

Insider Chat

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It's a Goal Day !!

By Dorya Huser, Chief, Long Term Care, OSDH

It is that time of year when lots of people think between 11:59 p.m. on 12/31 and 12:01a.m. on 1/1, they can change their lives with those magical “resolutions.” Never hurts to dream! Many made New Year’s resolutions and many have already “failed.” I hate to see that commentary on good intentions although they may have been decided in an impulsive moment when anything seemed possible. Perhaps they needed a little more in-depth evaluation as to what it was going to take to reach the goal. Sometimes success is measured in small steps consistently taken in the right direction. Don’t rule that course of action out. One of my favorites is “you have to eat the elephant one bite at a time.” Believe me, I know about elephants. Some might say the level of commitment needed was just not there. That may be true; however, who we are and how we live our life does not start on New Year’s Day each year. It is the subject of humor and laughter and some sighs that perhaps lofty goals were not achieved. I find that goals require groundwork and planning to succeed and that is still not a guarantee of success, but it does dramatically improve the odds. It also improves how you process and strategically plan which becomes more routine rather than exceptional. When you focus on a path, plan the route and keep your eye on the prize, your chances for success increase. This also requires personal responsibility that you do not look around you or to others to do your part.

I encourage you not to need validation by others, or look outside yourself for acceptance, or let others define who you are as a person. Self worth is determined and guided by you. Don’t let yourself or the team down. Be good to yourself. Make every day a good day. Taking care of yourself and those around you will help you attain many of your goals and celebrate goal day!

In the spirit,
Dorya Huser





“Approximately 20% less reporting is possible at most facilities, on average, by paying closer attention to those reports actually required to be reported!”

GIFTS FOR THE NEWYEAR FROM THE INTAKE AND INCIDENTS STAFF !

By Glenn Box, RN, OSDH

20% LESS WORK - Approximately 20% less reporting is possible at most facilities, on average, by paying closer attention to those reports actually required to be reported! Most common errors are reports self identified by the facility as “certain injuries”, but which do not meet any of the actual criteria for reporting. The definition used by OSDH for head injury (listed with certain injuries) is: “bleeding, pain, hematoma, bruising or abnormal neurological symptoms after trauma to the head.”

If the report documents “no injuries”, or minor injuries not described by the reference printed on the incident reporting form, the incident is not reportable to the OSDH . If the reporting facility needs to create their own new category for reporting, which does not already exist on the reporting form, the incident is not likely to be reportable!. Again, a reminder that the category “Injuries of unknown origin” (source) are reportable due to the requirement that events of bruising or injury of a resident which is suggestive of abuse, be identified by the facility, investigated, and reported. An “injury of unknown source” is defined as meeting both conditions of: “the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; AND the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time.”

FREE PROFESSIONAL CONSULTATION—Infectious disease and outbreak reporting allows access to the newest and best practice information through the Communicable Disease Division of the OSDH. The telephone number for the Communicable Disease Division is 1.405.271.4060, and is also provided on the incident report.



Background Checks and Fingerprinting

by James Joslin, Chief, HRDS, OSDH



[HB2582](#) requiring fingerprinting for all long term care facility staff with direct patient access passed with an effective date of November 1, 2012. However, the law authorized staggered implementation through rulemaking. We are still several months out from having the system and fingerprinting network in place. Updates will be provided. Check the background check program website for more details here: <http://onbc.health.ok.gov>.

The bill changed criminal offenses prohibiting employment for nurse aides in all long-term care settings and non-technical service workers in nursing facilities. Those changes are in effect now. The same list of offenses applies to both. Lesser offenses are now a bar to employment for seven years past the date the sentence is completed.

[Revised Barrier Offense for Nurse Aides](#); and [Revised Barrier Offenses for Nontechnical Services Workers](#) explain the changes in detail.

For now, keep doing name based background checks as you have done in the past but apply the new list of barrier offenses.

This hyperlinked [Uniform Employment Application for Nurse Aide Staff](#), on the Department website, is revised to reflect these changes. The revised form includes the revised list of offenses that are barriers to employment.

For questions, email the background check program office at: ok-screen@health.ok.gov or call 405-271-6868 or toll free at: 800-695-2157 and press zero for the attendant.

