Long Term Care Highlights

North Dakota Department of Health
Division of Health Facilities

OCTOBER 2007

Prevention of Backflow of Contaminated Water Into the Potable Water System

By Linda Maher, RN
Health Facilities Surveyor

The survey process includes general observations of the facility. The general objective of this task is to observe physical features in the facility's environment that affect the residents' quality of life, health and safety. The requirement at F465 states, "The facility must provide a safe, functional, sanitary and comfortable environment for residents, staff and the public."

During the past 18 months, five long term care facilities were issued citations at the requirement F465. These citations were concerning the failure to provide safety equipment to prevent backflow of contaminated water into the potable water system.

Water that is aesthetically acceptable, free from apparent turbidity, color, odor, objectionable taste, and disease-causing organisms is termed **potable**, meaning that it may be consumed in any desired amount without concern for adverse effects on health.1

The backflow of polluted or contaminated water or other fluid or substance into a water-distribution piping system through backpressure or backsiphonage is a very real possibility. The best way to eliminate

(Continued on page 2)

***Special points of interest*:**

Quality Care Series:
October 18, 2007

RAI WORKSHOP:
October 30, 2007

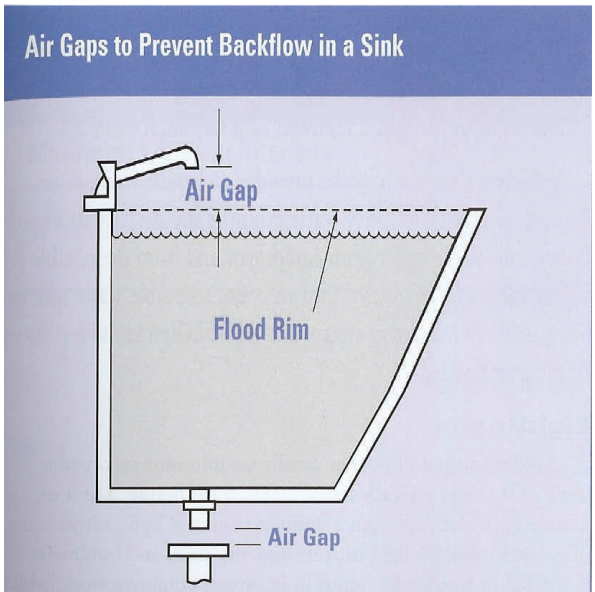
Quality Care Series:
November 29, 2007

***INSIDE THIS ISSUE*:**

Prevention of Backflow of Contaminated Water Into the Potable Water System — **Page 1, 2**
Improving Pain Assessment/Management for Impaired Residents — **Page 3**
Health-Care Facilities Policies (Life Safety Code) — **Page 4**
Exit Discharge (Sidewalks) — **Page 5**
RAI Updates — **Page 5, 6**
CNA Renewal Fact Sheet — **Page 6,7**

(Continued from page 1)

the danger is to prohibit any connections between the water system and any other system, fixture, vat or tank containing polluted or questionable water. This can be accomplished by terminating the water supply inlet or faucet a safe distance above the flood-level rim of the fixture. This distance is referred to as the air gap. Sometimes it is not possible or practical to provide an air gap.2 A back flow prevention device is used to avoid potential backflow of contaminated water into the potable water system when the air gap is not practical. The device provides a break to the atmosphere in the event of a negative pressure within the system.3



Air gaps between the faucet and the flood rim and between the drain pipe and floor drain of a sink prevent backflow.

Of the five citations issued, two were involving hoses attached to faucets in shower and bathing areas utilized by residents. The hoses reached below the rim of the tubs and/or showers. Therefore, the potential for backflow of contaminated water existed if the drains of the tubs and/or showers plugged and the water level reached the end of the shower/tub hoses.

Two citations involved janitor closets in which hoses were attached to faucets directly above mop sinks with floor drains. The hoses either reached below the rim of the mop sink or were long enough to rest on the floor of the mop sink near the floor drain.

