



Long Term Care

Oklahoma State
Department of Health



Insider Chat

VOLUME I, ISSUE II

July, 2010

SPECIAL POINTS OF IN- TEREST:

- Surveys On The Web
- Five Star Rating
- Working Together—
How would you handle it?
- Advancing Excellence
in America's Nursing
Homes

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CHOICES

Dorya Huser, Chief, Long Term Care

Hello Everyone:

Welcome back to Insider Chat. I want to talk about something a little different in this issue. We frequently hear these days the term “sustainable.” It is used to reference that which is in existence and can be kept in existence. It speaks to food, businesses, initiatives, health care, etc. I can tell you, after many years of being in existence, that I have seen many “sure bets” fail the test for being sustainable. I believe we all have to look at the past and learn from it, be good caretakers of the present so we do not look back with regrets, and look toward the future as open and not yet determined, but the end product of what we are doing today. Of concern, we have wildlife disappearing, oceanic food supplies threatened, deterioration of our planet environmentally, storms that alter lives and the landscape, and we have external threats and war, but we also have choices and our choices determine the final outcome on what is sustainable.

On a positive note, new developments can be very good and also become sustainable. We make choices on how to move forward. Currently, one watchword is to think “green.” We are being challenged to just maintain our precious resources and beauty of the land and people by motivating ourselves to change and take better care of what we have and teach our children the same. We are going to be saying goodbye to some aspects of our culture and hopefully paving the way for improvements. Some things that disappear will be sad because we could have made a better choice and saved them, but maybe that is just evolution. The best legacies are those that bring that warm fuzzy feeling to you or your generations to come because you made a good choice.

I think this is our dare today – to be able to really be innovative in ways to care for everything around us, including our residents in a way that will make their quality of life the best it can be and ensure the future of this care system is sustainable. Some people approach this as just a way to earn income



“....our choices determine the final outcome on what is sustainable..”

during their lifetime, while others are looking daily for ways to create and be more efficient so this system is “sustainable” and a true benefit to society and future generations. This will involve consistent re-evaluation and making needed change. You may have noticed that societies and cultures, throughout history, have a way of keeping or discarding or obliterating that which does not have enough significance or produce any harmony or reward. Some, I will have to admit, have been at the business of trying to obliterate for a long time and have just not managed to put an end to it. That too; however, may end one day and the focus will shift. I, myself, am all about the harmony and reward, which, by the way, comes in a lot of different packages. There are lots of opportunities for us to make even a small difference in the lives of our residents each day which cultivates that harmony and provides us with reward that we have made a difference; that we did what we could; that it is not just a j-o-b. You know who you are. Grow your numbers.

Society is ultimately measured by what it leaves behind and how it takes care of its people. Thank you for all you do every day, every night, every year. That’s it – you got it, keep it up.

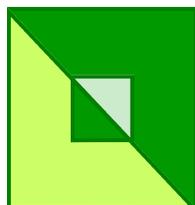
In the Spirit,
Dorya



"Did you know the staffing information you report on Form CMS-671...is used in the calculation for your Five Star Quality Rating?"

Today's preparation determines tomorrow's achievement.

- Author Unknown



Five Star Rating/CMS—671

Sue Davis, Administrative Programs Officer III

Did you know the staffing information you report on Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid at the time of your recertification survey/annual inspection, is used in the calculation for your Five Star Quality Rating? The information provided on this form is entered into a Centers for Medicare and Medicaid Services (CMS) database and then uploaded to the national database.

The staffing information is then used as a factor in determining your star rating. If the information is unreliable, your facility may be excluded from an overall star rating or with a staffing rating of 'data not available'. By sharing our part of this process, we hope to create a team effort ensuring the information for your facility is accurately reported. The end result will make all our jobs easier.

At the time of your survey, surveyors will provide Form CMS-671, for you to complete. The instructions and definitions for completing the form are attached. When we receive the form, it is checked for completeness and accuracy. If errors are noted, you will receive a phone call informing you the form will be faxed to you to make corrections for resubmission.

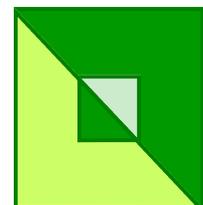
Long Term Care (LTC) office staff are unable to make changes to the form. It must be corrected by the individual who signed the form. The CMS database does not allow blank fields, therefore ensure all fields are completed.

