



Long Term Care Highlights



When is it necessary to complete a Level II Preadmission Screening and Resident Review (PASARR)?

By Joyce Johnson, Surveyor, Health Facilities

When a resident is admitted with a suspected mental disorder or intellectual disability or if those conditions are discovered at any time during the resident’s stay at the facility, the facility must perform a Level II assessment.

Appendix P of the State Operations Manual page 192-195 states, “The Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals who have a mental disorder (MD) or intellectual disabilities (ID) are inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings . . .”.

“Specializes Services for MD or ID” means the services specified by the state that exceed the services ordinarily provided by the nursing facility (NF) under its per diem rate. These services must be provided or arranged by the state and could include hiring additional staff or contractors such as qualified mental health/intellectual disability professionals. When specialized services are combined with services provided by the nursing facility, the result is a continuous and aggressive implementation of an individualized plan of care for individuals with MD or ID. The resident’s Level II PASARR identifies the specialized services required by the resident.

Examples of individuals who may not have previously been identified by PASARR to have MD, ID or a related are condition included below. **NOTE:** this is not an exhaustive list. (RAI Manual 2-29)

- A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).
- A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.
- A resident transferred, admitted, or readmitted to a nursing facility following an inpatient psychiatric stay or equally intensive treatment.

PROBES §483.20(e)

- For residents with a Level II determination and recommendations, has the facility incorporated the determination and recommendations into the resident’s assessment and care plan?
- How does the facility identify residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition?
- If a resident was identified with newly evident or possible serious mental disorder, intellectual disability, or a

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RETIREMENT

By Lucille Rostad, Manager, Health Facilities

It is a well-known fact that everything is bound to an end of time, especially the good things. It's been a good and eventful journey of more than 18 years with the North Dakota Department of Health.

My journey in this organization has been a beautiful phase of my life, but the time has come to explore the benefits of retirement.

I am truly proud to say I'm from North Dakota and that we have the best nursing homes in the nation!!

Kathy Laxdal has been training to take over my position and will formally assume my responsibilities on October 11, 2018. Here is her contact phone number 701-328-4836 and email address is klaxdal@nd.gov. She is looking forward to working with each of you in the near future!

Post-retirement, we plan to become Arizona snowbirds, travel and spend time with our children and grandchildren. As you can imagine, we are looking forward to this very much!

"Never believe that a few caring people can't change the world. For, indeed, that's all who ever have." ~ Margaret Mead

With gratitude and appreciation,

Lucille Rostad



Gradual Dose Reduction (GDR)

By Lucille Rostad, Manager, Health Facilities

I submitted the following question to CMS Central Office:

A SNF believes that within the first year, when first considering a GDR for a psychotropic, if the physician states a GDR is clinically contraindicated for a resident, the facility does not need to attempt a second GDR in a separate quarter that first year. Is that correct?

I'm thinking a second GDR must be attempted unless the physician again states in a separate quarter, it is clinically contraindicated.

Following is the CMS Central Office response:

"... recent inquiry regarding gradual dose reductions (GDR). After careful review and research, it has been determined that we agree with your response. (My response was "I'm thinking a second GDR must be attempted unless the physician again states in a separate quarter, it is clinically contraindicated.")

Based upon interpretative guidance at F758, a second GDR attempt must be considered unless the physician again, in a separate quarter, documents the rationale for why a GDR is clinically

contraindicated. Documentation should include monitoring for side effects and adverse consequences, as well as the effectiveness of all treatments, including any non-pharmacological approaches to care. Additionally, this process must involve the resident, his or her family, and/or the resident representative."

F758 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

- (i) Anti-psychotic;**
- (ii) Anti-depressant;**
- (iii) Anti-anxiety; and**
- (iv) Hypnotic**

The regulation addressing the use of *psychotropic* medications identifies the process of tapering as a GDR and requires a GDR, unless clinically contraindicated.

Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

- related condition; did the facility refer the resident to the appropriate state-designated authority for review?
- Is there evidence that the facility provides the next care setting with the resident's PASARR Level II recommendations when a resident with MD or ID transitions to another care setting?
- Has the facility arranged for the resident to receive specialized services through off-site visits, if appropriate, to meet the resident's needs as identified in the resident's PASARR Level II recommendations?