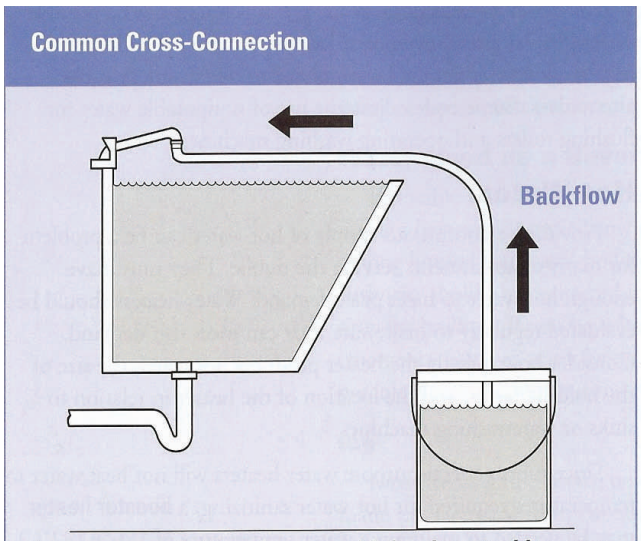
The fifth citation was related to a spray hose over the garbage disposal sink utilized in the dietary department. The hose had a part missing that allowed it to extend into the sink with the garbage disposal. Dietary staff was also observed placing the hose into a bucket of water which contained chemicals used to clean the dining room tables.

Other possibilities for the potential backflow of contaminated water into the potable water system are:

1. Ice machines.
2. Coffee urns.
3. Dishwashing machines.
4. Hoses connected to exterior faucets.

References:

- State Operations Manual for Long term Care Facilities
- Long Term Care Regulations
- 1-Environmental Health Specialist 1995 by the National Environment Health Association
- 2-Environmental Engineering and Sanitation 4th Edition Joseph Salvato Copyright 1992
- 3 -Food Code 2005 US Department of Health and Human Services.



A hose connected to a faucet and left submerged in a mop bucket creates a dangerous cross-connection.

Improving Pain Assessment/ Management for Cognitively Impaired Residents

By: Becky Humann, RN
Health Facilities Surveyor

According to a 1998 study published in the Journal of Gerontological Nursing, cognitively impaired residents were prescribed significantly less scheduled pain medication and received less pain medication compared to cognitively intact residents. Cognitive impairment does not automatically prevent self-reporting of pain by residents. Most residents with moderate cognitive impairment and approximately 30 percent of those with severe impairment are capable of using self-reporting methods. Consequences of untreated pain can be serious and may include depression, decreased socialization, sleep disturbances, impaired ambulation, increased in behaviors, slowed healing, and increased health-care costs.

Comprehensive assessment and evaluation are the keys to successfully managing pain in both cognitively impaired and intact residents. Assessing a cognitively impaired resident for pain is complicated by changes in memory, communication skills, and their ability to conceptualize pain. Therefore, the facility must develop and implement specific pain management policies and procedures indicating the facility's systemic approach in pain management for both cognitively impaired and intact residents. The facility's pain management policy and procedure should include assessment tools/scales/checklists, common observations of pain and nonverbal indicators of pain. Some common recognized pain tools for cognitively impaired residents include The Present Pain Intensity (PPI) Scale of the McGill Pain Questionnaire, the Verbal Descriptor Scale (VDS), and the Discomfort in Dementia of the Alzheimer's type (DS-DAT). In addition, the policy should specify the frequency of completing a comprehensive assessment: at a minimum on admission, quarterly, and any time a significant change Minimum Data Set is completed.

Observations of pain behavior should be made during movement or palpation of suspected painful area when the resident is more likely to perceive pain and cry out. These observations need to be documented and reviewed by the nurse. Common signs displayed by people with dementia experiencing physical discomfort include fidgeting, tense muscles, body bracing, increased calling out or repetitive verbalizations, noisy breathing, grimacing, moving extremely slowly, increase in pulse, blood pressure, and sweating. Other observations which may indicate pain include poor appetite, depressive symptoms, changes in sleep patterns, falling, refusal of care, and agitated behavior.

In order to meet regulatory guidelines, long-term care facilities will need to demonstrate assessment of pain for all residents. A pain assessment should include the location of pain, a pain score or a listing of nonverbal pain behaviors that will be used to track pain for the resident. Evidence of frequent reassessment must be documented for those who report pain. Chronic persistent pain should have routine, scheduled (rather than as-needed) treatment prescribed. Comfort or pain relief shall appear as a goal on the plan of care, with both pharmacologic and non-pharmacologic treatment strategies identified.

