

CERTIFICATION BUREAU HIGHLIGHTS

SPRING 2018

ALL FACILITY TYPES (HOSPITALS/CAHs/LTCs)

Legionella's Disease - CMS Requirements

By: Jennifer Andersen, LPN

Since its discovery in 1976, Legionnaires' Disease has been responsible for approximately 6,000 reported cases of Legionella pneumophila, with a reported 9% of those cases being fatal. In 2015, the CDC found that 76% of those cases were associated with healthcare facilities. Of those cases, 80% were connected to long-term care facilities. During a 2017 Briefing by the CDC Director, Anne Schuchat, M.D., stated, "Legionnaires' disease in healthcare facilities is widespread, deadly and preventable."

How is Legionnaires' Disease deadly? Legionnaires' Disease is caused by a bacterium called *Legionella pneumophila*. This bacterium is contracted through the inhalation of contaminated water droplets. It has also been known to be contracted through the aspiration of contaminated water. Those individuals at risk of contracting Legionnaires' Disease are persons who are at least 50 years old, smokers, or those with underlying medical conditions and/or lung disease.

The bacterium is spread through the poor maintenance of complex water distribution systems and then

vaporized through devices such as showerheads and air conditioning systems. Some LTC facilities have a higher chance of spreading Legionella through their water system due to their no-scald policy, which maintains a lower storage temperature of their water. However, not all water systems are the same, and not all water systems are managed the same.

So how is Legionnaires' Disease preventable? The spread of Legionella can be prevented through the development of water management policies and procedures, and the development of an effective water management plan to reduce the risk of the spread of *Legionella*. Per the industry standard¹, it is recommended to implement a water management program. In 2016, the CDC and its partners developed a toolkit to facilitate the implementation of the ASHRAE standard. Facilities should conduct a risk assessment to identify where *Legionella* may grow and be spread within their water system, and develop a protocol for the testing of the

water for contamination based on their specific facility's needs.

What are the expectations of surveyors? Surveyors, based on the Infection Control Regulations for Hospitals, LTC facilities, and CAH facilities, will review:

- A facility's risk assessment.
- Policies, procedures and reports which document the management, implementation, monitoring, and reporting of the management of an effective water management plan to identify *Legionella* and other opportunistic waterborne pathogens.

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- The implementation of a water management plan which considers the CDC toolkit and/or the ASHRAE industry standard measures for physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.

- Testing protocols, the development of acceptable ranges for control measures, the documentation of results, and any corrective actions taken to maintain a safe water system.

If you have not recently reviewed and updated your water management plan, now might be a good time. Additional help with development and implementation of a Legionella water management plan is available through the CDC toolkit:

(<https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html>), and

available through ASHRAE 188. Of course, for further information regarding regulations concerning the management of *Legionella*, refer

to the CMS S&C Letter 17-30-Hospitals/CAHs/NHs [Revised 6/9/2017].

It is also encouraged to contact your local Health Department and/or the State Epidemiology Department to report or ask any questions regarding Legionella.

¹ ASHRAE 188: Legionellosis: Risk Management for Building Water Systems June 26, 2015. ASHRAE: Atlanta. www.ashrae.org

LONG TERM CARE

Infection Preventionist Requirements: F882

By: Liz Adams, LPN

Phase 3- Full Implementation of QAPI (Quality Assurance Performance Improvement) and Integration of Infection Preventionist

Final rules to reform the requirements for Long-term Care Facilities regarding Infection Control and Quality Assurance are effective November 28th, 2019. Below are some reminders to ensure you are ready in time.

Effective November 28, 2019, the facility must designate one or more individual(s) as the Infection Preventionist(s) who are responsible for the facility's infection control program.

Required under 483.80(b)(1), the Infection Control Preventionist must

have **primary** training in nursing, medical technology, microbiology, epidemiology, or another related field. Surveyors will review personnel records for certifications and licenses.

Required under 483.80(b)(2), the Infection Control Preventionist must be qualified by education, training, experience or certification.

