



Nursing Facility Quality Review 2013

**As Required by
2014-15 General Appropriations Act (Article II, Department of
Aging and Disability Services, Rider 13, Senate Bill 1, 83rd
Legislature, Regular Session, 2013)**

Texas Department of Aging and Disability Services

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NFQR 2013 - Executive Summary

Introduction

Rider 13 of the General Appropriations Act (Senate Bill 1, Article II, Department of Aging and Disability Services, 83rd Texas Legislature Regular Session, 2013) directs the Texas Department of Aging and Disability Services (DADS) to conduct a statewide survey of people residing in Medicaid-certified nursing facilities, assessing their satisfaction with quality of care and quality of life. Rider 13 also requires a written report on the findings of the survey be prepared and submitted to the Legislature, Governor and Health and Human Services Commission Executive Commissioner. Since 2002, the Nursing Facility Quality Review (NFQR) has been the process used to meet this legislative requirement.

Methodology

DADS contracted with the Nurse Aide Competency Evaluation Service Plus Foundation, Inc. (NACES) to conduct quality of life and quality of care surveys for 2,166 residents in 1,074 Medicaid-certified nursing facilities across the state.

The sample size for NFQR 2013 was determined by the number of Minimum Data Set (MDS) assessments submitted in Fiscal Year 2012. Census information from each facility's most recent survey visit by DADS Regulatory Services was used to establish the upper limit of that facility's sample size. DADS then prepared a list of randomly generated numbers for each facility; this list and an alphabetized roster provided by the nursing facility were used by the NACES nurse reviewers to select residents for the sample. For example, if the random number was five, then the fifth resident on the facility's roster was selected for the sample.

NACES nurse reviewers used a structured survey tool to obtain information from the residents or their representatives and the residents' medical records. Data collected included demographic information about each resident in the sample, as well as information regarding specific areas of care and quality of life:

- Advance Care Planning
- Depression
- Diabetes Mellitus
- Fall Risk Management
- Immunizations
- Infectious Illnesses¹
- Medication Practices and Safety
- Nutrition, Unintended Weight Loss and Hydration
- Pain Assessment and Control
- Pressure Ulcers
- Restraints

¹ Data was collected, but not included in the detailed description of findings. The data gathered was not useful due to the small number of residents involved.

- Enteral Feedings²
- Urinary Continence
- Quality of Life/Consumer Satisfaction

DADS staff analyzed the NFQR 2013 data using statistical software to test for linear trends across time, either from the first year data was collected on a particular measure, or when there was a change in the wording of a question that prevented comparison to the data from previous years.³ Most of the data documented in this report came directly from the resident assessments and interviews completed by NACES nurse reviewers, in addition to findings from:

- Medication Administration Records (MARs) – residents’ MARs and supporting documentation were reviewed by pharmacists who contracted with NACES to evaluate prescribing practices and the appropriateness of psychoactive medication use; and
- Data provided by the Centers for Medicare & Medicaid Services (CMS).

Demographics

The NFQR survey tool is used to collect demographic information about the residents in the sample. In 2013, the findings revealed:

- The ages of the residents ranged from 20 to 113 years.
- 84% of residents were 65 years of age or older.
- 68% of residents were female and 32% were male.
- 68% of residents had a diagnosis of dementia, Alzheimer’s disease or other cognitive impairment.
- The median length of stay for residents in the sample was 452 days.

In 2013, information about the racial or ethnic background of the residents in the sample was collected for the first time. The racial and ethnic breakdown of the sample was as follows:

- White – 69%
- Hispanic/Latino – 17%
- Black/African American – 13%
- Asian – <1%
- American Indian/Alaska Native – <1%
- Native Hawaiian/Other Pacific Islander – <1%
- Other – <1%

In 2013, the racial and ethnic breakdown of the overall population of Texas was as follows (United States Census Bureau, 2014):

- White – 80.3%
- Hispanic/Latino – 38.4%

² Data was collected, but not included in the detailed description of findings. The data gathered was not useful due to the small number of residents involved.

³ Statistically significant differences that are unlikely to be due to chance are indicated by a footnote and corresponding p-value throughout this report. A p-value of <.01 means that there is a 99% chance that the observed difference is due to a real effect.

- Black/African American – 12.4%
- Asian – 4.3%
- American Indian/Alaska Native – 1.0%
- Native Hawaiian/Other Pacific Islander – <1.0%

Key Findings

This section includes items that have demonstrated statistically significant changes over time or, even if not statistically significant, are important measures of residents’ quality of care and quality of life. “Initial Findings” represents the first year of data collection for a specific measure, but not all measures will have the same start date. For example, data has been collected on antipsychotic medications since 2005, while data collection for Diabetes Mellitus did not begin until 2010.

