

Welcome
Residential Care and Assisted
Living Facilities
Survey Process

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Seniors and People with Disabilities
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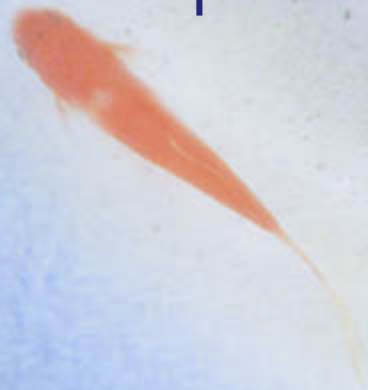


WEBSITES

- Documents will be available on the internet at <http://www.oregon.gov/DHS/spd>
- Click on “Tools for Providers”
- Click on “Manual, Guides & Instruction”

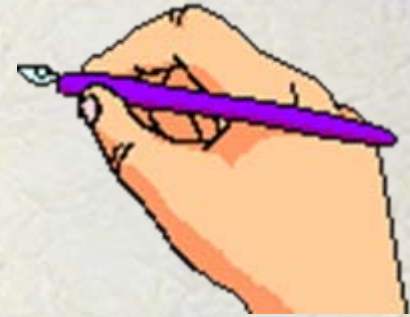
Residential Care & Assisted Living Rules

designed to enhance the dignity,
independence, individuality and
decision making ability of the
resident, maximize abilities to
function at the highest level
possible, in a safe & secure
environment



Surveying to the major RALF rule changes

Definitions:



Document means in the resident record.

Evaluation means

- Who: caregiver, administrator
- When: initial, 30-day, quarterly, ongoing as needed
- What: elements listed in C255

Assessment means

- Who: RN
- When: Significant change, delegation, & as needed
- What: RN professional judgment based on resident condition

24/7 Systems

Policies, procedures & protocols

- Firearms & ammunition C154
- Sexual relations between staff & residents C154
- Injury, loss of property & suspected abuse C200
- Resident monitoring & reporting 24/7 C270
- Resident emergency C280
- RN duties, responsibilities, & limitations C280
- Outside service providers C280
- Off-site providers providing care to residents C280
- Staffing system based on acuity C360
- Training program C365 & 370
- Personal incidental funds C410
- Emergency & Disaster Planning C435

C250, 252, 255 - Evaluation

- C250 Initial prior to move-in or reason why not & within 8 hours of move-in
- Initial is separate & distinct
- C252 - Quarterly evals
 - Past 24 months accessible & on-site
 - Initial & date all entries & changes
- C255 – elements addressed in evals

C260 – Service Plan (SP)

- Based on eval, reflective of resident
- Required prior to move-in
- Review required at 30 days after move-in
- Quarterly based on quarterly eval

All changes, entries, on-going reviews to be dated & initialed

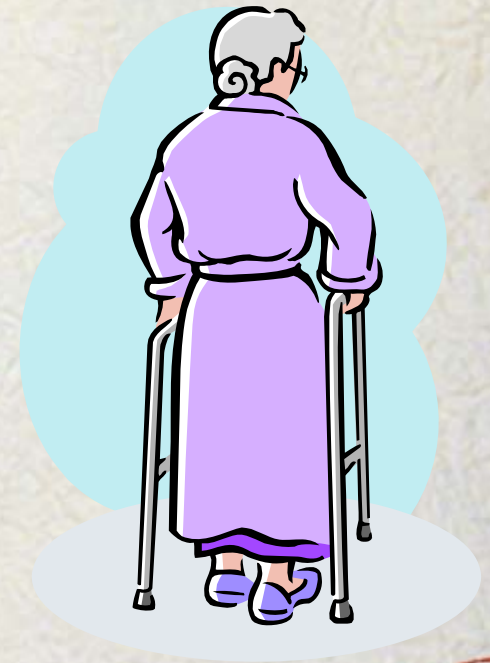


C270 - Change of condition

- Short term change of condition
 - Expected to resolve or be reversed with minimal intervention, or
 - Established, predictable, cyclical pattern associated with previously diagnosed condition.
- Significant change of condition
 - Major deviation from most recent eval that may affect multiple areas of functioning or health
 - Not expected to be short term
 - Imposes significant risk to resident.