The following are some of the most common problems encountered:

- F9 - Facility type. We find this is either not checked or checked incorrectly. The options are 01 Skilled (SNF)-Medicare Participation, 02 Nursing Facility – (NF) (Medicaid participation), 03 SNF/NF – Medicare/Medicaid.
- F12 - Ownership – This is a required field that is often left blank. The instructions provide definitions of the different ownership types: For Profit, Nonprofit or Government and the subtypes within those types.
- F13 - Owned or leased by a Multi-Facility Organization (Y or N). This field is often left blank.
- F14 - If Multi-Facility Organization, enter the name of organization. - This item is often left blank.
- Shaded areas do not require information to be provided.
- Facility staffing is based on a two week period. The instructions state to base your calculations on the staff hours worked in the most recent complete pay period.
- Many errors are noted in the staffing section. Hours should be rounded to the nearest whole hour. No fractions or decimals.
- Column A– Services Provided –Enter Y (Yes) or N (No) under each sub-column (1, 2, 3). Another problem is hours are entered in Columns B, C or D but Y is not entered in Column A (Services Provided).

If you are not clear on what information is required to determine hours worked, or how to report hours for a staff member, the instructions for the form are an excellent source of information. The instructions provide examples of staffing situations along with how to report the hours for each service area required.

If you encounter difficulties filling out these forms, do not hesitate to consult the survey team during the survey to answer any questions you may have.



How Would You Handle It? Jerry Taylor, Enforcement Coordinator

Long Term Care (LTC) frequently receives questions from facilities asking how to handle difficult situations. Sometimes we can provide guidance based on regulatory requirements but sometimes we cannot. There are a lot of situations where relevant laws and regulations are silent and provide very little direction. We would like to have an on-going column for the *Insider Chat* to present some of these situations and solicit input from the provider community. There's a good chance that many of you have had to deal with these situations in the past and have some excellent solutions that work...or maybe found out the hard way what *didn't* work! We would appreciate your feedback on how **you** dealt with similar situations. (If you wish for your name to remain anonymous, that's okay.) We'll publish the response(s) in the next issues.

Here's the situation for this issue, let us know how you would or have handled it:

It's a stormy spring afternoon in Oklahoma. Tornado warnings are posted, the weatherman says there is a tornado about fifteen miles from your facility and your facility sits directly in the storm's projected path. You decide that it's time to implement your emergency response plan, so you instruct staff to move residents out into the hall. One resident refuses to move and wants to remain in his room. The resident is ambulatory, oriented, alert and competent to make his own decision. He just doesn't see the need to move into the hall. There are still residents who need assistance, the tornado sirens are blaring, and there isn't much time to spend trying to convince this one resident to move to a safer place.

How would or have you handled it?

Send your responses to:

ltc@health.ok.gov



**Coming together is a beginning.
Keeping together is progress.
Working together is success.**

- Henry Ford

SURVEYS ON THE WEB Sue Davis, Administrative Programs Officer III



Have you been to the Oklahoma State Department of Health (OSDH) website lately? We want to share the latest update to the site – our Long Term Care facility public files are now online. These files contain surveys, correspondence, complaint investigation reports, and court orders. We believe this will

be a great customer service tool for the public and extremely helpful when making a decision of where to place a loved one. The site allows the viewing of all licensed facility types and one can search the site for a facility by name, city, county, or zip code

Not only will this site assist the general public in choosing a facility, but it will also assist in their ability to view the most recent visits made to a facility. They will be able to see if their concerns have already been identified and how the facility plans to address them. It could reconfirm that they have made the right decision by placing their loved one in your facility. We hope you will visit us

at <http://www.ok.gov/health/>. At the bottom half of the page there is a column that says "Online Services." Click on "Long Term Care Inspection Surveys" and select the facility type you wish to view. The system is easy to navigate and allows you to view, download or print public survey documents. Or you can go directly to <http://www.ok.gov/health/pub/wrapper/PHS-search.html>

**LONG TERM CARE
FACILITY PUBLIC FILES
ARE NOW ONLINE!**

Advancing Excellence In America's Nursing Homes

Mary Fleming, Director of Survey

The Oklahoma State Department of Health is proud to be a partner with the Local Area Network for Excellence. You can too!

