



Long Term Care Highlights



North Dakota Department of Health
Division of Health Facilities

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RESIDENT ACTIVITIES

By Dorrene Haugrud, Health Facility Surveyor

Effective June 01, 2006, the Centers for Medicare and Medicaid Services (CMS) issued revised Activities guidance regarding Tags F248 and F249. The revised guidance placed additional emphasis on the provision of individualized activities in accordance with, and based upon, a resident's comprehensive assessment. The guidance also emphasized the need for meaningful activities which reflect a resident's interests and lifestyle, and are enjoyable to the resident, and provide a feeling/sense of usefulness and belonging.

Often residents with behavioral symptoms present the greatest challenge to facility staff. The interpretive guidelines address these residents as follows: ". . . many behaviors take place about the same time every day (e.g., before lunch or mid-afternoon). The facility may have identified a resident's pattern of behavior symptoms and may offer activity interventions, whenever possible, prior to the behavior occurring. Once the behavior escalates, activities may

be less effective or may even cause further stress to the resident."

This guidance promotes the importance of utilizing meaningful, interesting and enjoyable "individualized interventions" designed and implemented to attain measurable goals of minimizing specific behavior(s). In order for this to occur, the guidance stresses the importance of a thorough assessment of the resident's history, preferences, strengths, and needs; and the development and implementation of "person-appropriate" individualized interventions rather than the typical "age-appropriate" concept.

Regardless of whether "Activities" triggers when completing the Minimum Data Set (MDS), every resident requires an individualized activity plan/program. For the resident who exhibits behavior, and may or may not trigger "Mood and Behavior Patterns," many conditions/factors may contribute/cause the behavior. These contributing factors need to be addressed when formulating an activity plan/program for the individual resident. Specific factors/conditions include, but are not limited to:

- Visual impairments.
- Hearing impairments.
- Physical limitations.
- Cognition.
- Attention span.
- Environmental factors/influences.
- Pain.
- Communication/language barriers.

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The federal guidance provides a number of suggested activities in response to specific behavioral symptoms; however, interventions used successfully for one resident may not work as positively for another. The success of the planned individualized program also depends on the interdisciplinary approach used for implementing/providing the program to, and with, the resident. “The outcome for the resident, the decrease or elimination of the behavior, either validates the activity intervention or suggests the need for a new approach.”

Although the North Dakota Department of Health does not advocate or promote any specific approaches or methods for providing

activities, the October 2007 Provider magazine included the following interesting article: “A Thief in the Night”, by Joanne Kaldy. In the article, Kaldy addresses interventions which do make memory-impaired individuals feel happier, more self-confident, and experience fewer behavioral problems.

The article provides a number of suggested activities and approaches which have proven successful in decreasing behavior(s) and improving the quality of life for memory-impaired individuals.

The article is available at: <http://www.providermagazine.com/pdf/2007/cover-10-2007.pdf>



SMOKING MATERIALS AT DESIGNATED SMOKING AREAS

By Monte Engel, Manager, Building Standards and Life Safety Code

The Life Safety Code requires ashtrays of noncombustible material and safe design and metal containers with self-closing cover devices into which ashtrays can be emptied be available in all areas where smoking is permitted. This applies to both indoor and outdoor designated smoking areas.

Our office has continued to receive questions about the use of the smoking “outposts.” These are the barrel shaped, noncombustible containers with the tall tapered neck into which cigarettes can be disposed.

Prior directions to our office had always indicated that these products were not acceptable for use in meeting the requirements of the Life Safety Code at designated smoking areas. However, the CMS Regional Office recently indicated the “outposts” are approved and can be used to meet the Life Safety Code requirements for ashtrays and the containers into which the ashtrays are emptied.

Therefore, we will accept the use of the smoking “outposts” at designated outdoor smoking areas.



“I CAN’T SLEEP”

By Debbie Baier, Health Facilities Surveyor

It’s no surprise that as a person gets older, problems with his or her health becomes worse. One such problem is the inability to sleep. Complaints of inability to sleep are much more frequent in people over the age of 65 than in younger individuals.