Improvements or declines in a particular measure may be represented by an increase or a decrease in the percentage of residents affected. For example: the percentage of residents who were assessed for weight loss risk factors increased, while the percentage of residents who were physically restrained decreased. In both situations, this is an improvement from previous NFQR findings.

Improving Trends in Resident Outcomes *(Statistically significant linear trends, improving over time)*

Observation	Initial Findings	NFQR 2013 Outcomes
Diabetes Mellitus		
Residents with diabetes with an eye exam, foot assessment and all recommended lab tests.	6%	15%
Medication Practices and Safety		
Residents prescribed a medication included on the Beers List.	17%	13%
Nutrition, Unintended Weight Loss and Hydration		
Residents assessed for weight loss risk factors.	65%	80%
Residents assessed for dehydration risk factors.	53%	83%
Pain Assessment and Control		
Residents with cognitive and/or verbal impairments assessed using a validated behavioral pain scale.	44%	78%
Residents who had no cognitive or verbal impairments assessed using a validated self-reporting pain scale.	73%	87%
Restraints		
Residents restrained using physical restraints (including bedrails of all types).	98%	46%
Quality of Life/Customer Satisfaction		
Residents who stated they liked the food they were served.	78%	83%
Residents who stated they enjoyed mealtimes.	85%	89%

Residents who stated weekend activities (other than religious activities) were available.	37%	52%
Residents who stated they felt safe and secure at the nursing facility.	94%	97%
Residents who stated they felt their possessions were safe.	79%	88%

Worsening Trends in Resident Outcomes
(Statistically significant linear trends, declining over time)

Observation	Initial Findings	NFQR 2013 Outcomes
Advance Care Planning		
Residents who had an advance directive in place.	69%	60%
Immunizations		
Residents who received the influenza vaccine.	74%	70%
Residents who received the pneumococcal vaccine.	61%	58%
Restraints		
Restraints initiated at the request of residents' family members or guardians.	31%	39%
Quality of Life/Consumer Satisfaction		
Residents who stated they did not express concerns due to a fear of retaliation.	4%	7%

Additional Survey Observations
(Items of interest, but not statistically significant over time)

Observation	Initial Findings	NFQR 2013 Outcomes
Pain Assessment and Control		
Residents who stated they were satisfied with their level of pain control.	93%	92%
Antipsychotic Medications		
Residents who received at least one antipsychotic medication.	34%	30%
Of those residents who received atypical antipsychotic medications, the percentage who received the medications for dementia-related behaviors.	41%	49%
Of those residents who received typical antipsychotic medications, the percentage who received the medications for dementia-related behaviors.	47%	59%
Quality of Life/Customer Satisfaction		
Residents who stated they had concerns that the nursing facility did not address.	13%	15%
Residents who stated they were satisfied with their experience in the nursing facility.	87%	88%
Residents who stated they were satisfied with the healthcare services they received at the nursing facility.	88%	90%

Summary of Findings

According to the NFQR survey findings, Texas nursing facility residents were generally satisfied with the quality of services they received. When interviewed, most of the residents indicated they felt safe and secure in their facilities, and that their possessions were safe as well.

A number of improvements were noted in the current survey findings, including:

- Residents with diabetes were more likely to have recommended exams, assessments and laboratory tests completed;
- Residents were more likely to be assessed for weight loss and dehydration risk factors;
- Residents were more likely to be assessed for pain using validated pain scales appropriate for their cognitive and verbal abilities; and
- Residents were less likely to be physically restrained.

The survey findings also identified opportunities for improvement:

- Although the number of residents prescribed antipsychotic medications decreased, nearly one-third of the residents in the sample received at least one antipsychotic medication, and the reason most often cited was management of dementia-related behavior;
- Fewer residents received the influenza and pneumococcal vaccines than in previous years;
- Fewer residents had an advance care planning document in place;
- More residents stated they had concerns that their facilities did not address; and
- The percentage of residents who did not express concerns due to a fear of retaliation increased.

Quality Improvement Initiatives

DADS Quality Monitoring Program (QMP) continues to provide technical assistance to nursing facilities through quality monitoring and in-service education visits. Quality monitoring visits focus on specific clinical topics, providing facilities with evidence-based information to improve the quality of care and quality of life for their residents. Each QMP focus area has been extensively researched to develop structured assessments, in-services and technical assistance toolkits representing evidence-based best practices.

In July 2014, the QMP expanded the Rapid Response Team (RRT) process to more effectively provide evidence-based information and resources to nursing facilities. Long-term care ombudsmen and nursing facility liaisons may participate in the RRT visits, in addition to QMP staff members (nurses, pharmacists and dietitians). The RRT visits are an intensive evaluation of a facility's systems and provide multiple opportunities for education and technical assistance targeted to the facility's specific needs. The RRT visits are intended to help nursing facilities improve services and supports so the *right* thing is done for the *right* person at the *right* time. RRT visits are conducted in an atmosphere that encourages learning and team building, which promotes positive relationships with providers through the use of diverse teaching techniques.