Response to Change of Condition

- **Short term change of condition**
 - Actions, Interventions, Monitoring
 - Progress noted at least weekly until condition resolves
 - Documentation
- **Significant change of condition**
 - Evaluation
 - Appropriate medical care
 - Referral to facility RN, Assessment
 - Update Service plan as needed
 - Appropriate follow-up care
 - Interventions, Monitoring
 - Documentation



Monitoring

- P&Ps to ensure monitoring & reporting system in place 24/7
- Monitor each resident consistent with needs
- Train staff to identify changes in condition, document and report
- Access to designated staff 24/7 who can determine what action is needed
- Written communication of change & interventions to all staff, all shifts

Example of significant change for level of functioning such as, ADLs (activities of daily living)

- A resident was able to transfer independently from a chair to a standing position & then walk, but now requires the assistance of staff & a walker to do the same activities



Example of significant change for level of functioning such as, hearing or vision

- A resident who could hear & see loses an ability or a resident with cognitive loss establishes a pattern of not using their hearing aids or glasses.
- This is likely to have an impact on the resident's ADL function.



Example of significant change for behaviors



Changes in the intensity & frequency such that:



- Behaviors that were easily altered by minimal intervention now require more frequent and intensive or complex interventions, or
- Development of new behaviors.
- Behaviors may include pacing, crying out, trying to leave the facility, being verbally or physically abusive, etc.

Example of significant change for continence pattern

- A resident who was continent of bowel or bladder becomes incontinent most or all of the time.



Example of significant change for weight

Regardless of cause,

- A change in pattern of eating
- Loss of appetite, or pattern of refusing to eat
- Difficulty swallowing or chewing

Parameters for evaluating significance

Significant Loss

- 5% in 1 mo.
- 7.5% in 3 mos.
- 10% in 6 mos.

Severe Loss

- Greater than 5% in 1 mo.
- Greater than 7.5% in 3 mos.
- Greater than 10% in 6 mos.

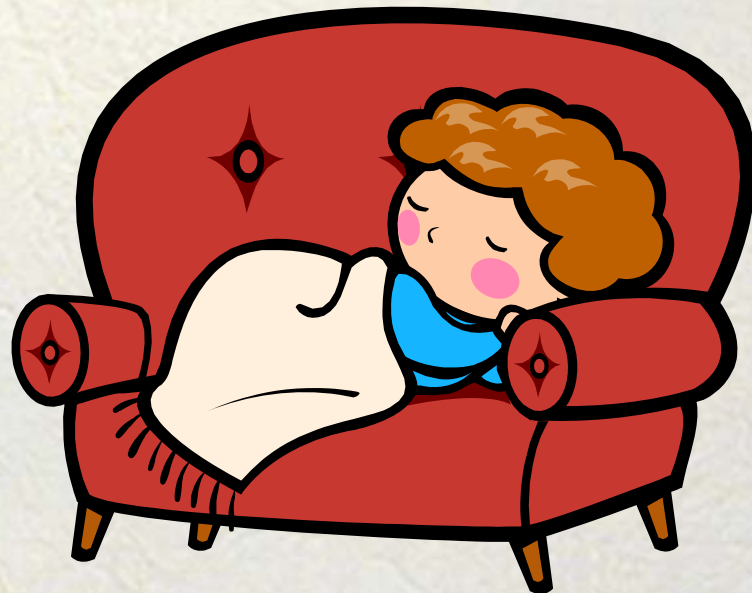
Example of significant change for mood

- Resident whose usual mood changes. They may appear sad or anxious & don't respond to staff interventions that have been effective in the past.



Example of significant change for level of consciousness

- The resident may be difficult to arouse, or appears less alert or to have difficulty communicating.