The Mission of the Advancing Excellence in America's Nursing Homes Campaign is to help nursing homes achieve excellence in the quality of care and quality of life for the more than 1.5 million residents of America's nursing homes by:

- ◆ Establishing and supporting an infrastructure of Local Area Networks for Excellence (LANEs);
- ◆ Strengthening the workforce, and;
- ◆ Improving clinical and organizational outcomes.

The Campaign works to achieve its mission by:

- Helping nursing homes make a difference in the lives of residents and staff by focusing on eight goals related to its mission;
- Providing free, practical, and evidence-based resources to support quality improvement efforts in America's nursing homes;
- Providing support to those on the frontlines of nursing home care; and
- Promoting open communication and transparency among families, residents, and nursing home staff.

The Campaign works closely with other national nursing home quality initiatives to streamline efforts and to prevent duplication of efforts. National quality initiatives such as Quality First, the Nursing Home Quality Initiative, the Culture Change movement, and the Quality Improvement Organization (QIO) 9th Scope of Work complement one another. Working with one initiative will usually strengthen results and outcomes of the other. To find out more, view the Advancing Excellence home page for providers and consumers can be found at the link below:

http://www.nhqualitycampaign.org/star_index.aspx?controls=mission



“The glory of young men is their strength, gray hair the splendor of the old.”
- Proverb

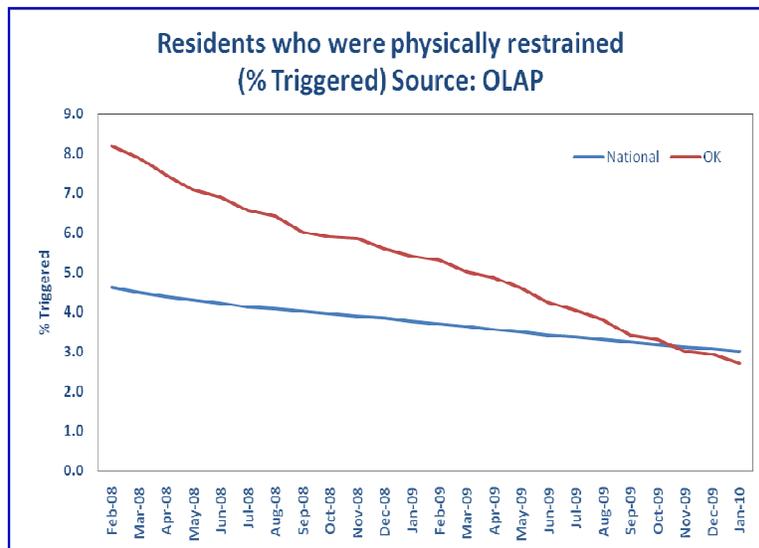
Restraint Use In Oklahoma

Mary Fleming, Director of Survey

OLAP (Online Analytical Processor), a Minimum Data Set (MDS) Aggregate Data Source indicates the prevalence of restraint use in Oklahoma Nursing Homes has dropped below the national average. The current National Benchmark is to reduce restraint use to below 2%.



“...the prevalence of restraint use in Oklahoma Nursing Homes has dropped below the national average.”



Congratulations
Oklahoma!

Congratulations for your hard work and diligence while addressing this critical issue!

To Report Or Not To Report, That Is The Question

Laura Crowley, R.N., Complaints Reviewer

Long Term Care (LTC) facilities operating in the State of Oklahoma are required to report certain types of incidents to the Oklahoma State Department of Health (OSDH). Some are clear and others may be more challenging to decide if they are required to be reported. We will examine two of the more challenging types, to help you work through the decision making process. Some facilities report everything, but the change to responsible reporting will be like riding a bicycle without training wheels. We'll run along beside you and you can always call for a "steadying hand". Here's a lesson we hope will help.

Let's acknowledge that each incident is unique and as such, has to be looked at individually. There's no rubber stamp used in making decisions. You have to make decisions based on knowledge of the incident and state licensure requirements.

The first type of incident we will examine is "missing residents". Facilities are required by state licensure to report missing residents.

When is a resident considered missing?

- As they head out the door with staff in pursuit?
- When a visitor reports they are in the parking lot?

According to licensure, a facility must report a resident missing, "*after a search of the facility and facility grounds has been conducted and a determination by the facility that the resident is missing*".