Required under 483.80(b)(3), the Infection Control Preventionist must work at least part-time at the facility. Surveyors will be requesting staffing hours for review.

Required under 483.80(b)(4), the Infection Control Preventionist must have completed specialized training in infection prevention and control. The regulation does not

specify how many hours or the source of the training. The training must be beyond the designated individual(s) initial professional degree. Surveyors will request staff training documentation for review.

Under 483.80(c), the infection control preventionist(s) must be a member of the facility's quality assessment and assurance committee, and report to the committee on the infection control program on a regular basis. Surveyors will be requesting items such as quarterly reports to QAPI, the Infection Control Annual Report, and infection control surveillance data, corrective actions, and monitoring for effectiveness documentation.

Restorative Nursing Programs: F676 and F688

By: Peggy Tressel, RN, WCC, RAC-CT

What's in a name?

In the case of a restorative nursing program, there are three components to the name that provide direction when building your program: restorative, nursing, and program. Each of these elements is a block in the foundation of a successful outcome for the resident.

Restorative, in this case, can mean returning a resident to a previous level of function, or it can be maintaining the current level of function, as much as possible, for as long as possible. The functional levels being addressed concern the Activities of Daily Living at F676, and Mobility at F688. Specifically, these requirements deal with dressing, eating, grooming, hygiene, bathing, toileting, transferring, walking, eating, range of motion, and let's not forget oral care. Really, let's not forget oral care. In addition, communication is also considered an activity of daily living, and can be a critical element to the quality of care and quality of life for a resident.

Nursing, not surprisingly, refers to the nursing department of your facility. Even though a restorative nursing program is a function of the nursing staff, we have often seen this task relegated to the therapy department. While skilled therapists can play a vital role in the restorative nursing program, it is time for nursing staff to step forward and take charge of this nursing

responsibility. Think about how residents are added to a restorative program in your facility. Are residents always added based on a referral from the therapist, after receiving therapy services? When a resident has been identified as having a decline in their functional ability, is the only option a referral to skilled therapy, with a plan for the therapist to create a restorative nursing program? These approaches are not wrong, but they do not utilize the bed-side expertise of the CNAs and nurses who work with the resident on a daily basis. Nurses have the ability to assess the basic functional needs of the resident and establish a program to address those needs. CNAs can carry out the interventions of the program. When a more complex assessment is needed, or specialized training is necessary for a CNA to safely carry out an exercise, the therapy team is the perfect partner. They possess the expert knowledge and skills when the needs of the resident require more than the nursing staff provide.

The last component of the name is program. A restorative nursing program is not the nursing staff completing the activities of daily living for dependent residents. The intent is that the resident will receive the appropriate services required to meet the needs assessed by the nursing and/or therapy staff to maintain or restore his/her functional ability or mobility. It is an

individualized plan with interventions based on the results of an individualized assessment. The plan should include a description of the problem being treated, a goal, timeframes of how often the services will be provided, specific interventions that will assist the resident to meet the goal, and who is responsible to provide the interventions. The effectiveness of the interventions should be evaluated on a regular basis, at least quarterly, to determine if changes to the plan are needed.

Surveyors will look for documentation that a resident's decline in activities of daily living or mobility was identified, the resident's needs were assessed, and the necessary services were provided. They refer to the activities of daily living flow sheets, MDS coding, the resident care plan, and resident and staff interviews, and other sources to establish a decline has occurred. Surveyors will look for evidence the facility identified and treated the cause of the decline, when possible. They will look to see if the restorative nursing services were initiated timely, and will also review the plan evaluation when determining if a resident decline was avoidable or unavoidable.

When considering a restorative nursing program, the name says it all.

Dementia & Person-Centered Care: F744

By: Kaye Tedesco, RN

December 12, 2017, the World Health Organization (WHO) reported that worldwide, there are 50 million people that have dementia with ten million new cases each year. Some other key facts the WHO reported were: Dementia is a syndrome which affects older people. Dementia is not a normal part of aging, and the most common form is Alzheimer's Dementia.