The elderly population may have difficulty falling asleep; they may experience frequent nighttime awakenings, or may awaken very early in the morning and can’t fall back asleep. This all adds up to less total sleep time, and a lot less time in deep, restful sleep. Sometimes their days and nights are reversed. All of this could result in excessive daytime sleepiness.

As people get older, they tend to sleep less, and their sleep stages also change. Although this is normal, this often makes older people think they aren’t getting enough sleep.

An early awakening might be a common occurrence, in which the person falls asleep only to wake up several hours later and is unable to fall asleep again. In some cases, this could be a sign of depression.

Frequent awakenings during the night might be due to physical conditions. It’s been shown that the aging process itself causes sleep to become more fragmented.

Experts believe there are a number of factors which may influence sleep in the elderly population, some of which are; 1) Naturally reduced melatonin, the hormone that helps control sleep; 2) sensitivity to the environment (on average, nursing home residents are exposed to 32 loud noises each night, such as staff members talking, use of intercoms, doors slamming, and staff that make rounds and wake up residents in the middle of the night; 3) an illness that may cause pain or discomfort; 4) a neurological disease such as Alzheimer’s or Parkinson’s disease; 5) side effects of medication the resident may be

taking; 6) depression or anxiety; 7) the need to use the bathroom frequently, might all contribute to “I can’t sleep.”

Three sleep disorders are more prevalent in the elderly: sleep apnea, restless legs syndrome (and periodic limb movements of sleep) and REM behavior disorder.

Sleep apnea is a breathing problem that can occur while sleeping. During sleep, the muscles of the pharynx (the back of the throat) relax, allowing it to constrict. The pharynx collapses partially, which sometimes leads to inadequate airflow. The body then notices the poor airflow and takes a deep breath. The deep breaths and arousals can occur 50 to 100 times per hour, which disrupts sleep.

Sleep apnea is diagnosed by an overnight study of sleep and breathing patterns. There are many treatments, but the most common is a nasal CPAP, which is a machine that blows pressurized air in through the nose, helping people get adequate airflow to the lungs, so the person can sleep well and feel refreshed. Signs to watch for are snoring, pauses in breathing, the need to urinate many times at night, being overweight and non-refreshing sleep. Many people over the age of 70 may have sleep apnea without snoring.

Restless Legs Syndrome (RLS) is not often discussed but is fairly common, occurring in about 10 to 15 percent of the population. The discomfort is in the legs and is relieved only by walking. It’s described as a feeling of ants crawling on the skin, occurs only when a person is not moving, and is always worse at night. Since it occurs mostly at night, falling asleep and staying asleep can become very difficult.

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When individuals with RLS manage to fall asleep, they have frequent jerking of the limbs called periodic limb movements of sleep (PLMS). Many elderly individuals develop this (34 percent over the age of 60, even those who don't have RLS and who have no other sleep complaints). Different medications are used to treat both RLS and PLMS. These include medications are usually used for Parkinson's disease, pain control and seizure disorders.

REM Behavior Disorder (RBD) occurs when someone acts out a dream in his or her sleep. Usually when you sleep, your muscle tone is decreased; you are in fact partially paralyzed. In rare instances, some people don't have a decrease in their muscle tone and begin to act out their dreams. If the dream becomes more violent than normal, they are often described as nightmares. RBD is very rare, occurring most frequently in older men. Common causes include the use of certain medications, such as anti-depressants like Prozac and Paxil, and withdrawal from certain sedatives. RBD can be associated with Parkinson's disease, narcolepsy and certain other neurological diseases.

Many changes in sleep occur with aging, and some disorders become more common as individuals age. It is therefore very important to remember to maintain healthy sleep hygiene as a person ages. Sweet Dreams!