Examples of significant change for health status

May include but not limited to:

- Unmanaged high or low blood sugar levels (blood sugar levels that exceed the parameters defined by the physician)
- Broken bone
- Stroke
- Heart attack
- Major surgery



These are likely to result in a sudden change in health status & way of life

Example of significant change for uncontrolled pain

- Resident experiencing continuous or intermittent pain state which is not being controlled by their current treatment plan &/or interventions.
 - Pain could have been gradually increasing over time or an acute change following an injury, surgery, or development of an infection or pressure ulcer.



Example of significant change for skin condition

Pressure Ulcer

- Injury to the skin from constant pressure due to staying in one position without moving.
- Blood flow is reduced & eventually causes cell death, skin breakdown & development of an open wound.
- Pressure ulcers usually occur over bony prominences (such as tail bone & heels) & are staged to classify the degree of tissue damage.

Resident Health Services C280

- Provide health services to respond to 24 hr care needs
- Include Licensed Nurse (LN) regularly scheduled onsite with adequate # of hours
- Define LN duties
- RN must assess all residents experiencing a significant change of condition
- Must specify RN role in monitoring
- If significant change of condition, RN must participate in SP team or review & sign SP

On- & off-site Health Services C290

- Must have P&Ps to ensure on-site health service providers leave written info in facility
- Must have P&Ps to facilitate receipt of information from off-site providers
- SP changes must be made as applicable to address services provided by on- & off-site providers & corresponding resident needs
- RN must review health-related SP changes made as result of on-site health services



NEW

Survey Protocols

- Unplanned weight change
- Pressure ulcer development & treatment
- Staffing

Protocols are written documents & guidelines for surveyors to use during survey to guide their investigation.

Severity Determination

- **Level 1:** Substantial Compliance - No harm, with potential for minimal harm
- **Level 2:** No harm, with potential for more than minimal harm; or minimal harm which does not significantly impact the resident's quality of life or physical function
- **Level 3:** Harm which significantly impacts the resident's quality of life or physical function
- **Level 4:** Imminent Danger - requiring immediate correction to protect resident health or safety

Unplanned weight change

Why are we concerned?

- Significant change of weight
 - Is not response to normal aging
 - Many causes
 - May signal worsening of a life-threatening illness
 - Should always be seen as a dramatic indicator of risk of sudden decline.
 - Loss is indicator of declining nutritional status.
 - Congestive heart failure (CHF)



Unplanned Weight Change Protocol

This protocol is to be used when

there is sampled resident who has an unplanned weight change



Risk factors evaluated/assessed?

- Cancer, renal disease, diabetes, depression, COPD, Parkinson's, Alzheimer's, dementias
- Malnutrition, infection, dehydration, constipation, diarrhea, pressure ulcer
- Chewing/swallowing problems, no teeth, ill fitting dentures, mouth pain, taste/sensory changes
- Bedfast, totally dependent for eating
- Use of medications such as diuretics, laxatives, or cardiovascular agents
- Use of assistive devices, cueing & supervision
- Food cultural/religious preferences, allergies & special diets

Service Plan (SP)

- Developed based on eval/assessment?
- Consistently implemented interventions?
- Interventions effective? Modified?
- Some interventions to think about
 - oral supplements
 - alternative eating schedules
 - nutrient supplements
 - adaptive utensils
 - assistance &/or increased time to eat



Determining percentage of weight loss

- % of body weight loss = (usual weight - actual weight)/(usual weight) x 100
- Or use the chart



Usual weight is the most recent stable weight in the facility prior to the weight change.

Not necessarily the ideal body weight.

Severity Level 1

- Level 1 is not appropriate for this rule.

Severity Level 2

- Examples may include, but are not limited to:
 - Residents at risk for weight change,
 - no eval &/or assessment
 - & weight change has occurred but not yet at significant level.

