



Detecting Change in a Resident’s Condition: Knowing When to Report These Changes

By Lisa Spilker, Health Facilities Surveyor

It’s a challenge for nursing assistants and licensed nurses to notice changes that matter and it can be hard to know when to react to a possible concern. Learning what information is important to report is significant aspect of meeting a resident’s need to maintain their well-being. When reviewing the long-term care federal tag 157, which identifies specific guidelines for notification of changes, knowing how to recognize and when to report changes is important. In order to meet these guideline specifications it is imperative for nursing assistants and licensed nurses to recognize changes in a resident’s condition, know when to document and report the changes, and notify the appropriate persons when there is a change.

Recognizing a change in condition to watch for in residents include physical and non-physical changes. The top 12 changes to watch for are:

<u>Physical Changes</u>	<u>Non-Physical Changes</u>
<ul style="list-style-type: none"> • Walking. • Urination and bowel patterns. • Skin. • Level of weakness. • Falls. • Vital signs. 	<ul style="list-style-type: none"> • Demeanor. • Appetite. • Sleeping. • Speech. • Confusion or agitation. • Resident complains of pain.

Here are some examples of how the interdisciplinary team can watch for the Top 12 changes.

Physical Changes:

Walking—If the resident needs assistance, watch how much assistance he/she needs with walking. You can watch to see if the resident changes mode of transportation (walking to wheelchair). You can watch the resident when they walk down the hall to see if he/she uses the guard rail more than usual.

Urination and bowel problems—Be sure to notice if the resident is incontinent of urine or stool, or if urination is more frequent, urine smells different, or if bowel movements are rare or change to diarrhea.

Skin—While bathing and dressing the resident, look to see if the resident’s skin is discolored or puffy.

Level of weakness—Watch when the resident raises his or her arms while eating, during activities or while performing personal hygiene to see if the resident has more difficulty than usual.

Fall—Watch the resident when doing things that could result in a fall (e.g., reaching for objects when in a wheelchair).

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Timing of Insulin Administration

By Joyce Johnson, Health Facilities Surveyor

Hypoglycemia is the most common adverse effect of insulin administration. Hypoglycemia is a lower than normal level of glucose in the blood. Symptoms may include headache, weakness, shakiness, nausea, anxiety, personality changes, and if untreated may lead to coma. Ensuring that the resident receives a meal or snack within recommended time frames following administration of rapid-acting (such as Humalog or NovoLog) or a mixture of long-acting and rapid-acting insulins (such as Humalog 75/25, Humalog 50/50, or NovoLog 70/30) may help prevent this adverse effect.



The following are manufacture's guidelines for timing of insulin administration if not listed below, check the package insert supplied with the insulin vial or pen):

- NovoLog - revised May 2015: “. . . Because Novolog has a more rapid onset and shorter duration of activity than human insulin, it should be injected immediately (within 5-10 minutes) before a meal . . .”

- NovoLog Mix 70/30 - revised April 2015: “. . . NovoLog Mix 70/30 has a faster onset of action than human insulin premix 70/30 and should be dosed within 15 minutes before meal initiation for patients with type 1 diabetes. For patient with type 2 diabetes, dosing should occur within 15 minutes before or after meal initiation . . .”
- Humalog, Humalog 75/25, and Humalog Mix 50/50 - dated May 26, 2015: “These insulins start working faster than other insulins that contain regular human insulin. You should take Humalog within 15 minutes before eating or right after eating a meal. You should take Humalog Mix 75/25 and Humalog Mix 50/50 within 15 minutes before eating.

Staff administering rapid-acting or a mixture of long-acting and rapid-acting insulin need to be aware and adhere to the recommendations for timing of the administration related to food consumption. Proper timing will decrease the incidence of a hypoglycemic reactions and improve glucose control for diabetic residents.

Observation of Care and Services During the Survey

By Kelly Beechie, Health Facilities Surveyor

More time than not, when a survey team enters a long term care facility for their annual survey, the facility's administrative staff are ready. It is the direct care staff that feel ill and want to hide in a corner for the next four days because they know the surveyors will be observing them and the care they provide to the residents. All of a sudden they have eight thumbs, two fingers, and can't remember their name.



One of the most important tasks in the survey process is Resident Review (Task 5-Sub-Task-5C), specifically care observations. This is the time when facility staff are to notify the surveyors when they provide care and/or services for the sampled residents.

The State Operations Manual (SOM), Appendix P-Survey Protocol for Long Term Care Facilities, states surveyors are to conduct ongoing resident observations and to observe the resident and caregivers during care and treatment, at meals, rehab services, activities, and various times of the day, including early morning and evening, over the entire survey period. The surveyor will determine when he/she no longer needs to observe cares for a resident. This usually occurs when a surveyor has collected enough information to determine whether a sampled resident has received care and services in accordance with his/her needs.

It is important that all staff in the facility, including the direct care staff, notify the surveyors for all resident cares and services until they have been instructed not to. This will help the survey process move more quickly and smoothly. The surveyors know the staff are nervous but will try their best to ease the anxiety.

Vital sign—Record the resident's blood pressure and heart rate and look for any changes in breathing and temperature.