References:

Lauren Broch, Ph.D- Sleep disorder Institute of Good Samaritan Hospital
Rochelle Zak, M.D. New York Presbyterian Hospital- Cornell Campus, New York, NY

Websites:

www.healthology.com/sleep-disorders/sleep-elderly/article1247.htm
www.ehealthmd.com/library/insomnia/INS_who.html

RAI Updates

By Joan Coleman
State RAI Coordinator

The Centers for Medicare and Medicaid Services (CMS) released new revisions to the Long-Term Care Facility Resident Instrument (RAI) User's Manual the last week of December 2007. These revisions correct errors and clarify sections of the Minimum Data Set (MDS). The following sections of the MDS have coding revisions: Section I. Disease Diagnosis; Section K. Oral/Nutritional Status; Section L. Oral/Dental Status; and Section M. Skin Condition. The updates were effective January 1, 2008 and can be found at this CMS website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#

CMS held an Open Door Forum on the MDS Version 3.0 on October 25, 2007. CMS posted the full timeline for implementation of MDS 3.0 in December 2007. There will be a two year phase-in period, with the final implementation scheduled for October 2009.

The Way to a Happy New Year

To leave the old with a burst of song;
To recall the right and forgive the wrong;
To forget the things that bind you fast
To the vain regrets of the year that's past;
To have the strength to let go your hold
Of the not worthwhile of the days grown old;
To dare go forth with a purpose true,
To the unknown task of the year that's new;
To help your brother along the road,
To do his work and lift his load;
To add your gift to the world's good cheer
Is to have and to give a Happy New Year.

- Robert Brewster Beattie



MDS Websites

Information	Website
<p>Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Training</p> <p>The Centers for Medicare and Medicaid Services contracted with a company to provide web-based MDS training. Each individual can set up their own account and password. This allows you to complete the training as time allows. Please use the help feature if you have any problems with the website. By doing this, the contracted company will know where the problems are and will be able to fix them.</p>	<p>www.mdstraining.org</p>
<p>CMS Webcast Training:</p> <p>Improving MDS Accuracy – ADLs & Restorative Nursing Improving MDS Accuracy – Disease Diagnoses, Medications & Health Conditions D.A.V.E. (Data Assessment & Verification) Project Nursing Home Immunization – (Coding Section W)</p>	<p>www.cms.internetstreaming.com/</p>
<p>Iowa Foundation for Medical Care (IFMC)</p> <p>Includes; MDS Long Term Care Facility’s User’s Manual; 2007 MDS Scheduling Calendars; Validation Report Messages & Descriptions Manual; Guide for MDS QI/QM Reports; MDS Correction Policy Instruction Manual; DAVE Tip Sheets; MDS Version 3.0; Etc. <i>Is a link to the CMS website.</i></p>	<p>www.qtso.com/mdsdownload.html</p> <p>This website generally will always state, “we recommend you not continue to this website” – but do select <i>Continue to this website (not recommended)</i>. For the Validation Messages & Descriptions Manual, once in the website – go to the bottom of the page and chose “Validation Report Messages and Descriptions” – bring the arrow down and again chose “Validation Report Messages & Descriptions”. Print the manual, which is about 80 pages.</p>
<p>Centers for Medicare and Medicaid Services</p> <p>MDS Forms, RAI User’s Manual, Etc.</p>	<p>www.cms.hhs.gov/ NursingHomeQuality- Initiatives/NHQIMDS20.asp</p>
<p>Medicare Scheduling Calendar</p>	<p>www.noridianmedicare.com/p-meda/train/ manuals/mds_calendar.xls</p>



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<p>American Association of Nurse Assessment Coordinators (AANAC)</p> <p>This association provides information on the MDS. You can email knowledgeable members of the association if you have questions on completing the MDS, etc. (Please Note: You cannot access many of the association's sites unless you are a member)</p>	<p>www.aanac.org/</p>
<p>Long Term Care - Federal Regulations (Appendix PP of the State Operations Manual)</p>	<p>www.cms.gov/Manuals/10Mlist.asp</p>
<p>Provider Instructions for Making Automated Corrections Using the MDS Correction Request Form</p>	<p>www.qtso.com/download/mds/prMn1002.pdf</p>
<p>Medicare SNF PPS Internet-Only Manual</p>	<p>www.cms.hhs.gov/Manuals/IOM/list.asp</p>
<p>The Healthcare Compliance Company (hcPro)</p> <p>This site has a lot of current MDS information.</p>	<p>www.sfinfo.com</p>
<p>United States Department of Health & Human Services Agency for Healthcare Policy and Research (AHCPR)</p> <p>This site has Clinical Practice Guidelines, Publications and Products</p>	<p>www.ahcpr.gov</p>