Severity Level 2

- Examples may include, but are not limited to:
 - Residents had significant or greater unplanned weight change,
 - RN not involved,
 - but resident returned to the previous weight or stabilized.
 - Resident had documented unplanned weight loss over time which was not significant.
 - Facility had not identified,
 - Not evaluated, developed a service plan
 - &/or implemented interventions.

Severity Level 3

- Examples of level 3 citations may include, but are not limited to:
 - Resident had significant or severe weight loss
 - not identified,
 - not evaluated, &/or assessed,
 - & no effective interventions in place.

Severity Level 3

- Examples of level 3 citations may include, but are not limited to:
 - Resident had documented weight gain & a diagnosis of congestive heart failure.
 - Facility did not identify the weight gain or evaluate/assess.
 - Resident's condition worsened as evidenced by increased coughing & difficulty breathing
 - Change of condition was not treated until resident was hospitalized.

Severity Level 4 Imminent Danger

- Examples of level 4 citations may include, but are not limited to:
 - One or more residents experiencing significant or severe weight change
 - without effective intervention
 - & without mitigating circumstances.
 - Residents unable to feed themselves
 - receive no assistance to eat or drink.

Pressure Ulcer Protocol

To determine if pressure ulcer(s) is identified & evaluated/assessed; &

To determine the adequacy of the facility's interventions & efforts to prevent & treat or obtain appropriate treatment for the pressure ulcer(s).



This protocol is to be used when a sampled resident has or is at risk of developing a pressure ulcer.



Pressure Ulcer defined

- Injury to the skin from constant pressure due to staying in one position without moving.
- Blood flow is reduced & eventually causes cell death, skin breakdown & development of an open wound.
- Pressure ulcers usually occur over bony prominences (such as tail bone & heels) & are staged to classify the degree of tissue damage.

A Stage 2 pressure ulcer

- any injury to the skin &/or underlying tissue in which some degree of skin has been lost
- skin loss primarily involves top layer of skin
- ulcer is superficial & looks like an abrasion, blister or shallow crater.
- injury is in an area of pressure, usually over a bony prominence.
- not skin tear, tape burn, rash or excoriation.

Looking for ...

- Was pressure ulcer identified timely by the facility?
- Evidence of consistent implementation of interventions & outcomes
- Service plan revised?
- Are staff aware of and following SP?
- RN referral, assessment, monitoring
- Coordination with service providers

Observation of Ulcer

- Indicated if, based on interviews and record review, the presence or current status of an ulcer is questionable
- With permission of resident/representative
- With assistance of facility staff, preferably the facility RN
- RN Surveyor would note
 - Condition of the wound
 - Progress toward healing

Pain and Ulcers

- If resident expresses (or appears to be in) pain related to ulcer
 - Surveyor would determine if resident's pain was
 - Assessed, addressed & interventions monitored for effectiveness;
 - Proactive measures for pain taken r/t dressing changes or other treatments

Severity Level 1

- Level 1 is not appropriate for this rule.

Severity Level 2

- Examples may include, but are not limited to:
 - Resident at risk for pressure ulcers
 - not eval &/or assessed & interventions not developed
 - Interventions not consistently implemented
 - but a stage 2 or greater pressure ulcer(s) has not yet developed.

Severity Level 2

- Examples may include, but are not limited to:
 - Resident developed single Stage 2 pressure ulcer,
 - treatment implemented,
 - but facility RN not involved,
 - & ulcer healed.

Severity Level 2

- Examples may include, but are not limited to:
 - Resident developed single Stage 2 pressure ulcer,
 - interventions not developed
 - or not implemented,
 - but ulcer has not worsened.

Severity Level 3

- Examples of level 3 citations may include, but are not limited to:
 - Resident had multiple Stage 2; or Stage 3 or 4 pressure ulcer(s)
 - which were not identified,
 - not evaluated, and/or assessed,
 - or effective interventions were either not developed
 - or consistently implemented.