Visit the Background Check Program website for more details here: <http://onbc.health.ok.gov>



HOW DO YOU EAT AN ELEPHANT? By Laura Crowley, R.N., OSDH

If you find the thought of eating an elephant (or something else that size) overwhelming, you are not alone. Preventing falls for our residents might easily be compared to eating an elephant. It just doesn't seem like it is possible to prevent all falls. Instead of being immobilized by the size of the project, let's take it one bite at a time.

If you attended the Long Term Care provider training available from the OSDH last summer, then you know falls and ways to avoid falls was the hot topic for half of the training. It was an encouraging, enthusiastic presentation. Did you and your staff leave the training energized to look for root cause and implement more meaningful interventions? *Or did you feel like you were being faced with eating an elephant?*

It is easy for all of us to 'ignore the elephant in the corner' but if residents continue to fall then most likely 'the elephant in the corner' is going to start to stink. It is time for us all to work smarter to help prevent falls. You notice, I said work smarter, not work harder. We know you work very hard but it is easy to get stuck in a rut and doggedly continue without realizing there is a 'smarter' way to achieve your goals. As we review the incident reports facilities submit regarding resident falls, we continue to see 'remind resident to use call light' and chair and bed alarms being implemented with first falls or continued when residents are removing the alarms.



Do you remember our dynamic speaker discussing ways to discontinue or reduce the use of alarms? And why would we want to stop using alarms? Our speakers likened alarms to the alarm on your oven or clothes dryer. Those alarms don't tell us our food is about to be ready or our clothes are almost done drying. They alarm to tell us the cycle has already finished. We don't want our resident to be 'done', and alarms tell us they have already attempted to rise and have fallen. Unfortunately, the alarms usually tell us they are already 'done' falling and need someone to come to their assistance. Alarms can contribute to immobility, sleep disturbance, discomfort and restlessness. Back to the interventions that may help in removing alarms. The speaker knows it would be a big challenge to implement the changes all at once so she gave some suggestions for how to triage residents for implementation:

- # Extra rounds on residents who have fallen
- # Don't place restraints or alarms on any new admission
- # Don't restrain or place an alarm on any resident who doesn't currently have one.
- # Remove the alarm if the resident has NOT fallen in the last 30 days.
- # Remove alarms from residents who have a history of removing the alarm.
- # Remove the alarm if the resident is agitated, scared or confused by the alarm.
- # Remove the alarm if the resident has fallen with an alarm in place.



Some environmental causes for falls were presented. Causes included noise levels at shift change, alarms with decibels similar to a lawn mower, call lights ringing and visual conditions just to name a few.

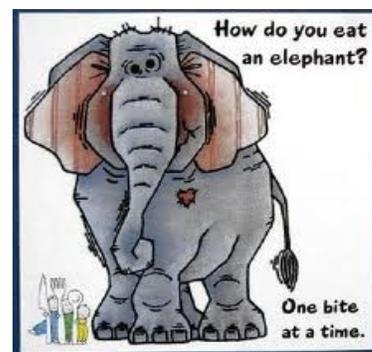
#What can be done about noise at shift change? Maybe staff can give and receive report in an office rather than the nurses' station. Maybe it is just a matter of staff being reminded that noise increases agitation and anxiety for residents. Perhaps you could 'sensitize' staff by having someone run the buffer near them while they try to listen to a staff meeting or have a couple of 'ringers' talk loudly to each other or on cell phones while you are trying to transmit some important information to the rest of the staff. They may understand better after they experience the frustration of trying to hear in an overly loud environment. Explain that even residents who are very hard of hearing may be agitated by the noise because they hear it but can't distinguish the sounds.

#But what can we do about call lights going off? The speaker encouraged staff to be proactive to residents' needs and not expect the resident to need to use the call lights to get their needs met. Most of our residents develop a pattern of activities and needs. They like their routines and if we are proactive in meeting their needs they are less likely to fall and more likely to seldom need to use the call light.

#Visual conditions are important as our elderly have more trouble with vision. We were encouraged to do things like providing black toilet seats to help residents be able to 'see' the toilet; wrap bright colored duct tape around the call light cord so residents can see it against the white sheets; 'decorate' the residents' walkers with their choice of colorful duct tape to add a visual cue.

We could discuss other recommendations presented at the training but maybe tackling one or two suggestions at a time is easier. You know what they say about how to eat an elephant, one bite at a time. We hope you are hungry enough to take that first bite! We are anxious to see creative and personalized interventions for residents with falls. If anyone has implemented some of the ideas presented, or ideas you've come up with on your own, we would love to hear from you about what you have done and how it is working. Please share your stories with us at: lrc@health.ok.gov

Bon Appétit!