THE "RED BOOK" NOW AVAILABLE

The North Dakota Requirements for Food & Beverage Establishments has been revised and reprinted (The Red Book). It was effective January 1, 2008. The Red Book will be available on the North Dakota Department of Health's website in the near future. We plan to provide the website address to nursing homes, basic care, and hospitals as soon as it is available. Watch for an email coming soon.

If you would like a copy of the Red Book mailed to you, please contact the Division of Food and Lodging at 701.328.1291, or the Division of Health Facilities at 701.328.2352.



IMPORTANT NOTICE - PLEASE READ CAREFULLY

Changing Bed Capacity in Medicare/Medicaid Certified Skilled Nursing Facilities (SNF) and Hospital Distinct Part SNFs

By Bruce Pritschet, Director

The process of changing the bed capacity in the healthcare facilities in North Dakota has, over the years, been viewed by the providers as something that can and will be accomplished according to their timeframes and specific needs. On many occasions notifications of bed changes are sent to the Division of Health Facilities after the effective date of the change has passed. In fact, the bed capacity change process is guided by the Centers for Medicare and Medicaid Services (CMS) for certified facilities and by licensing rules for the licensed facilities in the state.

In an effort to provide better directions and adhere more closely to the certification regulations and licensing rules, we are providing guidelines that apply to bed capacity changes in skilled nursing facilities and distinct part SNFs in hospitals. The licensing rules for skilled nursing facilities require a 30 day notice in writing for any change in bed capacity. Since all skilled nursing facilities in North Dakota are dually certified in the Medicare/Medicaid program, we are also obligated to follow the more stringent 45 day notice requirement for CMS certified skilled nursing facilities (SNFs/NFs). The CMS state operations manual at 3202B contains the following instructions for changing bed capacity in a certified facility.

An institution or institutional complex (nursing facility) seeking a change in the number of Medicare and/or Medicaid certified beds must:

1. Submit a written request to the State Survey Agency (SSA) for the change **45 calendar days before:**
 - The first day of its cost reporting year to effect a change on the first day of its cost reporting year; or
 - The first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter.
2. Submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the SSA to determine that the proposed change is in fact, in conformance with the rules for full participation or distinct part certification, whichever applies.

An institution or institutional complex may only change the bed size of its SNF/NF once on the first day of the beginning of its cost reporting year and again on the first day of a single cost reporting quarter within that same cost reporting year in order to affect one of the following combinations:

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- An increase in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year; **or**
- An increase in its bed size on the first day of the beginning of its cost reporting year and a decrease in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year; **or**
- A decrease in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year.

At no time can the Regional Office or the SSA approve two decreases in the bed size of an institution within the same cost-reporting year. The institution or institutional complex may submit only ONE change in bed size at a time. Furthermore, an institution cannot request a change in its bed size just because it undergoes a change of ownership (CHOW) or because it has been approved to change its cost reporting year.

A request for a change in the number of certified beds cannot be approved on a retroactive basis. All changes are made on a prospective basis only in accordance with the effective date indicated above. The institution requesting a change in bed size must submit a written request to the SSA in conformance with the guidelines listed above. An institution or institutional complex cannot self designate the effective date of a change in bed size.

These CMS requirements, as well as the licensing requirements, are in effect at this time. Beginning January 1, 2008, it is the expectation of the State Survey Agency that facilities adhere to these timelines when requesting a change in bed capacity. If you have question related to this notification of change, please contact our office at 701.328-2352.



"All labor that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence."

Dr. Martin Luther King Jr.



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