Severity Level 3

- Examples of level 3 citations may include, but are not limited to:
 - Resident had severe and/or untreated pain related to a pressure ulcer
 - which was either not identified or evaluated/assessed
 - or effective interventions were not developed
 - or consistently implemented.

Severity Level 4 Imminent Danger

- Examples of level 4 citations may include, but are not limited to:
 - One or more residents experiencing one or more Stage 3 or 4 pressure ulcers
 - without effective intervention
 - & without mitigating circumstances.
 - Stage 3 or 4 pressure ulcers with associated soft tissue or systemic infection
 - as a result of the facility's failure to assess or treat a resident with an infectious complication of a pressure ulcer.

Staffing Protocol

- To determine if facility has sufficient staff available to meet residents' needs.
- To determine if facility has staff available to provide & monitor delivery of resident care.



This protocol is to be used when:

- Resident requires 2 or more caregivers
- Concerns re: lack of awake &/or available staff in each building or distinct part of facility,
- Care problems identified, e.g.,
 - Development of pressure ulcer(s),
 - Lack of or inappropriate treatment,
 - Significant unplanned weight loss, &/or
 - Lack of services described in SP, such as bathing, dressing, grooming, transferring, ambulation, toileting, & eating

or when:

- Complaints received from residents, families or other resident representatives concerning care & services not provided or not provided timely due to a lack of staff, e.g., calls for assistance not being answered in timely fashion.

Interviews

- With supervisory staff re: staffing system
- With staff re: knowledge of residents' care needs, e.g., provision of
 - fluids & foods for residents who are unable
 - turning, positioning & skin care for those residents at risk for pressure ulcers; &
 - incontinence care as needed.
- With residents, families &/or significant others re: staff responsiveness to requests for assistance, & timeliness of response

Review staffing assignments

- to determine if minimum of 2 or more staff were available to meet needs of residents requiring assistance of two or more staff for scheduled & unscheduled needs
- to determine if minimum number of staff were awake & available in each building & each distinct part at all times based on structural design of facility

Severity Level 1

- Level 1 is not appropriate for this rule.

Severity Level 2

- Examples may include, but not limited to:
 - Less than sufficient staff scheduled when a resident requires the assistance of two or more caregivers,
 - Staff are not awake &/or available in each detached building or distinct part of a facility, or
 - Resident(s) wait long periods of time for services, not resulting in harm.

Severity Level 3 and Severity Level 4 Imminent Danger

- These levels would be used for this tag when there is also non-compliance in a resident services rule cited at level 3 or 4 which is associated with sufficiency of staff.

For all residents – a thoughtful process



- Evaluate
- Identify
- Plan
- Re-evaluate
- Revise Plan
- Etc.



Survey Process



- Is resident centered - focuses on how non-compliance with the rules affects or potentially affects residents
- Uses the reasonable person standard
- Investigative Process
 - Interview, observation, record review

Survey Tasks

- Task 1 – Preparation
- Task 2 – Entrance Conference
- Task 3 – Tour of Environment, Resident Areas and Kitchen
 - Includes interview of staff regarding resident health conditions, abilities, concerns, and recent changes
- Task 4 – Staff Interviews Regarding Systems
 - usually Administrator and RN
- Task 5 – Medication and Treatment Administration/ Med System

Task 6 - Resident Review

- Resident Sample Selection
- Initial Evaluation & Service Plan (SP) Review
- Resident Review and Investigation
- Systems in place to respond to 24 hour care needs of residents



Resident Sample Selection

- Sample
 - Approximately 10% of census
 - Includes 1-2 residents who moved in during the past year