Hopefully, with increased knowledge and the availability of appropriate pain assessments, pain in the cognitively impaired residents can be effectively managed to improve their quality of life.

References:

American Medical Directors Association 2003 Clinical Practice Guidelines for Pain Management in Long-Term Care Setting.

Feidt, K. (2000) Improving Assessment and Treatment of Pain in Cognitively Impaired Nursing Home Residents . Annals of Long-Term Care-ISSN 1524-7929, 8(9), 36-42.

Ferrell, B.A., Ferrell, B.R., & Osterweil, D. (1990); Pain in nursing home. Journal of the American Geriatrics Society, 38, 409-414.

Kaasainen, S., Middleton, J., Knezacek, S. Hartley, T., Stewart, N., Robinson, L., (1998); Journal of Gerontological Nursing, 24(8), 24-31.

Manz et. Al, Pain Management Nursing, 2000.

Witte, M. (1989) Pain control. Journal of Gerontological Nursing, 15, 32-37.

HEALTH CARE FACILITIES POLICIES (LIFE SAFETY CODE)

By Monte Engle
Building Standards / Life Safety Code Manager

All health-care facilities are required to have written policies to address the following requirements of the NFPA 101, Life Safety Code (2000 edition).

AUTOMATIC SPRINKLER SYSTEM OUT OF SERVICE

Section 9.7.6.1 Where a required automatic sprinkler system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.

If your facility has an automatic sprinkler system and it must be turned off for more than four hours, you must notify the Division of Health Facilities and implement a fire watch. Note that personnel conducting the fire watch during this period can have no other assigned duties.

FIRE ALARM SYSTEM OUT OF SERVICE

Section 9.6.1.8 Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.

If your fire alarm system must be turned off for more than four hours, you must notify the Division of Health Facilities and implement a fire watch. Note that personnel conducting the fire watch during this period can have no other assigned duties.

FIRE SAFETY PLAN

Section 19.7.2.2 A written health-care occupancy fire safety plan shall provide for the following:
(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Response to alarms
(4) Isolation of fire
(5) Evacuation of immediate area
(6) Evacuation of smoke compartment*
(7) Preparation of floors and building for evacuation
(8) Extinguishment of fire

*This is a new item. Check your fire safety emergency plan to ensure that this step is included.

Exit Discharge (Sidewalks)

By Monte Engel
Building Standards / Life Safety Code Manager

The 2000 edition of NFPA 101, Life Safety Code emphasizes the importance of maintaining the egress system usable at all times.

7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in case of fire or other emergency.

The means of egress includes the exit discharge, which is the portion of the means of egress between the building exit and a public way such as a street, alley, parking lot or similar open area. A proper means of egress allows unobstructed travel at all times. Any type of barrier including, but not limited to, the accumulations of snow and ice, is an impediment to free movement in the means of egress.

7.7.1 Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.

The Life Safety Code is not specific as to the surface required for the exit discharge. However, in northern states, it is very difficult for a resident to operate a wheelchair or walker across frozen grass or dirt. This situation is equally difficult for staff to provide assistance in a timely manner. Because exit discharges to the public way must be kept clear in inclement weather, such as rain or snow, the surface of choice would be an asphalt or concrete sidewalk. This type of surface is easier to keep clear as well as traverse by residents and staff.

The Centers for Medicare and Medicaid Services (CMS) has indicated that all required exit discharge surfaces must be an asphalt or concrete sidewalk.

RAI Updates

By Joan Coleman
State RAI Coordinator

The Centers for Medicare and Medicaid Services (CMS) released the latest revisions to the Long-Term Care Facility Resident Instrument (RAI) User's Manual in March 2007. The updates can be found at this CMS website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#

