alarm. It was identified through the investigation that the facility van parks near the exit doors to the Alzheimer's Care Unit and obstructs the view to the facility parking lot and grounds. Van parking spot was moved to another area. All staff will be reeducated on Elopement Guideline and the difference between the sound of the fire alarm and the sound of the door alarm. Through interview with resident's wife, she stated that the maintenance man had

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Online Reporting *(continued from page 5)*

purchased cigarettes for resident on Thursday, May 14th; the maintenance man gave him the change from the purchase of cigarettes. CEO, DON, and wife discussed that resident having money was most likely the root cause of resident leaving the facility. The maintenance man was educated on returning money to the business office to deposit in

resident trust fund on 5/21/18. QAPI Ad Hoc meeting completed on 5/21/18 and action items discussed with local ombudsman on 5/21/18 and she voiced agreement and understanding. Plan to monitor performance to ensure solutions are sustained: DON or designee will complete Elopement Drills on each shift weekly x 4 and

results of audits will be reported to QAPI committee monthly for further review and recommendations.

The final report does not need to be this long, but does need to include all the information to “paint the picture” to an individual who does not know your resident or your building.

CDC Sepsis Website

CDC has redesigned its sepsis website to make it easier for patients, families, and healthcare professionals to find the life-saving resources they need to protect their loved ones and patients from sepsis. Sepsis is the body’s extreme response to an infection, including those caused by antibiotic resistant bacteria. It is life-threatening, and without timely treatment, sepsis can rapidly cause tissue damage, organ failure, and death.

The new sepsis website includes:

- **Improved organization** of content and educational materials
- **Optimized search function** to find information quickly and easily
- **Mobile-friendly format** to access sepsis information on the go
- **Educational materials in Spanish** available for download

Visit the new website today to learn more about sepsis and how to prevent infections at www.cdc.gov/sepsis.

Event Reporting Link:

<http://doh.sd.gov/providers/licensure/complaints.aspx>

The Reporting of injuries of unknown and reasonable suspicion of a crime algorithm is located at the following link:

<https://apps.sd.gov/PH91HcOsr/Website/CompFormOnline.aspx>

Behaviors

Challenging: testing one's abilities, demanding.

Difficult: needing much effort or skill to accomplish.

Whether behaviors are called challenging or difficult, they are exacting – making great demands on skills, attention, and other resources. Behaviors may be exhausting as well, draining every bit of mental or physical reserve for those staff that are providing care.

A person who has always had a difficult personality may become even more difficult with the stress of an illness or disability. A person with a diagnosis of Alzheimer's or other dementia may exhibit challenging behavior as they lose their connection with communicating to the outer world. They are still communicating. Are we listening?

While staff are working daily with the multitude of behaviors, it would appear the best defense is a solid offense. Take the more proactive approach. Education, education, and education.

Just as staff must learn the specifics about such tasks as hand washing and hand hygiene, they must be provided every opportunity to address behaviors in a positive manner. Education may include

review of staffing numbers as well as if 1 to 1 observations are needed. Staff education about the use of appropriate response and appropriate alternatives increase the likelihood of maintaining staff, not turnover. Family education increases the likelihood of agreement to a positive working relationship with staff and reduces the likelihood of complaints or litigation resulting from adverse outcomes, e.g., falls, injuries.

Challenging and difficult behaviors are most likely not going away anytime soon. Regulations address behavioral management and promote very specific criteria for the use of pharmacological interventions.

A behavioral management program that complies with federal regulations includes the following:

- Identification of the problem – record reflects medical, psychiatric, environmental, and cognitive antecedents for the behavior.
- Person assessment – multidisciplinary assessment includes all involved (nursing, physician, etc.) and should reflect the severity of the symptoms, the nature of the problem, and the type of intervention.

- Specific systemic behavioral interventions – the determined intervention must be communicated to all staff and family so it may be implemented consistently. Think person-centered, what works for John, may not work for Martha.
- Documentation of outcomes for behavioral interventions – the record should include an initial note that describes the target symptoms and assessment; ongoing measurement may require checklists, flow sheets, nurse notes, etc.
- Necessary adjustment of program based on the observed results – persons who fail specific behavioral interventions must have an alternative plan to address the behavior.

Challenging and difficult behaviors are better addressed with a person-centered, multidisciplinary team approach. Focus on the behavior, not labeling the person as “bad.” Look for patterns. Break the pattern down. Avoid identified triggers. Choose the right battle. Be willing to take a breather. Educate, re-educate.

