



Resident Behavior and Facility Practices

By Patty Swenson, Health Surveyor

The section addressing Resident Behavior and Facility Practices is 42 Code of Federal Regulations §483.13 and corresponding sections of the State Operations Manual. This section Encompasses, 1) the process facilities approach regarding the utilization of physical and chemical restraints or to determine they are a “restraint-free” facility, 2) the resident’s right to be free of any type of abuse, including mistreatment, neglect and misappropriation of resident property, and 3) facility practices in screening of potential hires, training of employees, measures to prevent abuse, protection of residents identification of incidents/allegations, reporting/investigating and responding to the results of their investigations.

The resident behavior and facility practices regulations occur at 1) F 221 physical restraints, 2) F 222 chemical restraints, 3) F 223 abuse by anyone including staff, another resident, family or visitors, 4) F 224 mistreatment, neglect, or misappropriation of resident property, 5) F 225 concerning facility employment practices, investigation, reporting, prevention and corrective action for all allegations, and 6) F 226 the facility’s development and implementation of policies and procedures.

Review of deficiency reports for the past three years showed Health Facilities issued citations at F 221 on 11 occasions; F 224 on 10 occasions; F 225 on 22 occasions, and F 226 on 23 occasions. Each of these deficiencies were cited based on an outcome, or potential outcome, to a resident or residents, except F 226. The surveyors consider F 226 a process tag, looking at the “method of doing something with all the steps involved,” as defined by Webster’s Dictionary.



Citations for physical restraints (F 221) included limb restraints (hand mitts) to limit hand movement, side rails to block residents capable of exiting their beds, geriatric chairs with a lap tray, pelvic belt restraints, one-piece zip-up outfits, a lap buddy, and physically holding a resident to provide care.



Citations for neglect, mistreatment or misappropriation of resident property (F 224) occurred as the result of the facility failing to prevent the mistreatment of residents (including resident-to-resident abuse of cognitively impaired residents); develop intervention strategies to prevent occurrences; monitor for causative factors that could trigger abusive Behavior; and reassess the interventions

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implemented on a regular basis. Neglect, defined as providing “goods and services necessary to avoid physical harm, mental anguish or mental illness,” occurs when the facility fails to assess resident needs (to attain or maintain his or her highest practicable physical, mental and/or psychosocial well-being) and implement measures and evaluate those measures for effectiveness to meet those assessed needs. Among those needs, triggers for neglect could occur for residents with particularly troublesome behaviors, such as physical aggression toward other residents, wandering (within or outside of the facility into traffic or frigid temperatures), and suicidal ideation — each having a strong potential for harm to the resident themselves or others.

Citations at F 225 occur as the result of the facility failing to screen, report, investigate alleged occurrences and take corrective action. The potential or actual harm of abuse or neglect to residents could be significant. For example, by failing to screen all employees the facility may inadvertently hire an employee with a history of abuse, placing the residents at risk. If a facility staff member waited two weeks to report an allegation of abuse, or a facility failed to investigate an allegation, the alleged perpetrator could continue to have access to the vulnerable residents and cause additional harm. Monitoring at the state agency has identified there are a handful of facilities in N.D. that have not called in any allegations of abuse, neglect or misappropriation of resident property for over one year.

Citations at F 226 occurred as a result of the facility failing to develop and implement policies and procedures including the seven key components (screening, training, prevention, identification, investigation, protection and reporting/ response) of an effective Abuse Prohibition Policy. The purpose of this regulation is to ensure that the facility is doing all that is within its control to prevent occurrences. What is your facility’s process for the development and



implementation of these policies and procedures? Most often, the survey team cites the facility’s failure to implement their own policies.

So what is “Resident Behavior and Facility Practices?”

The following are some “facility practices” to consider:

- Are restraints “used for discipline or convenience and not required to treat medical symptoms?” Ask: “Is there any *medical symptom* in a long term care facility that warrants the use of restraints?”
 - Discipline is action taken by the facility for the purpose of punishing or penalizing residents. Have you ever heard, “Now you just sit here” spoken to a wandering resident?
 - Convenience is action taken by the facility to control behavior not in the resident’s best interest. Have you ever heard, “We are going to put your side rail up for the night so you don’t fall out of bed?” Does that mean the resident needs to wait until it is convenient for staff to take the resident to the bathroom?
 - ◆ Are side rails used to keep a resident from voluntarily getting out of bed? Are side rails being used in an attempt to prevent falls?
 - ◆ Are devices used that the resident can not remove easily, that prevent the resident from rising or restricts his or her freedom of movement or normal access to his or her body? If utilized, has an assessment determined it is necessary and the least restrictive?
- What did the facility do to ensure they are meeting all the resident’s physical, mental and psychosocial needs? Did facility staff assess the resident, develop a plan of care, implement measures, and evaluate those measures for effectiveness? Does staff know the individual residents care needs?
- Has your facility evaluated the emotional and

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behavioral conduct of the residents and the reactions and interventions by the staff?