DADS, TMF Health Quality Institute, the State Long-Term Care Ombudsman Program and other interested parties are collaborating on an initiative to reduce the inappropriate use of antipsychotic medications while improving the quality of care provided to residents with dementia. The TRAIN (Texas Reducing Antipsychotics in Nursing Homes) Initiative includes:

- Phase I: Between July 2014 and October 2014, day-long workshops were offered in several locations across the state. Each workshop provided a clinical perspective on the use of antipsychotic medications, including off-label use of these drugs in residents with dementia. The workshops also addressed pain management in residents with dementia, identified alternative strategies for managing behaviors associated with dementia and explained the survey implications of the relevant federal regulations. Nursing facilities attending these workshops were given an opportunity to sign up for individualized assistance to address their specific situation.
- Phase II: An interdisciplinary team provides individualized assistance and support to facilities. Team members may include any of the following: DADS QMP staff, TMF Health Quality Institute staff, and Long-Term Care Ombudsman Program staff. Team members will provide technical assistance face-to-face in the facility, by telephone or virtually through webinars.

Phase II of the initiative will also include regional peer-to-peer meetings. These meetings will be an opportunity for staff from different nursing facilities to share their experiences. The meetings will be facilitated by QMP staff, bringing together facilities that have successfully implemented effective processes to provide person-centered care while reducing the use of antipsychotic medications and those that are still struggling to implement systems to address those areas of concern.

The TRAIN initiative is anticipated to continue through Fiscal Year 2016.

Appendix A - Nursing Facility Quality Review 2013 Survey Findings

Advance Care Planning

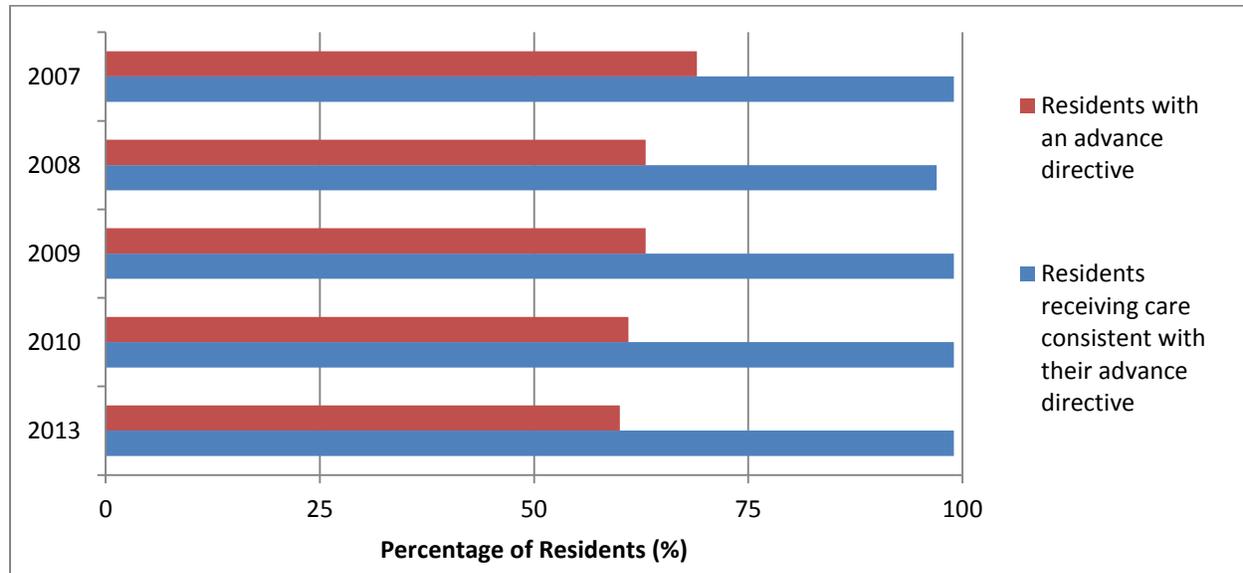
Advance care planning (ACP) provides residents or their family members an opportunity to make decisions (i.e., advance directives) about their current and future healthcare. Advance directives are the written instructions that reflect the decisions made during the ACP process and which inform facility staff about the resident’s wishes regarding the use of cardio-pulmonary resuscitation (CPR) if the resident’s heart stops beating, the use of a machine to assist with breathing, and the administration of food/nutrition and fluids given through a tube inserted into the stomach.