THANK YOU!
 By Karen Gray, MS, RD/LD
 Training Programs Manager, OSDH



As we begin our planning for the 2013 “Provider Training” programs, we wish to thank you for participating in the 2012 training programs. Your participation in the programs shows your desire to learn and to improve the quality of life and quality of care of the beneficiaries in your facilities. As I have professed for 21 years now, “We are all in this together, whether you are a provider or a surveyor. We all have the same goal!”

We recorded our highest number of participants at our “*Discover the Roots of Success*” training sessions in 2012! Here is a summary of the numbers and once again THANK YOU!

| Facility Type | Number of Participants | Number of Facilities Represented |
|--|------------------------|----------------------------------|
| LTC – June 27, 2012 OKC | 293 | 106 |
| LTC – July 26, 2012 Tulsa | 339 | 120 |
| Residential Care - August 16, 2012 | 100 | 55 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities - September 13, 2012 | 172 | 40 |
| Assisted Living – October 16, 2012 | 309 | 136 |

I also wish to extend a special thanks to the speakers, participants and collaborative partners who attended and supported “The Partnership to Improve Dementia Care in Nursing Homes” training on October 10, 2012. Due to the overwhelming response to this special conference and a lack of sufficient meeting space we were only able to accommodate 220 participants representing 107 facilities. We regret we had to turn so many people away. Please visit our website periodically in the next few months and watch for the scheduled dates for the 2013 provider trainings. Once the dates are set watch the website for registration forms. <http://www.ok.gov/health/Protective Health/Long Term Care Service/Long Term Care Meetings & Events/index.html>
Happy New Year everyone!

“We recorded our highest number of participants at our ‘Discover the Roots of Success’ training sessions in 2012!”

Optimist:
 Someone who figures that taking a step backward after taking a step forward is not a disaster, it is a cha-cha.
 ~Robert Brault



Diabetes and Your Residents' Eyes

By David Kolker, O.D.

As an optometric physician who has practiced eye care in nursing homes throughout Oklahoma for 10 years, I have noticed more and more patients with diabetes who exhibit diabetic retinopathy. In fact, a study published by the National Eye Institute confirms my observation: Between 2000 and 2010, there was an 89% spike in diabetic eye disease. This is an alarming increase and as the population ages and obesity rates continue to climb, this increase in diabetic eye disease will continue.

Already, diabetic retinopathy is the leading cause of new blindness in persons age 20 to 74. By far, the population group with the highest rates of diabetic eye disease is the 65+ year old age group. This means that a sizable percentage of the residents of your facility are at risk of blindness from diabetic eye disease. There is good news however: 90% of all blindness due to diabetes is preventable with regular, dilated eye exams.

So exactly how does diabetes affect a person's eyes? Just as diabetes is a complex and multi-faceted disease, its effect on eyes is varied and wide-ranging. Among the most common problems are:

Refractive Error. Fluctuations in blood sugar cause the swelling in the ocular structures responsible for focusing light, causing a temporary, transient nearsighted shift. This sudden change in vision is often the patient's first symptom of diabetes, so it is important to pay attention to your residents when they complain of sudden, temporary changes in vision.

Glaucoma. Changes in the vascular system around the eyes cause damage to the optic nerve, resulting in a specific type of glaucoma.

Cataracts. Individuals with diabetes have cataracts at a higher rate and at a younger age than individuals without diabetes. This is due to the changes in blood chemistry causing the lens inside the eye to get cloudy.

Retina. In diabetes, the tiny blood vessels that lay in the retina in the back of the eye can swell, weaken and leak blood, causing micro-aneurysms. Also new vessels can grow in (neovascularization), but these vessels too are weak and can leak blood. To treat this problem, a laser is used to 'spot-weld' these leaks and seal them shut.

And to complicate matters further, many of these eye diseases cause no symptoms at their earliest, most treatable stage. So how can you ensure that the residents of your facility minimize their risk of diabetic eye disease? Here's a couple of suggestions:

Work with your residents' physicians to control fluctuations in blood sugar. For every one percentage point drop in the hemoglobin A1c (say, from 7% to 6%), the risk of diabetic retinopathy decreases by 40%.