Reasoning would tell us a facility would want to document attempted elopements and develop corrective/protective measures, but some incidents may not need to be reported. Quality Assurance (QA) is part of the corrective process, so facilities will need to have internal documentation of residents that have been reported missing as well as attempts of elopement by residents.

The second type of incident we'll examine is "certain injuries".

Licensure states "*facilities shall report incidents that result in fractures, a head injury, or require treatment at a hospital.*"

For the purpose of reporting, the Oklahoma State Department of Health has defined head injury as "**bleeding, pain, hematoma, bruising or abnormal neurological signs after trauma to the head**".

Are these reportable incidents?

1. A resident fell and hit his/her head.
 - Did the resident have a HEAD INJURY based on the definition above? If not, this is not reportable.
2. A resident fell, has pain to the right hip, was sent to the hospital, x-rays were negative and the resident returned to the facility.
 - Did the resident receive TREATMENT? X-rays are diagnostic exams, not treatment. Therefore, this is not reportable. Treatment might consist of sutures, glue, cast, splint, etc.

We receive many incident reports for falls where residents are assessed and do not require treatment. These are not reportable.

It is not necessary to submit reports for changes in a resident's medical condition. There may be extenuating circumstances that would require reporting but would generally be due to staff negligence in not providing appropriate care, thus, the allegation of abuse or neglect. (A good topic for another time!)

A TIP TO REMEMBER: Facilities have twenty-four (24) hours after an incident before the report is due to the OSDH. If you send a resident to the hospital, you generally

know if treatment was received and the extent of injuries in less than twenty-four (24) hours. One would send the report as soon as you know the information or within twenty-four (24) hours, whichever comes first. You will need an INTERNAL report, but it may not be necessary to submit the report to OSDH. If you send the initial report, before you know the extent of the injury, treatment and corrective/protective measures, then you have to submit a final report even if you discover the incident did not reach the standard to require reporting. See? You have just saved time and effort.

As with all incidents, you need to continue to maintain internal reports, QA, tracking and trending and corrective/protective measures. Surveyors will need access to a facility's internal reports as well as all reports submitted to the OSDH.

During the year 2009, OSDH received 35,605 incident reports, of which 886, were for missing residents and 22,484 certain injuries. LTC estimates that 6,000 to 7,000 of the 35,605 incident reports submitted were unnecessary. Let's all work together with effective communication. Call (405) 271-6868 or email us at ltccomplaints@health.ok.gov if you have any questions about reporting. We're available to "run alongside" until you get used to the more discerning process.





“Following this process will strengthen your infection control program.”

“The greatest wealth is health.
—Virgil



Can Midnight Snacks Prevent Incidents?

Strengthen Your Infection Control Program

Chris Bundy, RN, Survey Coordinator

Infection Control (F441) was the most frequently cited deficiency in May 2010. Here are a few interventions to assist you in preventing infection control deficiencies in your facility.

Download a current copy of the Federal Regulations at the following CMS website:

http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

Familiarize yourself with this regulation and the interpretive guidelines. The guidelines contain very useful information to assist you with infection control in your facility. This information can be used:

- ◆ For development of your infection control policies and procedures;
- ◆ For training and educating staff;

◆ For Quality Assurance (QA) activities;

◆ For recognition of what surveyors will be looking for during survey (the Investigative Protocol contained in the interpretive guidelines will take you right through how the the surveyors investigate any concerns with infection control in your facility, including how you track and trend infections) and,

◆ For maintaining a healthy environment for your residents, staff, families, and visitors.

The Centers for Disease Control and Prevention (CDC) has an excellent website where you can find a wealth of information related to infection control. Access this information at:

<http://www.cdc.gov/ncidod/dhqp/>

The Oklahoma State Department of Health (OSDH) 2010 Infection Prevention and Control Manual is now available to download and print from the OSDH website. Download the manual using the following link:

<http://www.ok.gov/health/documents/ICM%202010%20Final.pdf>

We welcome any questions. Contact us at (405)271-6868 from 8:00 a.m. to 5:00 p.m., Monday through Friday. Please ask for a survey coordinator for assistance.

STOP THE PRESS!
Following this process will strengthen your infection control program.

STORIES FROM THE FIELD

Can Midnight Snacks Prevent Incidents?