Special points of interest:

- **Nursing Home Compare:** <http://www.medicare.gov/nursinghomecompare/?AspxAutoDetectCookieSupport=1>
- **CMS Memos:** <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html>
- **Licensure and Certification website:** <https://doh.sd.gov/providers/licensure/>

Falls — Long-Term Care Facilities

Providing the highest possible quality of life and level of care to the residents makes resident safety a priority. Safety means avoiding, preventing, and lessening the effects of harm and injury. In reviewing the falls reporting with South Dakota Department of Health (DOH) online reporting for 6/8/18 through 7/8/18, there were 121 falls reported (falls with and without injury). The following is an analysis of those reports:

- Of the 121 reports, there were 58 different facilities reporting.
 - Of the 58 facilities reporting, 42 were LTC and 16 were ALCs.
- Of the 121 reports, 81 were LTC residents and 40 were ALC residents.
- There were 45 fractures reports.
 - Of the 45 fractures reported, there were 30 in LTC and 15 in ALC.
 - Of the fractures reported, 20 were hip fractures.
 - Of the 20 hip fractures reported, 13 were LTC residents and 7 were ALC residents.

DOH has created a flow diagram to assist when to and when not to report a fall. This is to be used in combination with the other flow diagram of Reporting of Injuries

of Unknown Source and Reasonable Suspicion of a Crime.

Falls often have serious consequences. They decrease the resident's quality of life and ability to function. After falling once, a lot of times residents will self-impose activity limitations on themselves.

Falls are usually a combination of risk factors, both intrinsic and extrinsic. Agency for Healthcare Research and Quality (AHRQ) identifies these factors as:

Intrinsic:

- Effects of aging on gait, balance, and strength
- Acute medical conditions
- Chronic diseases
- Deconditioning from inactivity
- Behavioral symptoms and unsafe behaviors
- Medication side effects

Extrinsic:

- Environmental hazards: poor lighting, cluttered living space, uneven floors, wet areas
- Unsafe equipment: unstable furniture, ineffective wheelchair brakes, missing equipment parts
- Unsafe personal care items: improper footwear, hard to manage clothing, inaccessible personal items

A culture of safety has to be developed throughout the entire organizational system. This includes staff attitudes, beliefs, and behaviors with falls. Encouragement to report all the details of an unsafe condition needs to be developed. No one should be "blamed or shamed" with a fall. The system should view the fall as a team approach to make improvements for quality of care of all the residents within the facility. Strong leadership is essential in establishing this safety culture.

When reporting a fall, make sure interventions are implemented to prevent the fall from reoccurring. All residents should be assessed before trying any of the new interventions to ensure it is not a restraint. Every intervention should be specific to the individual.

You can find this entire article and the flow diagram on our website at <https://doh.sd.gov/providers/licensure/> under the **Provider Training** section.

South Dakota antipsychotic medication usage in nursing homes higher than national average— article provided by SD NHQCC News Tips

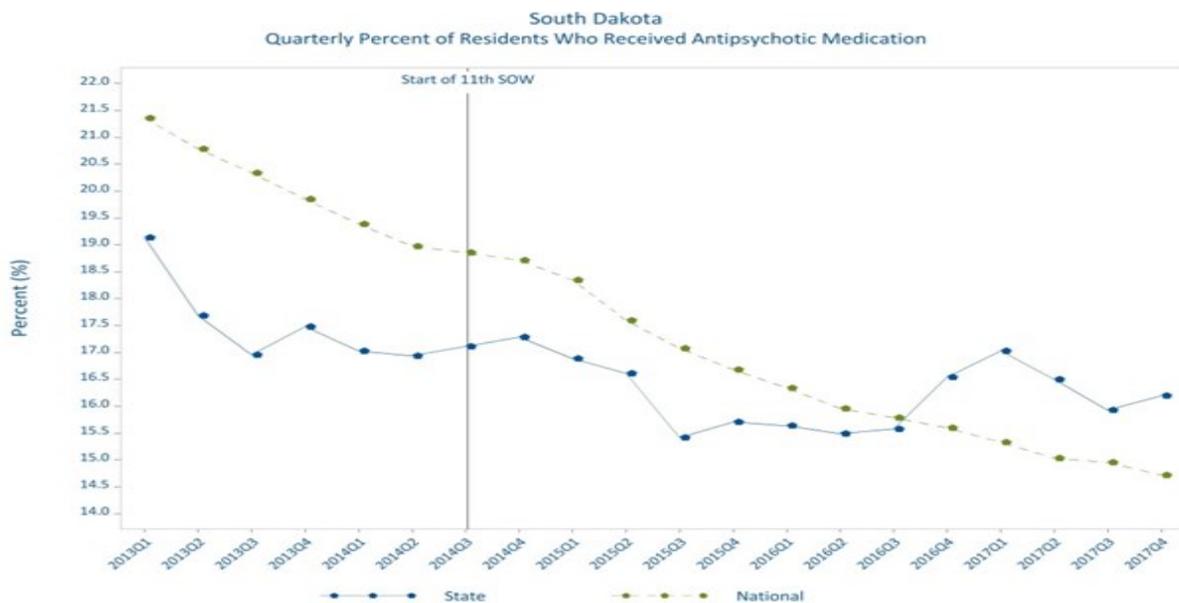
In the graph below, the blue line is South Dakota’s antipsychotic medication rate and the green dotted line is the national antipsychotic medication rate for long stay nursing home residents.