Findings

- While the majority of residents had completed an advance directive, residents were less likely to have an advance directive than in previous years.⁴
- Of those residents who had an advance directive, most were receiving care that was consistent with that advance directive.

	2007	2008	2009	2010	2013
Residents who had an advance directive	69%	63%	63%	61%	60%
Residents receiving care consistent with their advance directive	99%	97%	99%	99%	99%

Figure 1 - Advance directives, care consistent with advance directives



⁴ Statistically significant linear trend at $p < 0.1$.

Depression

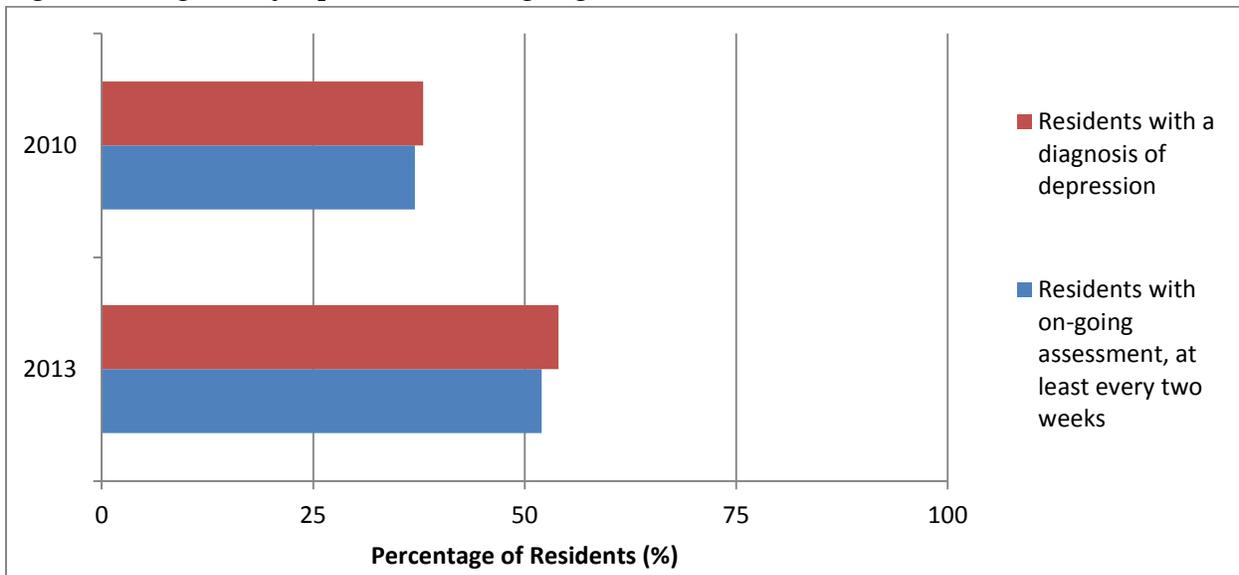
Depression occurs frequently in older adults, with nearly half of all nursing facility residents having a diagnosis of depression (Harris-Kojetin L, et al, 2013). Depression may go unrecognized, since the symptoms can mimic those of other illnesses. Dementia and other cognitive impairments can also make it difficult to identify the symptoms of depression, delaying the diagnosis and treatment. Appropriate diagnosis and treatment of depressive symptoms can significantly improve residents’ quality of life.

Findings

- Residents were more likely to be diagnosed with depression than in 2010.⁵
- Residents with depression were more likely to have on-going assessments of their symptoms than in 2010.⁶

	2010	2013
Residents with a diagnosis of depression	38%	54%
Residents who had on-going assessment of symptoms	37%	52%

Figure 2 - Diagnosis of depression and on-going assessment



Antidepressant medications are often prescribed to treat depression, but can have undesirable side effects ranging from headaches and gastrointestinal upset to an increased risk of falls and fractures. Other treatments for depression include psychotherapy, light therapy and exercise (American Medical Directors Association [AMDA], *Depression in the Long-Term Care Setting*, 2011).

⁵ Statistically significant linear trend at $p < 0.1$.