The Center for Medicare & Medicaid Services (CMS) expects, "A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being."

CMS defines "Dementia" as having a "group of symptoms related to memory loss, judgement, language, complex motor skills, and other intellectual functioning," caused by damage to or death of brain cells or neurons.

For a resident to "attain or maintain" their highest practicable level of functioning physically, mentally, and psychosocially, CMS requires it begins with the interdisciplinary team's comprehensive assessment. The resident's care is to address the whole person and must include the resident, the family, or the resident's representative. The resident's care is to be person centered with care

being directed toward understanding, preventing, relieving, and/or accommodating a resident's distress, or their loss of abilities due to their dementia. Staff must be qualified (competent and having the skills) to support the resident through the many changes that may occur throughout the resident's stay.

The person-centered care plan contains the resident's goals which must be, or should be, achievable. The facility must provide the necessary resources to assist the resident in reaching their goals. A facility must show continued monitoring and implementation of interventions to meet the resident's needs. If the facility has done this and can show what was attempted to help the resident achieve their highest well-being, but was unsuccessful, this could be considered an unavoidable decline. Documentation is very important when it comes to identifying deficiencies and deciding if they are avoidable or unavoidable.

In review, the dementia resident's plan of care must be person-centered, holistic, and driven by a comprehensive IDT assessment with achievable goals. Below is an example of a care plan:

Concern:

I forget where my room is and may walk into another resident's room due to my dementia.

Goal:

I will return to my own room each day for the next quarter.

Interventions:

A picture that I recognize will be placed on my door. (ACTIVITY STAFF)

Staff will show me the picture on my door each time they are with me. (ALL STAFF)

When I leave the dining room, staff will remind me where my room is or walk with me to my room. (ALL STAFF)

Staff will redirect me to my room. (ALL STAFF)

Should these interventions not achieve the desired outcome, the facility must assess the resident to determine if these interventions are still appropriate, and determine how they plan to add or modify interventions to achieve the goals for the resident.

There is some useful information under the guidance section within the regulation that can assist facilities in maintaining compliance with this regulatory area.



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LIFE SAFETY CODE

Staff Sleeping Rooms

By: Didem M. Park, RDN, LSCS

In the past year, surveyors have come across more sleeping rooms where the facility has designated 3 or 4 rooms on a wing.

The facility must ensure these rooms are code and survey ready:

- The facility can install battery operated single-station smoke alarms in rooms designated as staff sleeping rooms since these rooms are considered lodging or rooming houses (different occupancy) per 26.3.4.5.1 of NFPA 101-2012 Life Safety Code (LSC); or,

- The facility can install or use the smoke detectors connected to the facility's fire alarm system per 9.6.2.10 of NFPA 101-2012 LSC, instead of installing the battery-powered smoke alarms. However, section 9.6.2.10.1.4 says these system smoke detectors must be arranged to function in the same

manner as single-station or multiple-station smoke alarms.

The typical smoke detectors provided on the fire alarm system do not provide any occupant notification. However, single-station smoke alarms provide detection and occupant notification. On a technical standpoint, the basic fire alarm system smoke detectors are not enough and some sort of occupant notification system must be provided.

State Agencies surveying on behalf of CMS enforce the code and will cite the facility if there is not an occupant notification device in the room. Smoke alarms in the sleeping rooms are not required to be connected to the building fire alarm system (a smoke detector would be, but not a smoke alarm). The facility is not required to have an audible notification device in

the sleeping room which would activate every time the fire alarm system is activated. The facility may have a single-station smoke alarm that has an audible signal installed, which will only activate if a fire develops in the sleeping room.

In fully sprinklered buildings, doors that open onto the exit corridor are not required to have a minimum of 20-minute fire protection but resistance of passage of smoke per 29.3.6.2.2 and a self-closing/latching door closure per 29.3.6.2.3 of NFPA 101-2012 LSC.