- How does staff respond to resident behaviors such as crying out, disrobing, agitation, rocking, or pacing?
 - ◆ In what manner does staff address these behaviors?
 - ◆ How does staff interact with these residents?
 - ◆ How long does it take to respond to these residents?
 - ◆ Is there enough staff available to address behaviors?
 - ◆ Is your staff properly trained to be able to respond appropriately to each individual resident's behavior, including residents who are experiencing catastrophic reactions?

- Are staff adequately supervised to ensure inappropriate behaviors, such as derogatory language, rough handling, ignoring residents while providing care, and failing to provide necessary cares, are addressed before an abusive or neglectful situation occurs?
- Does the facility evaluate residents with a history of aggressive behaviors, wandering behaviors, self-injurious behaviors and communication disorders? The facility is responsible for the safety of any potential Resident-to-resident altercations while it assesses the circumstances of the resident's behavior.
- Do facility staff identify events, such as suspicious bruising and/or incidents, for patterns and trends that may constitute abuse?

This includes injuries of unknown origin, especially occurring to residents who are unable to communicate how the injury occurred.

- How are you ensuring that residents, families, and staff feel free to communicate concerns without fear of reprisal? Are residents, families, and staff aware of what, when, how and to whom to report allegations, incidents and/or complaints?

Substandard quality of care in the area of Resident Behavior and Facility Practices occurs with any of the following:

- A Level II (No actual harm with potential for more than minimal harm) citation which is widespread (F score).
- A Level III (Actual harm) citation with a pattern (H score) or widespread (I score).
- A Level IV (Immediate Jeopardy) situation which occurs to even just one resident (IJ). Also, a pattern of IJ or widespread IJ.

Facility practice establishes a reasonable degree of predictability of similar actions, situations, practices or incidents occurring in the future. Staying in tune with how your facility addresses resident behavior in the regulatory section titled "Resident Behavior and Facility Practices" will help avoid these citations.



Important Information

You should be aware as of April 1, 2011, the Division of Health Facilities began posting copies of nursing home survey results (CMS-2567) on our public web page. Going back to October 1, 2010, (Federal Fiscal Year 2011) the Health program report and the Life Safety survey report will eventually be scanned, with the plan of correction in place, and posted for public access. The link to the searchable site is www.ndhealth.gov/hf/deficiency/ds-search.aspx. If you do not find your facility's report posted yet, just be patient. Your facility may not have been surveyed in FY 2011 or we have not caught up with our scanning process. If you have any questions about what is or will be posted, please contact our office.

“Just Say No” to Multiple Drugs

By Annie Skattum, Health Surveyor

Did you know that people age 65 and older account for 12 percent of the population in the United States? Thirty percent of all prescription medications are prescribed to this age group, largely because of chronic diseases. A regimen that includes multiple medications, combined with the physiologic effects of aging, increases this population's chances of experiencing adverse events (ADEs) and drug-to-drug interactions.

Taking multiple prescription medications is sometimes referred to as “polypharmacy.” Generally defined as five or more prescribed medications, it also can include using two or more medications to treat the same condition, using two or more medications in the same drug class, and/or using medications that aren't clinically indicated or that should be avoided in certain populations. Polypharmacy may lead to shortness of breath, hypertension, decreased lower extremity function, dependency with activities of daily living, and other serious problems.

Certain physiologic changes occur as we age, such as:

- Decreased cardiac output, and thus, decreased perfusion.
- Decreased gastrointestinal motility and blood flow.
- Decreased hydrochloric acid in the stomach.
- Decreased lean muscle mass.
- Decreased liver and kidney function.