Initial Eval & SP Review

- Initial
 - Evaluation
 - Service plan
 - 30-day update



Resident Review & Investigation

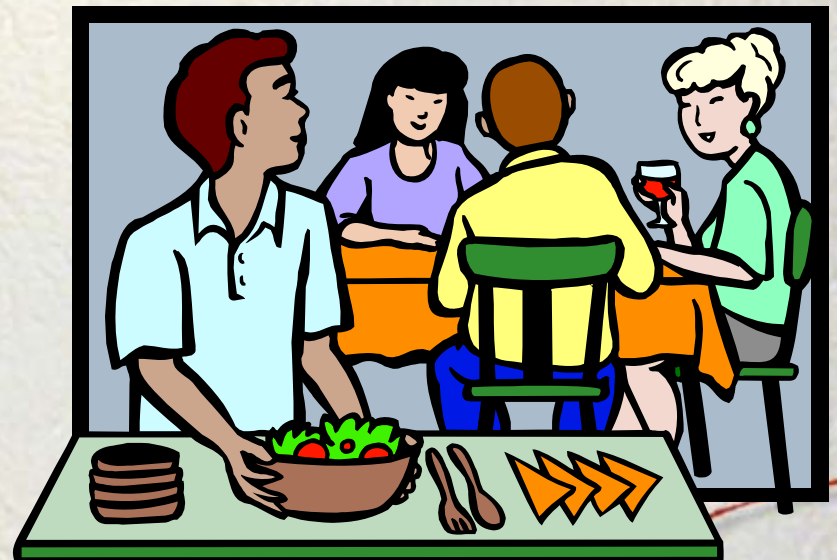
- Evals/assessments, SP reflective of resident
- Facility response to short term or significant change of condition
- MARs and TARs - medication and treatment administration records
- PRN parameters
- Delegation
- Coordination with on/off-site providers

Interviews

- Individual Resident
 - including resident's opinions/choices & how they were accommodated
- Resident Group Interview
- Families, significant others, legal representatives
- Staff & other relevant parties, such as:
 - home health, dialysis, hospice, etc
 - Prescriber, ancillary service providers, hospital personnel, facility nurse
 - Case manager, APS, Ombudsmen

Observations

- Observe resident & caregivers
 - during care & treatments
 - at meals, &
 - various times of the day, including early morning & evening, over the entire survey period
 - Staff/resident interactions



Record review

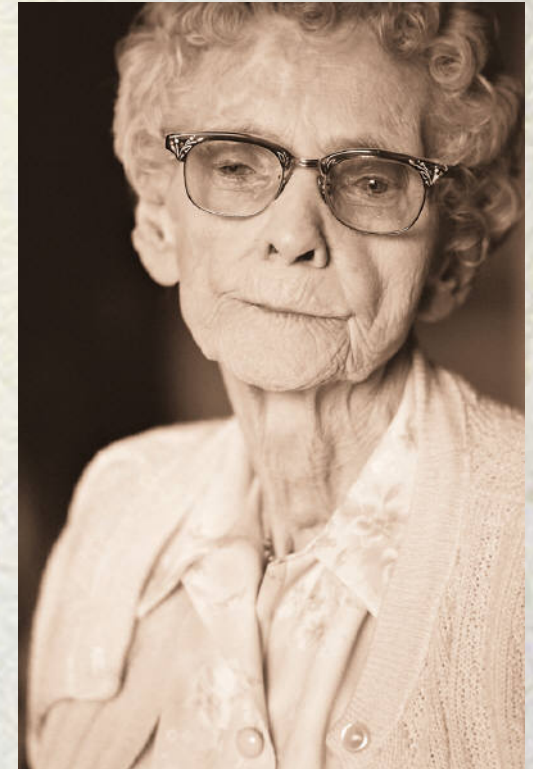


- Quarterly evaluations
- Assessments (if present)
- Service plans
- Prescriber's orders
- MARs & TARs
- Progress notes

Task 7: Team Decision Making

The team

- analyses the data,
- reviews the rule,
- determines if deficient practices & non-compliance exist,
- determines the harm or potential for harm based upon the following levels of severity.



Task 8: Exit Conference Plan of Correction (POC)

- Exit
 - gives Preliminary Findings
- POC
 - Actions taken to correct for each example/resident?
 - How will system be corrected?
 - Who will be responsible?
 - How often will system correction be evaluated?
 - When will corrective action be completed?



Questions?