There is no requirement to separate the different occupancies with a fire rated barrier per 6.1.14.3 of NFPA 101-2012 LSC. The separation between the occupancies is not required, provided the most restrictive requirements of the occupancies involved complies.

NON-LONG TERM CARE

Hospice Coordination

By: Ronda Ward

F849: The New LTC Regulation that Hospice Agencies will want to know about

If one or more hospice patients reside in a LTC (Long Term Care) facility, your facility should be aware of the LTC regulation **F849**. Now, along with the hospice regulatory

enforcement directing the coordination of care for LTC residents, CMS has added a regulation directing the LTC facility to also have responsibilities for the hospice patient, residing in a LTC facility.

LTC Regulation F849; *Hospice services*, was implemented on

11/28/17, replacing F526, which took effect on 11/28/16. Prior to F526, there had not been a specific deficiency making the LTC responsible for coordination of care for the hospice patient residing in a LTC facility. Hospice was left holding the bag, with specific regulations for patients within the LTC setting. There

had been no regulation for overall coordination of care for these patients. LTC and hospice agencies were often observed working as separate entities.

F849 is a stringent and detailed regulation the LTC must now follow, and share in the responsibility for coordinating care of the hospice patient, in a LTC setting.

F849 also specifies the LTC facility will be responsible for obtaining:

- The most recent hospice plan of care specific to each patient.
- The hospice election form.
- The physician's current period certification and recertification of the terminal illness specific to each patient.

- Names and contact information for hospice personnel involved in hospice care of each patient.
- Instructions on how to access the hospice's 24-hour on-call system.
- Hospice medication information specific to each patient.
- Hospice physician and attending physician (if any) orders specific to each patient.

The LTC must ensure and provide:

- Orientation in the policies and procedures of the facility, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.
- Each resident's written plan of care includes both the most recent hospice plan of care and a

description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required.

-An interdisciplinary team responsible for working with hospice representatives to coordinate the care of the hospice patient/LTC resident. The plan must be current and internally consistent to assure that the needs of the resident are always met. The hospice patient residing in a nursing home should not experience any lack of services or personal care because of his or her status as a hospice patient.

Please do not hesitate to call our office with any questions you may have.

MANAGEMENT & CERTIFICATION SPECIALISTS' CORNER

Behavioral Sense

By: Tina Frenick, NHA, LTC Supervisor

Have you ever been stuck in the check-out line with an incessantly chatty clerk at the store? Did you think of the frustration the clerk caused, the audacity of the lack of recognition of your needs? How did you display your frustration or impatience? Did you roll your eyes, cross your arms, or perhaps even make a comment under your breath for others to hear? Was your behavior, if displayed, a behavior that would be accepted in any other social setting?

What is the definition of **behavior**? *It is the way a person or animal acts or behaves; the way*

something moves, functions, or reacts; or the whole activity of something, and especially a living being.

From my college days, I recall the five basic needs of children included survival, belonging, power, freedom, and fun. It was identified that behavior related to unmet needs. The goal was to find ways to help the child deal with the behavior in socially acceptable ways and when an adult they would manage their own behavior. I believe we still have the five basic needs, as an adult. There are many philosophies attempting to explain

why individuals may display a behavior which may not be socially acceptable.

The nursing home environment is the resident's community. Because of this, it is important to identify a resident's specific needs throughout their stay, which begins on admission. The goal is to attempt to prevent negative outcomes (behaviors) related to the unmet needs. The comprehensive assessment process may include the identification for the deficits of the five senses a resident either possesses or does not possess, which are seeing, hearing, touching,

smelling, and feeling. As an example, a resident who has a hearing deficit may get frustrated when the resident does not hear staff enter the room, and the resident becomes angry and yells at the staff when startled.