Make sure your residents receive annual, dilated eye examinations. It bears repeating: 90% of all blindness due to diabetes can be avoided with regular, dilated eye exams. Dilating the pupil is necessary for the optometrist to see the entire retina inside the eye. Annual dilated exams are recommended and are considered standard of care by the American Diabetes Association, the American Optometric Association, the American Academy of Ophthalmology and the Centers for Medicare and Medicaid Services (CMS). Because of this, Medicare and Medicaid covers the cost of annual eye exams for persons with diabetes. An experienced optometric physician can examine patients on-site, regardless of the level of cognitive impairment a resident may have.

Controlling diabetes in your residents requires a team approach: from the physician, to the nurses, to the dietary staff and the patient herself. Timely eye care can minimize the risk of vision loss and maximize the quality of life for your residents.

If you have any questions or would like further information, Dr. Kolker can be reached at dkolker@swbell.net or 918-381-9363

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Jerry Taylor, OSDH Enforcement Coordinator

Simply put, CMS has updated the terminology that references the condition formerly known as Mental Retardation. Based on changes made in Rosa's Law in 2010, Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) will now reflect nationwide changes and be referred to as **INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES** or **ICF/IIDs**.

This was published in the FEDERAL REGISTER on May 16, 2012 with an effective date of July 16, 2012. This issue is available on the Government Printing Office website at www.gpo.gov.

In addition, CMS issued several other regulatory changes that affect facilities that provide care for individuals with intellectual disabilities. Those changes include: **No more Time Limited Agreements and no more Certification Expiration Dates.**

Once a facility is certified for Medicaid, that certification will continue so long as the facility continues to meet all Medicaid Conditions of Participation for ICF/IIDs.

No More Automatic Cancellation Dates. In these same rule changes, CMS eliminated the provision for Automatic Cancellation Dates in provider agreements. So even if a deficiency is not corrected on the revisit, as long as all Conditions of Participation are still met, there will be no severe consequences to an ICF/IID.

Medicaid certification continues until it is cancelled. Essentially, if all Conditions of Participation (COPs) are "Met" there are no sanctions under Medicaid. So Medicaid certification is now an "All or Nothing" proposition. You're either certified or you're not. If all COPs are met, you're in; if they're not, you're out. It's just that simple.

Surveys are to be done every twelve months on a state-wide basis with a maximum interval of 15 months for any individual facility.

This will allow surveys to be done on a less predictable schedule and allows us more flexibility in scheduling. This is still very new to us and there has been very little guidance from CMS. The Code of Federal Regulations (CFR) has been revised and the revisions have been published, but they are not yet available in printed copies available for distribution. Federal Register, May 16, 2012.

Electronic versions of the CFR had not been revised as of December 4, 2012.

There will undoubtedly be more information forthcoming concerning these changes. When available it will be provided either through mass mailings to you, the provider or by way of this newsletter. Stay tuned.

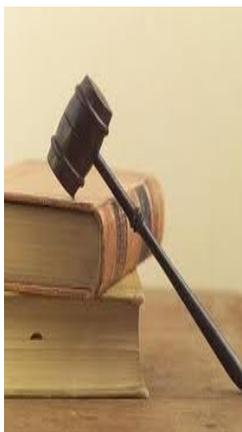
"CMS has updated the terminology that references the condition formerly known as Mental Retardation."

Top Five Immediate Jeopardy Citations for 2012

by Paula Terrel, R.N., Coordinator, OSDH



The OSDH has cited eighty-two (82) Immediate Jeopardy (IJ) citations for Nursing Facilities for 2012, from 01/01/12 through 12/14/12. Of these, one was cited for a life safety code violation



The top five Immediate Jeopardy (IJ) citations for nursing facilities were:

#1 **F323 – Accidents and Supervision – (29.2% of the IJ citations)**

These citations were related to the facility's failure to:

- ~provide supervision to prevent falls;
- ~provide supervision of aggressive/abusive residents;
- ~provide supervision of residents with swallowing problems to prevent choking;
- ~protect residents from accident hazards related to side rails, positioning devices or restraints;
- ~provide supervision with smoking;
- ~provide supervision to prevent elopement;
- ~to ensure hot water temperatures were not an accident hazard;
- ~ensure chemicals or other dangerous items were not accessible to residents;
- ~ensure lifts were used appropriately and did not create an accident hazard for residents;
- ~ensure suction equipment and emergency carts were available to staff; and
- ~ensure steam tables were not accessible to residents in the dining room