According to a March 16, 2010 article on the National Public Radio website entitled: “*Midnight Munchies Keep Elderly Safer In NY Nursing Home*”, by Peggy Girshman, midnight snacks just might be the solution to incidents or accidents that happen to residents in the middle of the night.

Read the article at: http://www.npr.org/blogs/health/2010/03/midnight_munchies_keep_elderly.html and see if this might work in your facility.

Character is like a tree, and reputation is like a shadow. The shadow is what we think of it, the tree is the real thing.

☞ Abraham Lincoln

Moving Toward Electronic Health Record in Long-term Care

Melissa Green, RN, Division Vice President of Clinical Operations,
Western Division, SunBridge Healthcare Corporation

Technology continues to push long-term healthcare providers in to the 21st century, and SunBridge Healthcare is no different. In 2009, we embarked on the conversion of key electronic systems throughout our Oklahoma centers.

Not only have our Oklahoma locations converted to an automated time and attendance system that requires a thumbprint to clock in and out, but they have also begun phase one of an electronic health record system called Point Click Care (PCC). Our nine Oklahoma centers were part of SunBridge's conversion to PCC by all 205 of its centers from 25 states. The targeted completion date for the conversion is August 2010.

PCC is a web-based software package that consolidates the clinical, financial and business development systems of what were four different programs in use throughout SunBridge. With PCC, data is now entered only once and is shared throughout the complete enterprise, a truly integrated system.

PCC is intended to fulfill the following three key business drivers in our centers:

1. Simplify/integrate core systems;
 - reduce administrative burden;
 - eliminate redundant data entry;
 - improve communication and coordination both within the center and with external audiences
2. Improve key business processes
 - transparent/efficient referral/admission process;
 - clean/consistent care plans and orders;
 - Organized/visual accounting dashboard;
 - billing, reconciliation and close efficiencies;
 - automated remit advice posting
3. Create foundation for electronic health record;
 - allow staff to spend more time with residents;

- enhance quality of care by providing key performance indicators real time with automatic alerts; and
- develop electronic documentation by all care givers as we move toward a paperless health record

Prior to PCC's roll out to any center, more than 12 months of planning will have occurred and numerous requests for proposals (RFPs) will have been reviewed to determine the best software system to meet our needs with MDS 3.0 and RUGs IV right around the corner. In addition, numerous meetings are held with field-based employees to determine how best to modify the modules within PCC to fit their needs and processes. Key clinical, financial and business development employees within the company were chosen and they formed the implementation and training teams and were supported by a key account manager from PCC.

Phase I of the implementation consists of three functions along with their imperatives. For the clinical function, this consists of MDS/RAPs, care plans, physician orders, immunization and medical diagnosis and real-time census management. For the business office function, the imperatives are accounts receivable/billing, automated remit advice posting, complete census lines and collections. For the marketing and admissions function, they consist of inquiry/referral management, bed availability, pre-admission screening, customer relationship management and marketing action plans.

"Technology continues to push long-term healthcare providers in to the 21st century,"

Prior to a "go-live" date with the system, an in-depth training occurs that takes as little as two days for the marketing and

admissions function up to 20 hours for the clinical teams at the centers. Once a center goes "live," during the second week a coach is present at the center to assist the interdisciplinary team in some of the new and efficient processes that PCC brings. PCC is a sole-source depository for key information regarding each and every resident. As a result, key staff, such as the management team, marketing and admissions, licensed nurses, MDS coordinators, health information management, business office and key interdisciplinary team members responsible for MDS completion, must be fluent in using PCC.

Future phases of moving to the electronic health record will include electronic medication and treatment records with electronic communication to the pharmacy as well as on-line clinical documentation involving both licensed and non-licensed staff. Another phase will consist of payer clearinghouse functions to expand electronic billing.

Changing to a new software system challenges the current ways of doing business in the centers that often resulted in duplication between departments. It has not been an easy journey, but it is one that builds efficiencies into patient care delivery that, in the long run, provide for a greater focus on quality healthcare for residents and patients in post-acute care.



Technology has advanced more in the last thirty years than in the previous two thousand.

- Niels Bohr

Frequently Asked Questions (FAQs) for O² Nursing Home/Facilities Life Safety Code 2000 Edition

Louis Smith, Life Safety Code Surveyor



What is required for separation of oxygen from combustibles or incompatible materials?