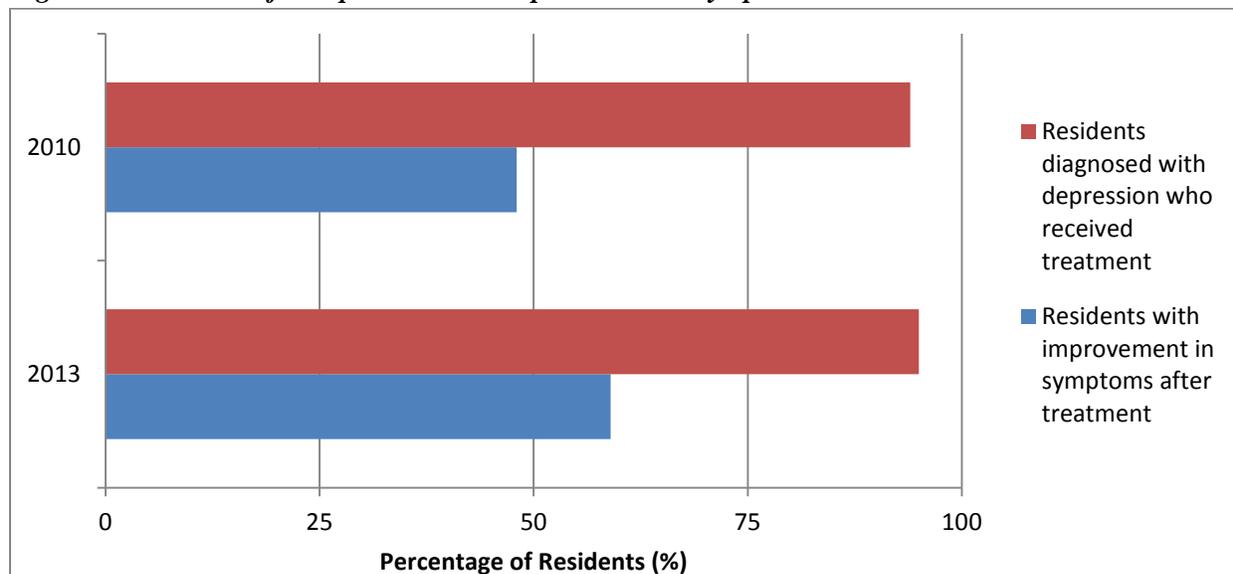
⁶ Statistically significant linear trend at $p < 0.1$.

Findings

- The majority of residents diagnosed with depression were receiving treatment.
- Residents were more likely to show improvement in their symptoms with treatment than in 2010.⁷

	2010	2013
Residents diagnosed with depression who received treatment	94%	95%
Residents who had improvement in their symptoms with treatment	48%	59%

Figure 3 - Treatment for depression and improvement in symptoms



Diabetes Mellitus

Diabetes Mellitus is a chronic disease that can lead to serious complications, including vision loss, kidney failure, amputations and death. In 2012, more than 11 million adults 65 years of age and older had been diagnosed with diabetes (Centers for Disease Control and Prevention [CDC], *National Diabetes Statistics Report*, 2014).

In 2010, 23 percent of Texans 65 years of age or older had been diagnosed with diabetes (Texas Department of State Health Services [DSHS], *Texas Health Indicators: Diabetes Prevalence*, 2010). In 2012, diabetes was the fifth leading cause of death in Texans between the ages of 65 and 74 years (DSHS, *Center for Health Statistics*, 2012).

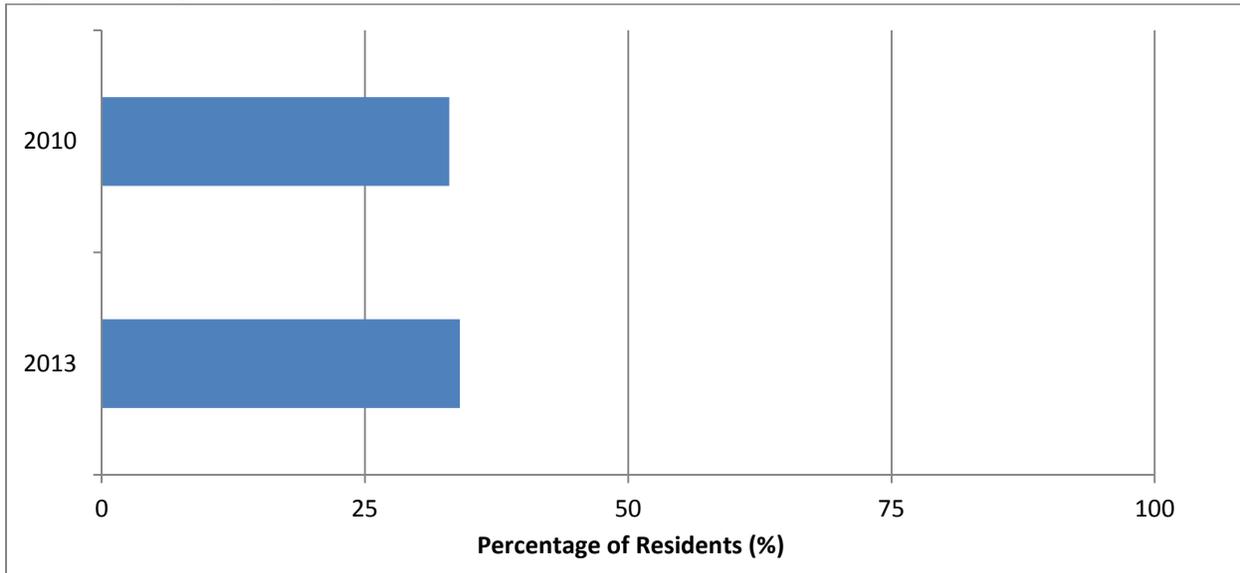
Findings

- More than a third of the residents in the sample had been diagnosed with diabetes.