#2 **F309 - Provision of care and services to maintain the resident's highest practicable well-being – (14.6% of the IJ citations)**

These citations were related to the facility's failure to:

- ~immediately provide CPR when required;
- ~assess, monitor and intervene for a resident with a change in condition, including constipation and low blood sugars;
- ~provide diagnostic tests; and
- ~respond to critical lab values

#3 **F226 – Development and implementation of abuse policies and procedures – (12.1% of the IJ citations)**

These citations were related to the facility's failure to implement their abuse policies to screen individuals with a history of violence prior to admission; screen employees prior to hire; identify abuse; thoroughly investigate allegations of abuse; ensure protection of residents; and report allegations of abuse to administration, law enforcement and/or the OSDH.

#4 **F225 – Abuse - (10.9 % of the IJ citations)**

These citations were related to the facility's failure to ensure allegations of abuse were reported to administration, the OSDH and/or local law enforcement; thoroughly investigated; and/or residents were protected from abuse.

#5 **F371 – Kitchen Sanitation – and F490 – Administration (Each were 4.8% of the IJ citations)**

F371 – These citations were related to mouse droppings and urine trails in the food preparation and storage areas of the kitchen and undercooked unpasteurized eggs.

F490 – These citations were related to the failure to have administration that implemented abuse policies to investigate abuse, act on findings of investigations and protect residents from abuse.

TOP 10 DEFICIENCIES FOR **NURSING HOMES** JUNE – DECEMBER 2012

by Mary Fleming, Director of Survey, OSDH



1. **F441**—INFECTION CONTROL, PREVENT SPREAD OF INFECTIONS, LINEN HANDLING
2. **F309**—PROVIDE CARE / SERVICES FOR HIGHEST WELL BEING
3. **F279**—DEVELOP COMPREHENSIVE CARE PLANS
4. **F323**—MAINTAIN ENVIRONMENT FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES
5. **F514**—RESIDENT RECORDS-COMPLETE / ACCURATE / ACCESSIBLE
6. **F371**—FOOD PROCURE, STORE / PREPARE / SERVE, IN SANITARY MANNER
7. **F280**—RIGHT TO PARTICIPATE PLANNING CARE - REVISE CARE PLANS
8. **F312**—ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
9. **F157**—NOTIFY DOCTOR / FAMILY OF CHANGES (INJURY / DECLINE / ROOM, ETC)
10. **F226**—DEVELOP / IMPLEMENT ABUSE / NEGLECT POLICIES

TOP 10 DEFICIENCIES FOR **ICF / IID** JUNE – DECEMBER 2012

by Mary Fleming, Director of Survey, OSDH



- | | |
|-------------------------------|-------------------------------------|
| 1. W104 - GOVERNING BODY | 6. W460—FOOD and NUTRITION SERVICES |
| 2. W322 - PHYSICIAN SERVICES | 7. W189—STAFF TRAINING PROGRAM |
| 3. W436 - SPACE AND EQUIPMENT | 8. W249—PROGRAM IMPLEMENTATION |
| 4. W325 - PHYSICIAN SERVICES | 9. W369—DRUG ADMINISTRATION |
| 5. W455 - INFECTION CONTROL | 10. W388—DRUG LABELING |

**TOP 10 DEFICIENCIES FOR
ASSISTED LIVING CENTERS
JUNE – DECEMBER 2012**

by Mary Fleming, Director of Survey, OSDH



1. C1512 - RESIDENT RIGHTS, ABUSE / NEGLECT / MISAPPROPRIATION
2. C1505 - RESIDENT RIGHTS, FOLLOW PHYSICIAN'S ORDERS, NURSING INTERVENTION / MONITORING
3. C0552 - USE OF ASSESSMENT TO ENSURE APPROPRIATE PLACEMENT
4. C1923 - MEDICATION ADMINISTRATION, SELF ADMINISTRATION
5. C0522 - ASSESSMENT TIMEFRAMES
6. C0391 - FOOD STORAGE, PREPARATION AND SERVICE IN SANITARY MANNER
7. C1110 - QUALITY ASSURANCE COMMITTEE
8. C1911 - INCIDENT REPORT TIMELINES
9. C0532 - ASSESSMENT FORM, ACCURATE AND COMPLETE
10. C0921 - MEDICATION STAFFING, UNQUALIFIED PERSONNEL



PORTABLE SPACE HEATERS BY NATHAN JOHNS, LSC Supervisor

Despite the fact that electric space heaters do not have an open flame, according to the National Fire Protection Agency (NFPA), space heaters (portable or stationary) accounted for 30% of the home heating fires and 75% of home heating fire deaths in 2006.