STOP and Think
Before You Act

Question:
What are the ventilation requirements for oxygen storage?

Answer:
When the total volume of the oxygen cylinders is less than 3000 cubic feet, there are no ventilation requirements.

When the total volume is greater than 3000 cubic feet, the area must be mechanically ventilated per National Fire Protection Association (NFPA) 99, 1999 Edition, Chapter 4-3.1.1.2(b)4.

Locations for supply systems of more than 3000 cubic feet total capacity (connected and in storage) shall be vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 square inches in total free area.

Question:
What is required for separation of oxygen from combustibles or incompatible materials?

Answer:
NFPA 99, 1999 Edition Chapter 8 -3.1.11.2 (c) 2 requires a minimum distance of five feet if the entire storage location is protected by an automatic sprinkler system designed in accordance with

National Fire Protection Association (NFPA) 13, *Standard for the Installation of Sprinkler Systems, 1999 Edition*; or Chapter 8 - 3.1.11.2 (c) 3 requires an enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. Also an approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.

Question:
What are the oxygen cylinder sizes as in cubic feet?

Answer:
To determine the total cubic feet of oxygen storage, follow the chart size listed below:

- D cylinders - 15 cubic feet
- E cylinders - 24 cubic feet
- M cylinders - 122 cubic feet
- G cylinders - 244 cubic feet
- H or K cylinders - 250 cubic feet

Question:
Is it permitted to store a limited number of oxygen cylinders in an area that does not meet code requirements pertaining to the storage of oxygen?

Answer:
Yes, one or two cylinders may be stored at a nurse's station or on a crash cart when they are going to be used for emergency purposes

only. They must be secured in an upright position with a regulator attached to the cylinder.

CMS guidance has allowed the storage in resident rooms of one day's supply of oxygen. Cylinders in resident rooms still must be stored properly upright either in a stand, rack or individually chained.

If you have any additional questions on O², PLEASE contact OSDH at (405) 271-6868 and ask for a Life Safety Code Surveyor.



“The door to safety swings on the hinges of common sense.”

Summertime Risk for Heat Exhaustion or Heat Stroke

Patty Scott, Director
Enforcement and Complaints

Prevention and Intervention:

As temperatures rise, the risk for heat exhaustion and heat stroke is a concern for the long term care population. It is important to minimize the risk and train staff to recognize warning signs in order to prevent and appropriately respond to heat-related illness. This article will list some of the risk factors, provide temperature related rules, identify warning signs and provide Centers for Disease Control and Prevention (CDC) guidance for responding to the warning signs.

While anyone can suffer from heat-related illness, residents in your facilities may be at higher risk. A few of the risk factors include:

- ◆ People age 65 or older, due to their inability to compensate for heat stress efficiently, are less likely to sense and respond to temperature changes
- ◆ People who are overweight, due to body heat retention
- ◆ People who are physically ill, especially with heart disease or high blood pressure
- ◆ People who take medications for depression, insomnia, or poor circulation

According to the CDC, "...from 1979 – 2003, excessive heat exposure caused 8,015 deaths in the United States. During this period, more people died from extreme heat than from hurricanes, lightning, tornadoes, floods, and earthquakes combined."

Air conditioning is the number one (1) protective factor. Therefore, facilities should service air conditioning units as early as possible. Residents in all long term care facilities have the right to reasonable accommodations, to

include air conditioning when temperatures rise.

Heat Related Illness

Heat exhaustion is a milder form of the illness that develops after exposure to high temperatures for several days and inadequate replacement of fluids. If an individual has heart problems or high blood pressure and presents with the following symptoms **or** the symptoms are severe and last longer than 1 hour, seek medical attention.

CDC Heat Exhaustion Warning Signs:

Heavy sweating, Paleness, Muscle cramps, Tiredness, Weakness, Dizziness, Headache, Nausea or Vomiting, Fainting

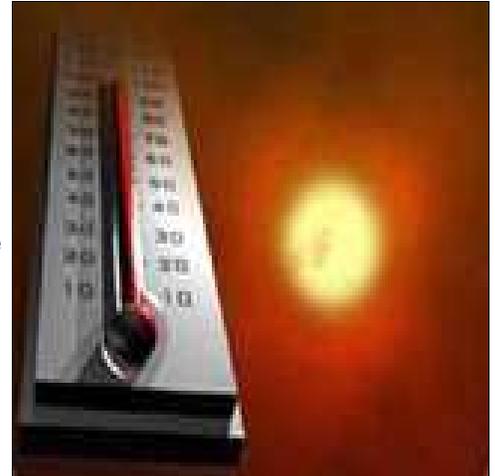
What to Do When Signs of Heat Exhaustion are Exhibited:

Cool down the individual, Provide non-alcoholic beverages, Rest, Take a cool shower or bath, Wear lightweight clothing, Stay in a shaded area or when possible, stay in an air-conditioned environment.