Non-physical Changes:

Demeanor—Observe the resident to see if he or she socializes less or participates in activities less than usual.

Appetite—Observe the resident during meals (and the tray after meals) to see if the resident is not interested in his or her food.

Sleeping—Observe during the day to see if the resident falls asleep in unusual places.

Speech—Talk to the resident to see if speech is slurred.

Confusion or agitation—Watch the resident for new fidgeting. When approaching the resident to give normal care, ask the resident structured questions to see if he/she talks more or less.

Resident complains of pain—When transferring a resident or when the resident is moving, look to see if the resident is grimacing or wincing.

What Should Be Reported

What is important enough to report? Sometimes it is hard to know when a change is really a change and that it should be reported. Here are some things you can do to be confident that you are looking at a real change and also that you are not waiting too long to decide that it is a real change that should be reported.

How to Follow Up on the First Sign of Changes

Shift-to-shift comparisons.

Are there any changes that should be watched for or reported?

Early Warning tool:

Form that nursing assistants can use to write down what they have noticed about a resident's condition.

Use the tool anytime a resident has had a change.

SBAR tool:

SBAR stands for Situation, Background, Assessment, and Recommendation

Responsibility for Observation and Reporting

Team members have to pull their own weight, but they also rely on other team members. Front-line providers are the eyes and ears for the team. Medical personnel have to make decisions based on the information that comes to them through the chain of command, including nursing assistants, licensed nurses, and other staff. Keep this in mind when reporting changes in residents; part of helping the team perform best is sharing information.

Notification of Change

Specific guidelines in the long-term care federal tag 157, which identifies specific guidelines for notification of changes, states:

1. A facility must immediately inform the resident; consult with the resident's physician; and if know, notify the resident's legal representative or an interested family member when there is:
 - a. An accident involving the resident which results in injury and has the potential for requiring physician intervention.
 - b. A significant change in the resident's physical, mental or psychosocial status.
 - c. A need to alter treatment significantly.
 - d. A decision to transfer or discharge the resident from the facility.

When reviewing these guidelines, it is easy to recognize the importance of why care providers in facilities must be able to efficiently recognize changes in a resident's condition and report the changes appropriately. Failure to recognize the changes and take the appropriate response leads to lack of communication with the team members caring for the resident to provide a safe environment and may effect a resident's well-being. Often the lack of reporting changes leads to citations of tag 157 which could be avoided.

Centers for Medicare & Medicaid Services Final Rule for Long-Term Care Facility Requirements

In Oct. 2016, the Centers for Medicare & Medicaid (CMS) published its final rule to **Reform the Requirements for Long-Term Care Facilities** in the *Federal Register*. It is the first time since 1991, that the conditions for participation for long-term care facilities have been significantly modified. The final rule revises Part 483 of Title 42 of the *Code of Federal Regulations*.

CMS stated that the rule was “necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety” in the long-term care setting.

While the regulations became effective on Nov. 28, 2016, they can be implemented by providers in three phases:

- Phase 1: Existing requirements, those requirements relatively straightforward to implement, and require minor changes to survey process (*Nov. 28, 2016*).
- Phase 2: All Phase 1 requirements, and those that providers need more time to develop, foundational elements, new survey process to assess compliance (*Nov. 28, 2017*).
- Phase 3: All Phase 1 and 2, those requirements that need more time implement (personnel hiring and training, implementation of systems approaches to quality) (*Nov. 29, 2019*).

Changes finalized in this rule include:

- Strengthening the rights of long-term care facility residents, including prohibiting the use of pre-dispute binding arbitration agreements.
- Ensuring that long-term care facility staff members are properly trained on caring for residents with dementia and in preventing elder abuse.
- Ensuring that long-term care facilities take into consideration the health of residents when making decision on the kinds and levels of staffing a facility needs to properly take care of its residents.
- Ensuring that staff members have the right skill sets and competencies to provide person-centered care to residents. The care plans developed for residents will take into consideration their goals of care and preferences.
- Improving care planning, including discharge planning for all residents with involvement of the facility’s interdisciplinary team and consideration of the caregiver’s capacity, giving residents information they need for follow-up after discharge, and ensuring that instructions are transmitted to any receiving facilities or services.
- Allowing dietitians and therapy providers the authority to write orders in their areas of expertise when a physician delegate the responsibility and state licensing laws allow.
- Updating the long-term care facility’s infection prevention and control program, including requiring an infection prevention and control officer and an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.



CMS held a national provider call on Oct. 27, 2016. During the presentation, CMS provided information about the changes included in the final rule, with a question and answer session at the end. The slide presentation, audio recording, and a written transcript of this national provider call is available at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2016-10-27-LTC.html>.

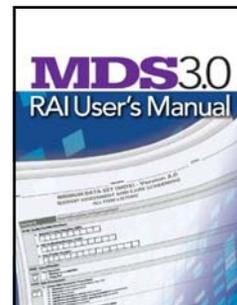
The final rule is available on the *Federal Register* at: <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>.