The North Dakota PASARR Provider Manual page 13 states, “. . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process and that condition later emerged or was discovered . . .”.

Personal Funds

By Lisa Fries, Surveyor, Health Facilities

The intent of personal funds is to assure residents who have authorized the facility to manage their money have readily available access to their funds. For a resident who is requesting a facility to manage his/her money, the facility needs to have a system in place to document the date, time, amount, and who the funds were received from or dispersed to. A couple questions to keep in mind when managing the funds:



- Are residents able access money on weekends and in evening hours?
- Are quarterly statements provided?

It is important for the facility to provide the resident with their money as soon as possible. According to the F567 regulation, the facility should provide the money request in the same day for amounts less than \$100 (\$50 for Medicaid residents). For amounts of \$100 or more (\$50 for Medicaid residents) the facility should provide the money within three banking days. Also, the facility must have a system in place to safeguard against any misappropriation of resident's funds.

New Long Term Care Program Manager Announced

By Bruce Pritschet, Director, Health Facilities

On October 10, 2018, Lucille Rostad retired from her position as Long Term Care (LTC) program manager. Health Facilities is pleased to announce that Kathy Laxdal has accepted our offer of LTC program manager. Kathy is a licensed social worker and has a Bachelors of Science in Social Work. She has experience in nutrition research and as Director of Social Services in a long-term care setting; and brings years of survey and team coordinator experience to the Long Term Care program. Kathy's first day was on September 24, 2018. Since then, Lucille and Kathy have been working together to create a smooth transition. Please join me in welcoming Kathy into her new position. You may contact her at klaxdal@nd.gov or 701-328-2352.



Skilled Nursing Facility Bed Capacity Change

By Lucille Rostad, Manager, Health Facilities

What happens after the State Survey Agency (SSA) receives your request for an increase or decrease in bed capacity:

Since all skilled nursing facilities (SNF) in North Dakota are dully 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). When the SSA receives your request with the required paperwork, approximately 3-5 days before the change is to be effective, the SSA will issue your facility an amended license/certificate showing the change in bed capacity with the effective date. The amended license/certificate will then be emailed and mailed to your facility.

Dehydration

By Samantha Schell, Surveyor, Health Facilities

Dehydration occurs when an individual uses or loses more fluid than the individual consumes, and the body does not have enough fluids stored to carry out the normal functions. If the fluids the individual has lost are not replaced the individual will become dehydrated. It is extremely important in the elderly to keep hydrated to help prevent infections, delirium, or even hospitalizations.

Dehydration can happen to anyone. As the body starts to age, the function begins to decrease, therefore decreasing the storage of fluids and thirst senses become less.



This places the elderly population at greater risk for dehydration. Elderly who have a chronic illness such as diabetes and dementia, use certain medications or are unable to obtain water on their own have an even

greater chance for dehydration.

Watch for these signs of dehydration:

- Extreme thirst
- Less frequent urination
- Dark colored urine
- Fatigue
- Dizziness
- Confusion and/or disorientation
- Skin turgor
- Dry mouth

The elderly should be drinking plenty of water throughout the day! Caregivers should encourage fluids in moderate amounts during every interaction with the resident and water should be easily accessible at all times.

Sources:
<https://www.mayoclinic.org/diseases-conditions/dehydration/diagnosis-treatment/drc-20354092>

What is the Significance of Providing Vigilant Oral Cares?

By Bobbie Houn, Surveyor, Health Facilities

Did you know trillions of microorganisms live in a person's mouth? Saliva helps to facilitate a healthy balance of chemicals and bacteria in the oral cavity. Residents who require prolonged hospitalization and/or have a diagnosis of dysphagia are vulnerable to bacterial colonization.

The many functions of saliva include:

- * assisting with food breakdown,
- * carrying food chemicals to the taste buds,
- * lubricating the oral cavity and esophageal tracts,
- * defending against viral, bacterial and fungal colonization,
- * removing bacterial, plaque, and microorganisms as we swallow,
- * maintaining tooth enamel integrity, and
- * neutralizing acid levels; protecting tooth enamel from decay.