CMS continues to strive for improving the accuracy of the Minimum Data Set (MDS). As part of this commitment, CMS is sponsoring the DAVE 2 project. The primary purpose of the Data Assessment and Verification project is to assess the integrity of MDS information and to measure and improve the accuracy of MDS assessments. Under a contract, CMS has authorized Abt Associates Inc. to conduct on-site audits of MDS assessments and supporting documentation for nursing facilities participating in the Medicare and/or Medicaid programs. Findings on MDS assessment accuracy will be used to enhance the RAI User's Manual and develop additional training materials. Currently, there are three downloadable DAVE TIP Sheets on proper coding for the following MDS Sections: Section G on Self-Performance, Section P on Physician Visits and Physician Orders, and Section P on Therapies. According to a DAVE representative, future TIP Sheets will include the proper coding of turning and repositioning programs as well as scheduled toileting programs. The DAVE TIP Sheets can be found at this CMS website: http://www.cms.hhs.gov/NursingHomeQualityInits/30_NHQIDAVE2.asp

(Continued on Page 6)

(Continued from page 5)

In December 2006, CMS contracted with a company to provide web-based MDS training. This training is available on-line at www.mdstraining.org. Each staff member may set up their own account and password, which permits them to complete the training as time allows.

With the CMS web-based MDS training, the Basic RAI Training Course provided by North Dakota is being revised. More emphasis is being be placed on state specific requirements and on MDS items having the greatest potential for discrepancies. The next Basic RAI Training workshop is Oct. 30, 2007, in Bismarck, N.D. Brochures will be sent to all facilities approximately four weeks prior to this date.

Quality Care Series

October 18, 2007
Doublewood Inn, Bismarck

"You Don't Know What You Don't Know About Dementia"

November 29, 2007
"Achieving Staff Stability: The Pre-requisite for Culture Change

EXPLANATION OF CNA FACT SHEET ON Page 7

By Cindy Kupfer
CNA Registry

To assist both CNA's and their employers with the CNA renewal process, we have created the CNA FACT SHEET on page 7. The fact sheet answers frequently asked questions and provides explanation on how the CNA renewal process flows.

This new form will be included with every new card sent by the Division of Health Facilities.

This fact sheet also provides guidelines for the completion of the renewal form.

The link on line eight of the fact sheet will give examples to help you decide if a CNA is eligible to renew their certification.

Quote of the Month

"People rarely succeed unless they have fun in what they are doing."

- Dale Carnegie

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Fact Sheet

Certified Nurse Assistant

North Dakota Renewal Guidelines

1. A renewal form will be mailed out approximately four months before your CNA certification expires
2. If you have not returned your completed renewal form to us after three months a "FINAL NOTICE" will be mailed to you one month before your CNA certification expiration date.
3. There is no charge or fee for CNA renewal on the North Dakota Department of Health's CNA Registry.
4. If you have taken and passed both the written and skills CNA test, your first expiration date is two years from your test date.
5. If you choose to endorse into North Dakota after working as a CNA in another state, your first expiration date in ND will be two years from your date of endorsement.
6. After your first renewal, your expiration date is expected to change each time your certification is renewed.
7. In order to renew your certification, you must have worked at least eight hours in nursing or nursing related services in the last 24 months as a CNA and received payment for your hours worked.
8. The eight hours worked does not have to be eight consecutive hours. The time can be broken down into two four-hour blocks, or four two-hour blocks and so on. As long as the total amount of time worked in a 24-month period adds up to eight hours or more, your certification can be renewed. For more details go to www.health.state.nd.us/HF/North_Dakota_certified_nurse_aide.htm
9. Your renewal is based on your last date worked. If you add two years to your last date worked, as specified on your renewal form, you will know your next expiration date.
10. Upon receipt of your renewal form, make any changes to your name or address on the designated lines to the right of your address information.
11. DO NOT FILL IN ANY OTHER PORTION OF THE FORM, AS THIS WILL DELAY THE RENEWAL PROCESS.
12. Name and address changes are very important information. Please be certain your current name and address are always provided to the registry, especially if either your name or address changes between renewal periods. Your renewal information form will not be delivered to you if your address is not current on the registry.
13. If you are currently working as a CNA, send or hand your renewal form to your current employer. The signature on the renewal form must be your employer's.
14. If your only employment was orientation, this will not count toward your renewal. You must have worked independently after completing your orientation.
15. If you were employed within your certification period and not currently employed, have your past employer fill in and sign your renewal form.
16. As you prepare to mail the completed and signed renewal form back to the CNA Registry, use the exact address as listed at the bottom of the renewal form.

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