All of these changes can impact how medications are absorbed, distributed, metabolized and excreted. As a result, medications may be longer-acting than anticipated and may produce undesirable effects in the body. Older adults receiving multiple medications are at risk for multiple ADEs. Common ADEs include nausea, vomiting, diarrhea, constipation and abdominal pain. Less commonly, confusion, drowsiness, weakness, loss of coordination and loss of appetite may occur. Polypharmacy also increases the risk for falls, which are already common in older adults. The use of diuretics, antidepressants, antipsychotics and antiarrhythmics, even when prescribed appropriately, can be a contributing factor for falls. This danger increases when these drugs are part of a regimen that includes multiple medications. Other common ADEs in older adults include hemorrhage related to anticoagulant therapy, delirium related to antipsychotic use, constipation and sedation related to opioid use, and dehydration related to diuretic use.

So what can be done to help prevent irrational polypharmacy? First, ensure a complete resident history is obtained and perform medication reconciliation. Verify the dosing of the medications is correct. Decide if the medications are still appropriate and if they have an adequate indication for their use. Ask yourself if the medication can be



discontinued or the dose reduced. Monitor for ADEs and ensure signs and symptoms are not misinterpreted as the onset of a new illness. Notify prescribers if ADEs are discovered so the medication can be replaced or discontinued. Make sure to educate residents about their medications and ask about any ADEs they might be experiencing. Re-evaluate therapeutic goals periodically and ensure appropriate laboratory monitoring is being performed. Encourage adequate nutrition and an active lifestyle. Consider nonpharmacologic interventions for problems such as difficulty sleeping, pain, anxiety, behaviors, incontinence, etc. Utilizing nonpharmacologic approaches may allow for dose reductions and decrease risks associated with certain medications.

By taking these precautions, you can help ensure residents' drug regimens remain appropriate, minimize adverse-drug events, and reduce drug-to-drug interactions. This in turn will lead to better resident outcomes and an enhanced quality of life. And, after all, isn't that what we're striving for?

REFERENCES

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- Molony, S. (January 2009). Monitoring Medication Use in Older Adults [Electronic Version]. *AJN, American Journal of Nursing*, 109(1), 68-78.
- Zurakowski, T. (April 2009). The practicalities and pitfalls of polypharmacy [Electronic Version]. *The Nurse Practitioner: The American Journal of Primary Health Care*, 34(4), 36-41.

The Plan of Correction — A Roadmap to Improvement

By Ken Gieser, Health Surveyor

The State Operations Manual (SOM), Chapter 7 — Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, Sept. 10, 2010, 7304.4 — states “Except in cases of past noncompliance, facilities having deficiencies (other than those at scope and severity level, A) must submit an acceptable plan of correction. . . An acceptable plan of correction must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. . . Facilities should be cautioned that they are

ultimately accountable for their own compliance. . . The plan of correction will serve as the facility’s allegation of compliance. . .

At the completion of the long term care facility survey, the survey Team Leader provides a Division of Health Facilities form, INSTRUCTIONS FOR COMPLETION OF THE LONG TERM CARE DEFICIENCY REPORT, to the facility administrator. These instructions include the requirements from SOM.



After the Division of Health Facilities receives the plan of correction (POC), it is

reviewed by one or more surveyors to determine if the requirements adequately are addressed to assist the facility and its staff in returning to compliance with the cited deficient practices. After review, if necessary, the facility is provided the opportunity to modify the POC to ensure compliance and acceptability.

Acceptable Plan of Correction

- Those residents affected - As stated, the facility must address the corrective action taken for those residents in the cited deficiency. If the residents are no longer in the facility, this should be

stated. If the deficient practice for the resident(s) was corrected during the survey, this should be stated. If the issue is environmental in nature, state the corrective action for the specific location, i.e. dusty vent in Room 1 was cleaned.

- Identify other residents having the potential to be affected - As stated, the facility must review its residents or the facility to determine if others may be affected by the same practice, but were not identified during the survey. The statement “All residents may be affected” only is acceptable if it is accurate, i.e. all residents are not transferred with a full body lift; all residents do not require assistance with meals. If the issue is environmental in nature, review all similar areas, i.e. soiled utility rooms, chemical storage areas, room doors for rough edges, etc. Consider the nature of citation, not only the deficient practice, i.e. if resident grievances regarding linen is cited, the facility must look at other grievances and how they are handled, not just the linen.
- Measures or systemic changes implemented to ensure non-recurrence - The facility must look at its

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system and determine if modifications are needed or if a new system needs to be developed. This may include policies/procedures, equipment, protocols, staff education/training, etc. Whatever changes are implemented, appropriate staff must be informed, educated, re-educated when necessary, and these changes must be documented. Simply reviewing the survey report with facility staff is not acceptable.