South Dakota is not keeping in line with the consistent downward national trend. In fact, only one other state in the nation has made less relative rate of improvement than South Dakota in antipsychotic reduction in nursing homes, and this state had a very low percentage to begin with. As of 2017 Quarter 4, South Dakota’s long stay antipsychotic rate was 16.19 percent, compared to 14.72 percent nationally.

Every antipsychotic medication discontinuation contributes to lowering the state rate. The percentage rate is calculated by dividing the total number of residents on an antipsychotic medication (numerator) by

those who could have been on the medication (denominator) multiplied by 100. The diagnosis exclusions from being counted in the rate calculation are schizophrenia, Huntington’s disease, or Tourette syndrome. Other cognitive and mental diagnosis such as bipolar and schizoaffective are not excluded at this time.

To be clear, it is not the expectation South Dakota needs a zero antipsychotic medication rate and should not use any antipsychotic medications, because absolutely there are incidences when antipsychotics are needed and appropriate. In addition, it is acknowledged some facilities will have a higher antipsychotic medication usage based on the demographics and residents they care for. With that being said, is South Dakota that much different from the majority of states that have made significant process toward unnecessary antipsychotic reduction?



South Dakota antipsychotic medication usage in nursing homes higher than national average—

article provided by SD NHQCC News Tips

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Approximately one-third of South Dakota nursing homes have facility antipsychotic medication rates less than 11 percent, leading to the assumption that there is opportunity to further drive unnecessary antipsychotic medication usage down in the state. What is your facility percentage? Is your facility giving this issue enough focus and attention? Many South Dakota nursing homes have a small census, so reducing antipsychotic medication by two or three residents would result in considerable improvement in this quality measure rate for the nursing home and contribute to the statewide antipsychotic reduction effort.

Strategies shared toward dementia care and antipsychotic reduction:

- Lara Bryan, Therapeutic Recreation Specialist at South Dakota Human Services Center, Geriatric Unit, Yankton, compiled strategies she uses during recreational activities as nonpharmacological interventions for reducing behavioral symptoms. Individualizing person-centered care and individualizing successful approaches are keys in reducing behavioral symptoms, thereby lessening the need to use antipsychotic medications.
- Designate an antipsychotic reduction champion in your facility. Before anyone calls the doctor requesting an order for “something to calm one down”, the caregiver must visit with the antipsychotic reduction champion to ensure nonpharmacological approaches have been exhausted and an exploration process of understanding what and why the resident is trying to express has been completed.
- Assess and address needs frequently for: Pain? Hunger? Toileting? Repositioning? Boredom? Tired? Overstimulated? Scared? Coming down with an illness?
- Familiarizing caregivers about the resident’s life prior to coming to nursing home (vocation, hobbies, daily routines, significant life events, likes and dislikes) when trying to understand agitation. Use approaches and conversations that align with the resident’s unique characteristics, focusing on residents feelings first, before actions and words.
- If your resident is prescribed an antipsychotic medication and still exhibiting the target behavior, then it is not working to produce the desired effect. Consider gradual dose reduction and discontinuation.

Providers interested in joining the listserv can subscribe at <https://listserv.sd.gov/scripts/wa.exe?A0=SDOLC>.

Click on the **Subscribe** function found on the right side of the page.

Receive newsletters as well as updates and information on licensing, survey, certification, rules, and regulations.