Fiscal Year (FY) 2016 and 2017 Minimum Data Set (MDS) 3.0 Focused Surveys ***By Lucille Rostad, Manager***

In FY 2015, CMS rolled out the MDS 3.0 Staffing Focused Surveys nationwide. These surveys focused on assessing facility MDS coding practices as compared to the residents' medical records and actual health status. These surveys also included a review of facility compliance with the requirements for nurse staffing posting. Below is a summary of the top deficiencies cited from those surveys.

Top Cited Deficiencies in FY 2015

- F278 -MDS Accuracy
- F356 -Posted Staffing Information
- F279 -Develop Comprehensive Care Plan
- F329 -Free from unnecessary drugs
- F314 -Pressure Ulcers
- F315 -No catheter/prevent UTI/restore bladder
- F274 -Comprehensive Assessment after a Significant Change



These focused surveys will continue throughout FY 2016 and FY 2017.

Survey Process Enhancements

CMS took a number of steps to enhance the survey process after receiving feedback from Regional Offices (ROs) and States, and analyzing the survey findings and worksheets submitted by the survey teams. After conducting these steps, the survey process was altered to increase efficiency and effectiveness. Some of the enhancements are:

- Removed collection of CMS Form-671 and review of posted staffing information;
- Removed request of facilities to provide hand written information which caused delays in completing the survey;
- Simplified and shortened the survey process and tools; and,
- Revised sample selection process.

The MDS 3.0 Staffing Focused Survey is not to be included in the recertification survey process. The MDS 3.0 Focused Survey can be done in coordination with a complaint survey as long as the two surveys are completed as two separate surveys with two separate 2567's.

Assessing Regulatory Compliance

These surveys will focus on assessing compliance with the regulations listed below. Facilities are also subject to an assessment of compliance with any applicable regulations based on what surveyors identify during the investigatory process.

MDS Assessment Compliance

The CMS regulations for the Resident Assessment Instrument (RAI), including the MDS 3.0 and the Care Area Assessments (CAAs) are found at 42 CFR 483.20, and the guidance is found in Appendix PP of the State Operations Manual (SOM) at F-Tags F272 through F287. These requirements apply to all residents in Medicare and/or Medicaid certified nursing homes. These regulations relate to MDS assessment accuracy (42 CFR 483.20 (g) *Accuracy of Assessment*) as well as completion and timing (42 CFR 483.20(b) *Comprehensive Assessments* and 42 CFR 483.20(c) *Quarterly Review Assessment*). In 42 CFR 483.20(i) *Certification*, CMS requires that each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment and that a RN must sign and certify that the assessment is completed. Federal regulations state at 42 CFR 483.20(j) *Penalty for Falsification* that those who falsify assessments are subject to CMPs. All other areas identified during the survey process that show regulatory noncompliance will also be cited under the appropriate regulatory group.

In the event that additional care concerns (beyond the MDS and staffing foci of this focused survey) are identified during on-site reviews, those concerns should be investigated during the survey or, if immediate investigation is not possible, registered with the SA as a complaint for further review as soon as possible.

Complaint Free Nursing Homes in North Dakota

By Bruce Pritchet, Division Director

While reviewing some complaint survey data for the past ten survey years, (May 2006 to May 2016) it became very apparent that North Dakota has a few Long Term Care nursing homes (SNFs) that have not had a complaint lodged against them in the past ten years. I believe this is a very excellent achievement. Most nursing home complaints we receive at the Division of Health Facilities are from families, resident, visitors or employees of the facility. To span ten years without a single complaint is really an accomplishment. I would like to congratulate each of the thirteen facilities on a fine decade of caring for the residents of their respected facility. Many more North Dakota nursing homes had only one complaint or had a complaint that was not substantiated. These facilities have also done very well. The thirteen complaint free facilities are as follows in alphabetical order by city:

1. Southwest Healthcare Services, Bowman
2. Towner County Living Center, Cando
3. Marian Manor Healthcare Center, Glen Ullin
4. St. Gerard's Community of Care, Hankinson
5. Hatton Prairie Village, Hatton
6. Good Samaritan Society-Lakota, Lakota
7. Maple Manor Care Center, Langdon
8. North Dakota Veteran's Home, Lisbon
9. Nelson County Health System, McVie
10. Napoleon Care Center, Napoleon
11. Good Samaritan Society-Park River, Park River
12. Tioga Medical Center LTC, Tioga
13. Souris Valley Care Center, Velva



*"Timeless thoughts of a winter's stare;
eyes gazing over a landscape bare.
Memories drift on a blustery breeze;
dying light ushers in the freeze.
Reaching out for a grasp on the
present; stillness sets in alone, and
desolate. Future unknown, outcome
uncertain; brilliance shadowed by a
drawn curtain. Path now set, laid
before me known; closing light now
emanating from home. Enter my
homestead, heart filled with glee; two
eyes of the future peering upward at
me. Trusting in him to forge forward
until fulfilled; basis of strength,
values I have instilled. A wary mind
at last permitted to rest, reflecting on
the realization of how I am blessed."*

*~ Michael A Barron,
Winter's Epiphany*



Long Term Care Highlights is published by:
Division of Health Facilities
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