According to the CDC article, Extreme Heat: A Prevention Guide to Promote Your Personal Health and Safety, heat stroke can cause death or permanent disability if emergency treatment is not provided. When your body cannot regulate its own temperature, heat stroke can occur. It's a condition where the body's temperature rises rapidly and the body's sweating mechanism fails.

CDC Heat Stroke Warning Signs:

An extremely high body temperature (above 103 degrees Fahrenheit orally), Red, Hot and Dry skin with no sweating, Rapid strong pulse, Throbbing headache, Dizziness, Nausea, Confusion, Unconsciousness.



What to Do When Signs of Heat Stroke are Exhibited:

Get the individual to a shaded area, cool the individual using whatever methods you can (i.e. cool water from a garden hose or immersion in a tub of cool water), monitor body temperature and continue cooling methods until temperature drops to 101-102 degrees Fahrenheit. **Do not give the heat stroke victim fluids to drink**, get medical assistance as soon as possible.

Heat related deaths are preventable and long term care facility staff needs to be aware of the risk factors, understand preventative measures and respond appropriately when heat related illness signs occur.

According to the CDC, "... from 1979 – 2003, ... more people died from extreme heat than from hurricanes, lightning, tornadoes, floods, and earthquakes combined."

Provider Letter

July 15, 2010

To: Licensed Nursing, Skilled and Intermediate Care Facilities for the Mentally Retarded

RE: Provider Letter 10-03
Air Conditioning and Comfort Levels
Incident Reporting Procedures

Dear Administrator:

Frail and/or elderly residents and clients are particularly vulnerable to adverse effects from heat exposure. It is a licensure requirement for long term care nursing facilities and for intermediate care facilities for persons with mental retardation to maintain inside temperatures not to exceed 80 degrees in the common areas or resident rooms. In addition, the comfort of the residents needs to be considered even when the room temperature has not reached 80 degrees Fahrenheit.

If your air conditioning fails or is not cooling adequately, it is important to have the air conditioners repaired or replaced as soon as possible. Meantime, it is also important that you have a plan in place and to implement that plan to keep the residents comfortable and hydrated in accordance with their medical plans of care.

It is recommended that all long term care facilities monitor and record the daily temperature reading in each hall between 3:30 PM and 5:30 PM including the resident rooms at the end of the halls. When indoor temperatures rise to above 80 degrees, as a temporary short-term measure, the air conditioning should be supplemented with fans in the resident rooms and corridors of hallways to provide movement of air for the comfort of the residents. If there is any danger of fire resulting from overload of electrical circuits or to the safety of the residents through the use of room and corridor fans, it will be necessary for the facility to remove residents to other, safer facilities.

Indoor temperatures above 80 degrees need to be monitored every two hours and measured four or five feet from the floor. When the temperature of any distinct portion of the facility exceeds 85 degrees, residents in that portion of the facility must be removed to a complying portion of the facility or to other appropriate placement and this agency notified of the action.

If your facility exceeds 80 degrees, this is a reportable incident that affects the life and safety of the residents as it could cause physical harm or mental anguish and you will need to include a plan to protect the residents. If this occurs in your facility, fax an incident report within 24 hours to the Oklahoma State Department of Health, fax number 405-271-3442.

The follow up report must be submitted within five days and will need to include measures that have been taken to correct the problem and to prevent residents from further exposure to excessive temperatures. If the incident has not been fully resolved, a final report is required at the time of resolution. The required incident reporting form can be found online at www.health.ok.gov. This can be filled out online, printed and faxed to OSDH Long Term Care using the fax number mentioned above.