- Monitoring performance - The facility must monitor the measures or systemic changes it has made to ensure non-recurrence. A QA/QI process must be implemented by the facility's identified date of compliance. The facility must identify the title of the person responsible for monitoring, the frequency and duration of monitoring, and the number of cases to be monitored. A general statement such as "Monitor resident toileting for three months" is not acceptable. The number per shift, by whom, with a declining frequency over a longer duration (such as six months) must be identified. A monitoring cycle may not be completed by the compliance date. However, survey staff will expect to see a monitoring format and raw data by the compliance date.
- Dates for completion of corrective action - This date can be no earlier than the day after the last day of the survey. The Division of Health Facilities has established a maximum completion date of 35 days from the last day of the survey. The facility may establish any date in the 35-day window that it finds appropriate. This time period allows the division time to complete the revisit and the facility time for corrective action if it is not found to be in compliance on the revisit. **ALL** POC components **MUST** be completed by this date with the exception of the monitoring being completed. If a facility finds it is not able to complete the POC activities in 35 days, it **MUST** contact the division as soon as possible.

Key Points

- The facility administrator must sign the Plan of Correction. If state licensing requirements are cited, this deficiency report requires a separate signature.
- Consider **ALL** five points of the Plan of Correction for **EACH** citation.
- Document the facility's response to **ALL** five points of the Plan of Correction for **EACH** citation.
- If a citation has more than one issue, i.e. unsafe transfers and failure to use fall alarms at F323, each issue **MUST** be addressed on the Plan of Correction.
- Consider the nature of the citation, not just the deficient practice.
- Document **EVERY** part of the corrective action.
- Use the Plan of Corrections as a QA/QI method for the benefit of residents and families and education of staff.
- The Plan of Correction is a work in progress. If the facility finds a form or policy requires modification to be most effective, the staff should document, implement and monitor the changes. In most instances, approval is not required to change the Plan of Correction.
- Facilities are responsible for their own compliance, including the information contained in the Plan of Correction.
- If there are questions, contact the Division of Health Facilities, at 701.328.2352.



Most Commonly Cited Deficiencies in Nursing Homes

Following is a breakdown of the most common deficiencies cited in nursing homes from Oct. 1, 2010, to March 1, 2011.

- F323 – Facility is Free of Accident Hazards
- F441 – Facility Establishes Infection Control Program
- F241 – Dignity
- F329 – Drug Regimen is Free from Unnecessary Drugs
- F248 – Activity Program Meets Individual Needs
- F281 – Services Provided Meet Professional Standards
- F309 – Provide Necessary Care for Highest Practicable Well-Being
- F371 – Store/Prepare/Distribute Food under Sanitary Conditions

Legislative Session Passes House Bill 1041

The 2011 North Dakota Legislative Assembly recently passed House Bill 1041. This bill changes the authority, registry and training programs for nurse aides, home health aides, and medication assistants I & II from the North Dakota Board of Nursing to the Department of Health, Division of Health Facilities. This change will go into effect on July 1, 2011. On that date, the department will assume responsibility for the registration of nurse aides, home health aides, and medication assistants I and II. This includes all related training programs for each category listed above, fee payments, renewals, initial applications and disciplinary actions that are currently the responsibility of the North Dakota Board of Nursing.

Questions, inquiries and resource information requests should be directed to the North Dakota Department of Health after July 1, 2011. You may contact our office by phone (701.328.2353) or e-mail (cnaregistry@nd.gov). You also may visit our website at www.ndhealth.gov/hf.

Phone Contacts

Over the past several months, it has been necessary for our state survey agency to make contact with several of the nursing homes around the state. The reasons for the contacts vary from flood-related questions to end-of-year licensing questions and bed capacity questions. During these phone contacts, we became aware of many instances when the administrator was gone, the DON was not available and we were told there was no one we could speak to regarding our questions. We do not plan to single out any one nursing facility at this time, but would like to focus your attention on the Licensing Rules for Nursing Homes in N.D. (NDAC 33-07-03.2-07) Governing Body. At 2. B. it states, *in the absence of the administrator, an employee must be designated in writing to act on behalf of the administrator.* Please be certain, through written communication in the absence of the administrator someone in the nursing facility is acting on the behalf of the administrator.

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