	2010	2013
Residents with a diagnosis of diabetes	33%	34%

⁷ Statistically significant linear trend at $p < 0.1$.

Figure 4 - Diagnosis of diabetes



Residents with diabetes should have a comprehensive eye exam and a complete foot assessment at least annually. Certain lab tests can provide information about how well the resident’s diabetes is controlled; therefore, each resident with diabetes should have their blood lipid (cholesterol and triglyceride) levels and urine protein checked at least annually, and their hemoglobin (Hgb) A1C checked every six months (American Diabetes Association [ADA], *Standards of Medical Care*, 2014).

Findings

- Residents were more likely to have had all of the recommended evaluations and lab tests performed than in 2010.⁸
- More residents had the individual lab tests completed: lipid profile⁹, urine protein¹⁰, and HgB A1C.

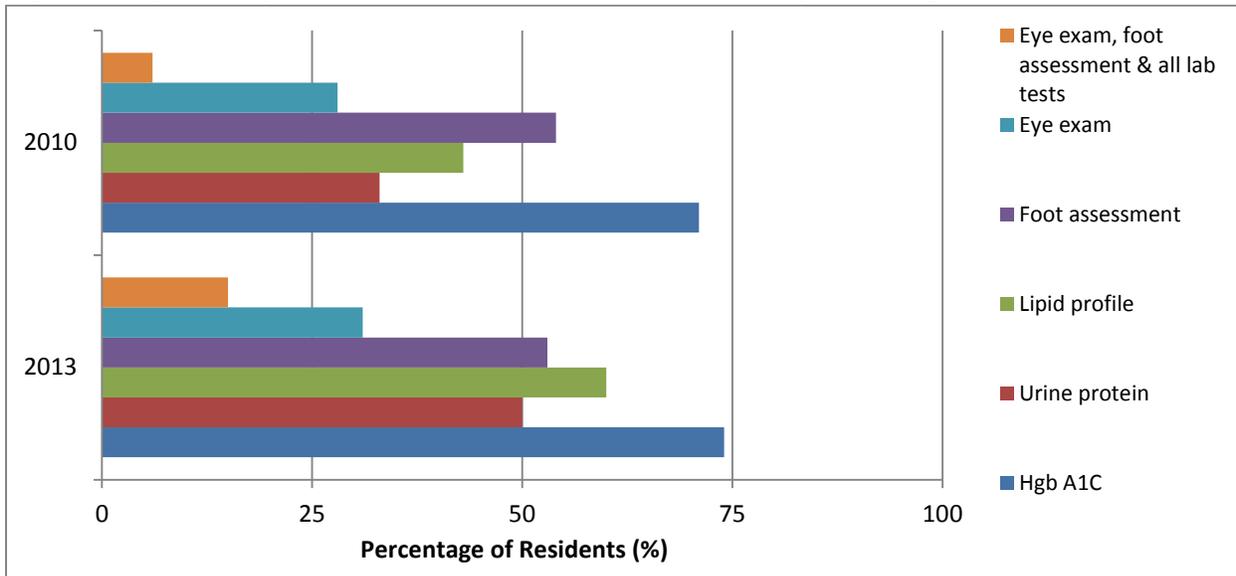
	2010	2013
Residents with diabetes who had received an eye exam, a foot assessment and all recommended lab tests	6%	15%
Residents with diabetes who had received an eye exam	28%	31%
Residents with diabetes who had received a foot assessment	54%	53%
Residents with diabetes who had a lipid profile completed	43%	60%
Residents with diabetes who had a urine protein completed	33%	50%
Residents with diabetes who had a HgB A1C completed	71%	74%

⁸ Statistically significant linear trend at $p < 0.1$.

⁹ Statistically significant linear trend at $p < 0.1$.

¹⁰ Statistically significant linear trend at $p < 0.1$.