While attending a conference I received further education on how to individualize care plans. A myriad of examples of what was not considered an individualized care plan was provided. I learned, for example, the resident noted above, may have a generic care plan that shows an intervention as, "Knock before entering room." But really, what was the unmet need? Staff startled the resident, due to his hearing impairment, so the care plan modification may be a more individualized approach, such as, "I am hard of hearing and startle easily. Approach from the side, so I can see you, so I am not startled."

Care planning is a road map of sorts, which guides staff involved in a resident's care. To be effective and comprehensive, the care planning process must involve all disciplines that are involved in the care of a resident. For a resident with Alzheimer's or dementia, stimulating the five senses may positively or negatively affect the resident's mood. The staff who are frequently in the resident rooms more often, such as the CNAs, housekeepers, activities, or even maintenance, may be the staff who come up with unique ideas or interventions to be added to the care plan and it may require some ingenuity. If a facility

encourages all staff to come up with solutions for unmet needs which may cause an exhibited behavior, then the ideas should not be discounted, but valued. The facility may wish to try an intervention to see if it will benefit the resident, and if the intervention alleviates an exhibited behavior even one time, then the intervention was a success. We all have needs met in a variety of ways which improves our quality of life, and the care plan interventions should reflect the resident's individuality.

I always smile when I recall a social worker I mentored. She would make it a point to meet all new residents. After becoming acquainted, she would prompt a discussion by saying to the resident, "Are you married?" and "Tell me your love story." She shared precious memories and sorrows during these discussions. If the resident was not married, she would modify her question by saying, "Have you ever been in love?" She identified historical information, likes, dislikes, relationships, rituals, struggles, and daily life patterns. The same social worker would visit a female resident each day and watch some of the Oprah show on the television. During this time, the two would often laugh together and share life. The same resident struggled with a mental health disease. She would teeter on the brink of reality versus volatility. The social worker was the unlikely ally, and she was frequently called when the resident escalated and staff were unable to identify what

the resident's unmet needs were, even though the staff worked with the resident daily. The social worker, by her daily visits, honed her ability to understand the resident's needs and communication style, and she developed an interpersonal relationship with the resident.

Compassion, patience, and the willingness to accept that we may not always know what is best for the resident, is integral to the success of behavior management. We should not "manage" a resident's behavior, but identify the unmet need of the resident and focus our attention on fulfilling the need before the resident experiences a negative outcome. The long-term care industry has been attempting to extinguish "unwanted" behaviors for years. Pharmacological interventions are becoming more regulated, and there is not an easy formula for decreasing unwanted behaviors.

Considerations for interventions to meet a resident's needs should include contributing factors from the environment, and the resident's individual contributing factors. The facility may investigate each behavioral event, to identify the need which was not met, which in turn prompted a behavior. Environmental factors may include: lighting, room temperature, door open or closed, call light availability, odor, or the noise level. Contributing factors for the individual resident may include: comfort, pain level and control of pain, disease process, equipment concerns, staffing availability and assistance provided,

hunger/thirst, loneliness, or depression. Giving the resident a choice and offering staff training on how to better identify individualized needs will benefit the residents.

Resident's with combative behaviors pose a risk to themselves and others. Review of the article, published by Medical Mutual, titled, "Residents with Combative Behavior in Long Term Care," showed on average, 1.5 million residents received care in nursing homes each day. Of these, 6% displayed physical aggression each week.

And, "...by understanding extrinsic and intrinsic factors and triggers which may contribute to a resident's escalation in behaviors, caregivers can implement strategies that will address the resident's predisposition to certain triggers..." Trending showed communication issues played a primary role in the aggression or combativeness. This includes the inability to communicate individualized needs. The article went on to show contributing factors to resident

combativeness, and interventions to help deter negative outcomes.

In summary, staff should be mindful of their approach and evaluate every situation when an unmet need is exhibited. There are many resources available for use, but when you want to prevent or de-escalate a resident, first and foremost, look at your own emotions, tone, and body language. Ask yourself, what are you attempting to do for the resident; then ask yourself, is this what the resident really wants?

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