A dense bacterial biofilm will form in the mouth of any resident receiving poor oral cares. This can lead to gum problems and tooth decay, which can in turn create even more bacteria. Vigilant oral cares are essential to prevent this from happening. Vigilant cares include brushing a resident's teeth every four hours or once per shift and using a mouthwash to rinse away debris.

Many staff members consider toothbrushing a comfort measure and fail to make it a priority. They will utilize foam swabs with no toothpaste or mouthwash over a toothbrush. Foam swabs are not as successful at removing plaque and biofilm.

Studies show toothbrushing can lead to a significant reduction in pneumonia rates. The preventative measure of brushing a resident's teeth costs pennies a day. The CDC estimated it costs approximately \$23,000 to treat each case of pneumonia. You have the power to protect your residents by providing vigilant oral cares.

References:

"The Power of the Toothbrush," by Karen Sheffler, The ASHA Leader, May 2018, pages 51-57.

RAI Updates

By Kelly Beechie, RAI Coordinator, Health Facilities

Greetings!

The 2018 RAI Manual updates were effective as of October 1, 2018. Some of the updates included:

1. Additional coding tips and some clarification to Sections B, C, D, F, and J
2. Section GG – Two new Items (GG0100-Prior functioning: Everyday Activities) and GG0110 (Prior Device Use); a new code (Code 10-Not attempted due to environmental limitations; new definitions; clarification, and terminology; new self-care items added to GG0130; and new mobility items added to GG0170.
3. Section I – New Item I0020 (Indicate the resident’s primary medical condition category). This item is only completed if the assessment is a 5-day PPS assessment. Item I5100 (Quadriplegia) was clarified.
4. Section J – New Item-J0200 (Prior Surgery). This item is only completed if the assessment is a 5-day PPS assessment.
5. Section K – CMS will no longer require completion of K0501 Column 1 and K0710 Column 1. The State of ND does not require completion of these items either).
6. Section M – M0300B3, M0610, M0700, M0800, and M0900 all retired. There were some new definitions and new steps to assessment.
7. Section N – Three new Items- N2001, N2003, and N2005. These items are only completed if the assessment is a 5-day PPS.
8. Section O – Expanded chemotherapy coding tips; new names for some special treatments; new verbiage for the influenza vaccine and contraindications; and new verbiage and coding tips related to the pneumococcal vaccine.

I provided a webinar on September 19, 2018 related to the MDS updates. The training was recorded and can be accessed at: [mms://video.ndhealth.gov/health/20180919_RAI_Update.wmv](https://video.ndhealth.gov/health/20180919_RAI_Update.wmv)

The MDS 3.0 RAI Manual version 1.6 October 2018 and Errata can be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

I will provide Basic MDS training via webinar on November 27 and 28, 2018. The time will be provided later.

If you have any questions, feel free to contact me by phone or email. My email address is kbeechie@nd.gov and my phone number is 701-328-2178.

Most Commonly Cited Deficiencies in Nursing Homes

Following is a breakdown of the most common deficiencies cited in nursing homes from June 1, 2018 to September 29, 2018.

- F657 — Care Plan Timing and Revision
- F880 — Infection Prevention & Control
- F644 — Coordination of PASARR and Assessments
- F658 — Services Provided Meet Professional Standards
- F689 — Free of Accident Hazards/Supervision/ Devices
- F695 — Respiratory/Tracheostomy Care and Suctioning
- F812 — Food Procurement, Store/Prepare/Serve-Sanitary
- F761 — Label/Store Drugs and Biologicals
- F684 — Quality of Care
- F578 — Request/Refuse/Discontinue Treatment; Formulate Adv Dir

Fall 2018

North Dakota Nurse Aide Registry By Bruce Pritschet, Director, Health Facilities

IMPORTANT ANNOUNCEMENT

On September 30, 2018, the plastic cards currently sent to initial applicants will no longer be used by the Registry. You may print out your own card from the following website at any time: <https://www.ndhealth.gov/hf/registry/print-certification-card.aspx>.



Long Term Care Highlights is published by:
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