Figure 5 - Eye exam, foot assessment and recommended laboratory tests completed



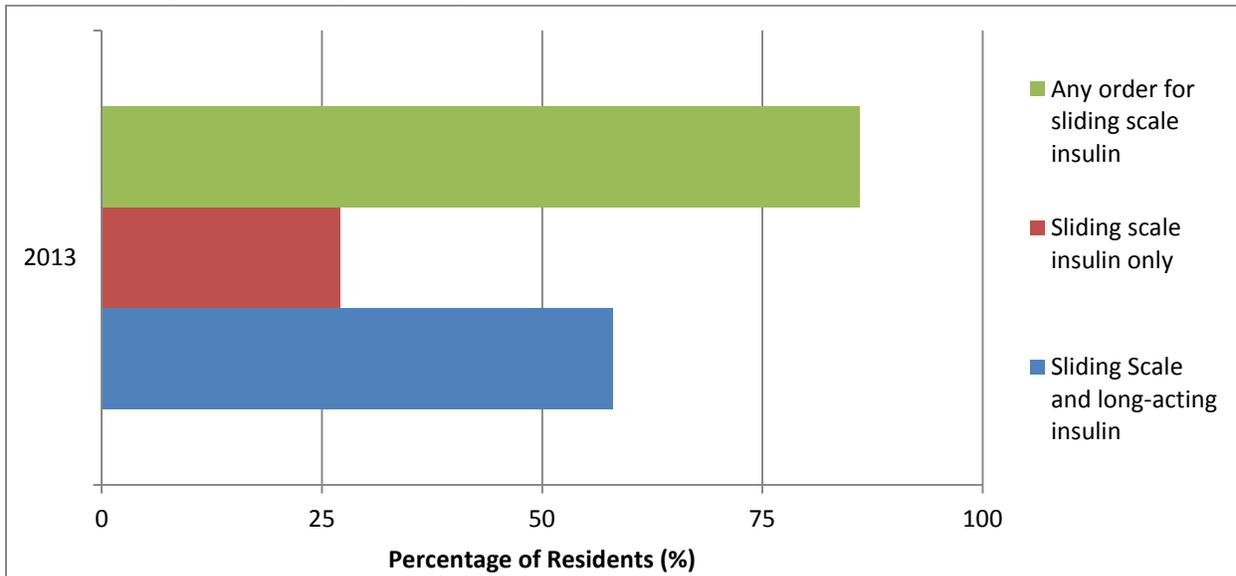
The treatment for diabetes is based on the resident’s individual needs and can include changes in diet, oral medications and insulin therapy. For many years, sliding scale dosing of insulin has been used to manage changes in blood sugar. When dosing by sliding scale, the amount of insulin given is based on the capillary blood sugar level at that specific time, usually with no consideration of meal intake. Sliding scale dosing is not an effective way to manage diabetes, but is still frequently ordered, even though other dosing regimens are more useful for treating diabetes (ADA, 2014).

Findings

- The majority of residents with diabetes had a physician’s order for sliding scale insulin therapy.
- Of those residents, some had orders for sliding scale insulin only and were not receiving long-acting insulin.
- Other residents were receiving long-acting insulin, but still had orders for sliding scale insulin on an as needed basis.

	2013
Residents with a diagnosis of diabetes and any order for sliding scale insulin	86%
Residents with a diagnosis of diabetes and insulin orders for sliding scale only	27%
Residents with a diagnosis of diabetes and orders for sliding scale and long-acting insulin	58%

Figure 6 - Physician orders for sliding scale insulin



Fall Risk Management Practices

In the United States, falls are a leading cause of fatal and non-fatal injuries in older adults. In 2012, 2.4 million people over the age of 65 were treated in hospital emergency rooms for fall-related injuries, and over 722,000 were hospitalized for further treatment. In 2011, nearly 23,000 people over the age of 65 died of fall-related injuries (CDC, *Web-based Injury Statistics Query and Reporting System*, 2014). An estimated five percent of adults 65 and older live in nursing homes, but those residents account for around 20 percent of all fall-related deaths in this age group (CDC, *Falls Among Older Adults: An Overview*, 2014).