Regulatory References for Summer Temperature (State)

Chapter 675, Nursing and Specialized Facilities and The Nursing Home Care Act, Subchapter 5. Physical Plant, 310:675-5-20. Mechanical requirements (b)(1) states that the indoor summer design temperature shall be 80 degrees Fahrenheit for all areas occupied by residents.

Regulatory Reference for temperatures at a safe and comfortable level (Federal Nursing and Skilled Nursing Facilities)

The Code of Regulations at 42 CFR 483.15(h)(6), states facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81 degrees Fahrenheit.

Regulatory Reference for temperatures within normal comfort range (Intermediate Care Facilities for Persons with Mental Retardation)

The Code of Regulations at 42 CFR 483.470(e)(2) states the facility must maintain the temperature and humidity within a normal comfort range. 483.470(e)(i) states a "normal comfort range" in most instances is defined as not going below a temperature of 68 degrees Fahrenheit or exceeding a temperature of 81 degrees Fahrenheit.

"Frail and/or elderly residents and clients are particularly vulnerable to adverse effects from heat exposure."



If you do the little jobs well, the big ones will tend to take care of themselves.
-Dale Carnegie

LTC Services Training Opportunities

Karen Gray, Training Programs Manager

2010 Provider Training Dates

- Long Term Care – Tulsa- July 21st & 22nd
- **NEW** Long Term Care/Residential Care Mental Health Program – OKC – August 3rd
- Residential Care – OKC – August 19th
- ICF/MR – OKC – September 15th
- Assisted Living – OKC – October 21st
- Best Friends Approach to Alzheimer's Care – OKC – October 28th
- Best Friends Approach to Alzheimer's Care – OKC – October 29th



Watch our website at: http://www.ok.gov/health/Protective_Health/Long_Term_Care_Service/Long_Term_Care_Meetings_&_Events/index.html for program and registration information. Registration forms will be mailed to facilities approximately four (4) weeks prior to the event.

Best Friends Approach to Alzheimer's Care New Directions in Research, Treatment, Program Development and Care

Long Term Care (LTC) Services is pleased to announce the return of David Troxel, MPH, co-developer of the Best Friends model of dementia care. David will present two (2) one-day seminars on October 28th and 29th, 2010. David has become nationally and internationally known for his work in dementia care and for his optimism, practical advice, humor and story telling that will inspire each conference participant to go back to their care setting with new ideas and energy. At this day long program, you will learn the latest in dementia care and program development and learn how to attract and motivate the best staff. An emphasis will also be given to activities and how even simple ideas can transform your care giving program.

David Troxel, MPH is a writer, lecturer and long-term care consultant based in Sacramento, California. He has had a long career in adult day care, university and Alzheimer's Association settings, most recently being the Executive Director of the Santa Barbara Alzheimer's Association. He has co-authored five influential books on dementia care including *The Best Friends Approach to Alzheimer's Care*. He is past board member of the American Public Health Association, the national Alzheimer's Association, the national Alzheimer's Association Ethics Advisory Panel and the editorial board of *Alzheimer's Care Today*. He and his father are also caregivers for his mother, Dorothy, who has Alzheimer's Disease and now resides in an assisted living memory care community. Learn more about David at this website www.bestfriendsapproach.com

Mark your calendars and start making plans to send your staff to this fun and motivating seminar. Registration information will be mailed to Long Term Care, ICF/MR, Assisted Living, Residential Care and Adult Day Care facilities in September. The registration form will also be posted on our website at: http://www.ok.gov/health/Protective_Health/Long_Term_Care_Service/Long_Term_Care_Meetings_&_Events/index.html

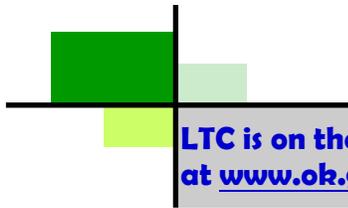
"Always bear in mind that your own resolution to success is more important than any other one thing."
 -Abraham Lincoln

OSDH

“Creating A State of Health”

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at www.ok.gov/health/**

Introduction to Protective Health Services

The Protective Health Services Program areas provide regulatory oversight of the state’s health care delivery service through a system of inspection, licensure, and/or certification. Several other trades/professions are also licensed.

Protective Health Services’ Mission:

To promote and assess conformance to public health standards, to protect and help ensure quality health and health care for Oklahomans.

Insider Chat: Edited by Donna Bell and Joyce Bittner

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