Space heaters (portable and stationary) were involved in an estimated 64,100 U.S. home structure fires, 540 civilian deaths, 1,400 civilian injuries, and \$9.4 million in direct property damage. Much of the injury and damage was caused by the heating elements used in some types of electric heaters, which are hot enough to ignite nearby combustibles such as draperies, paper, clothing, furniture, and flammable liquids.

In 2009, heating equipment was involved in an estimated 58,900 reported home structure fires, 480 civilian deaths, 1,520 civilian injuries, and \$1.1 billion in direct property damage. Fires, injuries,

and damages were all lower than in 2008 (and deaths were virtually unchanged) and fit into a largely level trend over the past few years, coming after a sharp decline from the early 1980s to the late 1990s. In 2005-2009, most home heating fire deaths (79%) and injuries (66%) and half (52%) of associated direct property damage involved stationary or portable space heaters. Space heating poses a much higher risk of fire, death, injury, and loss per million users than central heating.

The NFPA 101, Life Safety Code section 19.7.8 prohibits the use of portable space heaters in health care occupancies but provides the following exception: Portable space heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F.

With this in mind, if you use a space heater

in non-sleeping staff and employee only areas you must have the manufacturers documentation indicating the heating element does not exceed 212°F. This documentation will need to be reviewed by the Life Safety Code surveyor at the time of the standard survey, complaint investigation or revisit to ensure that the space heater being used is Life Safety Code compliant.

Reference:
<http://www.nfpa.org/assets/files//PDF/OS.heating.pdf>



**National Fire Protection Association
Fire Analysis and Research Division**





Long Term Care

Oklahoma State
Department of Health

OSDH

1000 N.E. 10TH STREET
Oklahoma City, OK
73117-1299

*Insider Chat: Edited
by Donna Bell and
Barbara Reed*

Phone: 405-271-6868
Fax: 405-271-3442
Email:
ltc@health.ok.gov

**“Toolkits
will be
mailed
FREE to
all nursing
homes!”**

**LTC is on the web! Visit us at:
www.health.ok.gov**

Watch for the CMS **Free Hand in Hand** Training Series in the Mail by Karen Gray, R.D., Training Programs Manager, OSDH

The Centers for Medicare and Medicaid (CMS) has begun distribution of **Hand in Hand**: a high quality training series for nursing homes that emphasizes person-centered care for persons with dementia, as well as the prevention of abuse. These Toolkits will be mailed **FREE** to all nursing homes, CMS Regional Offices and State Survey Agencies by January 2013.

Section 6121 of the Affordable Care Act requires CMS to ensure that nurse aides receive regular training on caring for residents with dementia and on preventing abuse. CMS, supported by a team of instructional designers and subject matter experts, created **Hand in Hand**, the training you will be receiving soon, to address the annual requirement for nurse aide training on these important topics.

The CMS mission is to provide nursing homes with one option for a high-quality program that emphasizes person-centered care for persons with dementia and also addresses prevention of abuse. Person-centered care is about seeing the person first, not as a task to be accomplished or a condition to be managed. It is the fulfillment of the Nursing Home Reform Law to consider each resident's individual preferences, needs, strengths, and lifestyle in order to provide the optimum quality of care and quality of life for each person.

The **Hand in Hand** training materials consist of an orientation guide and six one-hour video-based modules, each of which has a DVD and an accompanying instructor guide. Though **Hand in Hand** is targeted to nurse aides, it has real value for all nursing home caregivers, administrative staff, and anyone who touches the lives of nursing home residents. Thank you for your commitment to encouraging the use of available materials such as **Hand in Hand** for the required annual training for nurse aides. We anticipate that these enhanced training programs will enable you to continuously improve dementia care and prevent abuse, as well as enhance resident and staff satisfaction in your community.

While annual training for nurse aides on dementia care and abuse prevention is required in current nursing home regulations, we do not require nursing homes to use the **Hand in Hand** training specifically. Other tools and resources are also available.

For information, to download the training modules or inquire about replacement copies of the **Hand in Hand** Toolkit please visit <http://www.cms-handinhandtoolkit.info/Index.aspx>

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