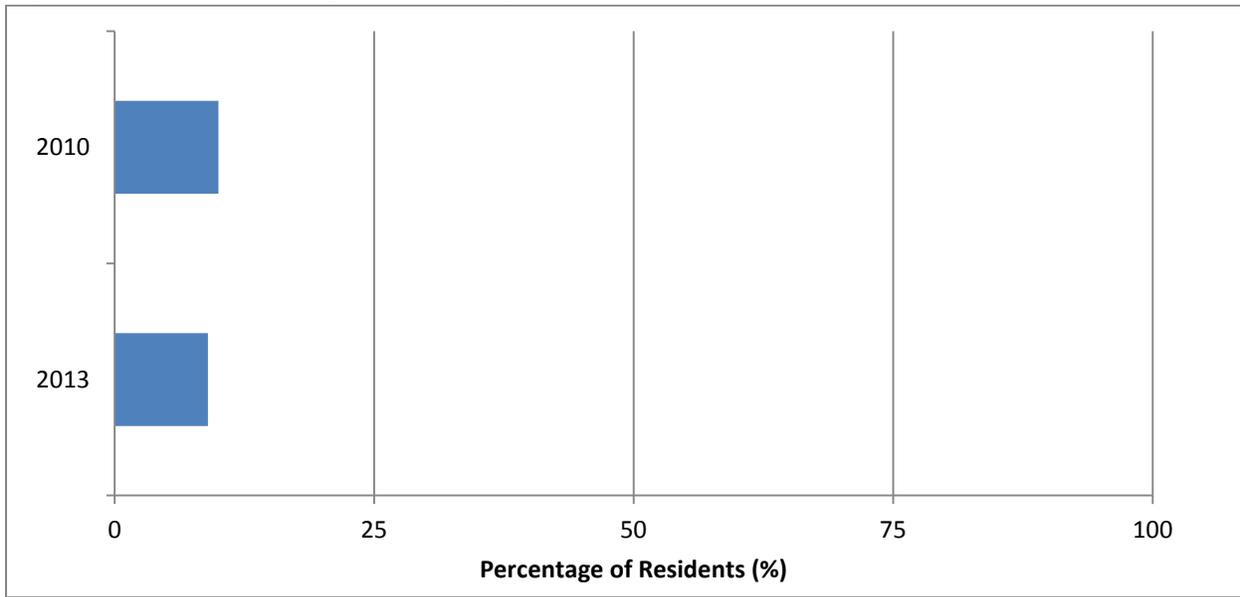
In Texas, falls are the leading cause of injury in older adults. In 2013, there were more than 53,000 hospitalizations due to falls, with over half of those being people age 65 and older (DSHS, *Environmental Epi and Injury Surveillance, Data and Statistics: Mechanism of Injury Report*, 2013).

Findings:

- Residents were as likely to have fallen in the 30 days prior to the survey as in 2010.

	2010	2013
Residents who had at least one fall in the previous 30 days	10%	9%

Figure 7 - Falls within the previous 30 days



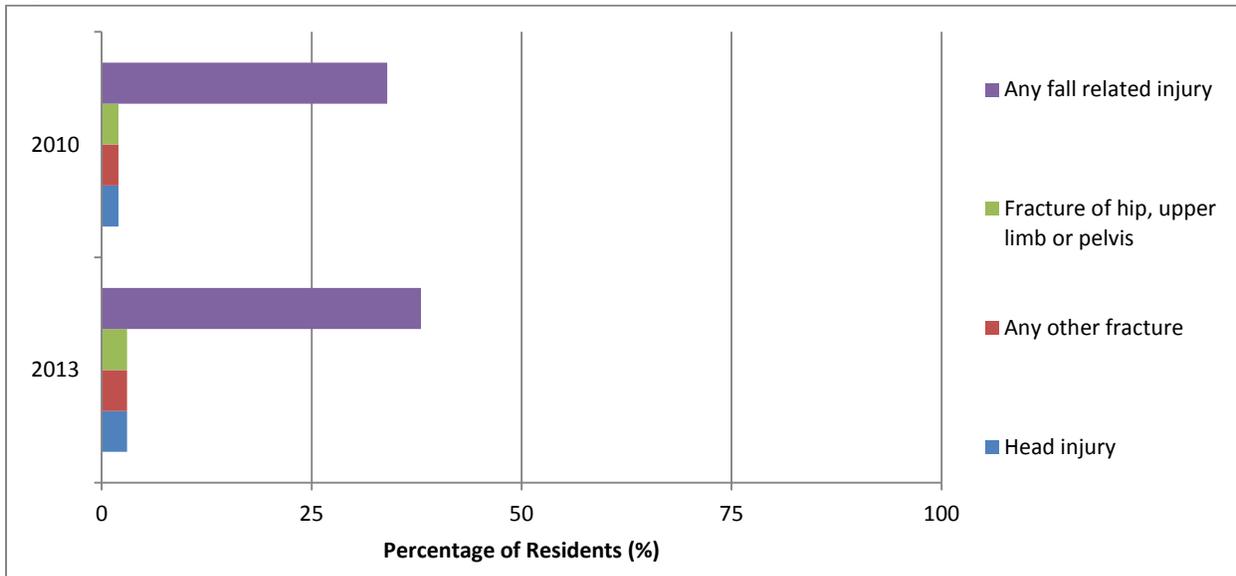
Most falls do not result in significant injury, but older adults are at higher risk for serious fall-related injuries, including fractures and head trauma. The most common fall-related fractures include hip, pelvis, arm and hand fractures.

Findings

- Of those residents who had fallen, more had experienced an injury related to a fall than in 2010.
- The percentage of residents who had a fall-related fracture or head injury increased.

	2010	2013
Of residents who had fallen, those with any injury	34%	38%
Of residents who had fallen, those with a fractured hip, upper limb or pelvis	2%	3%
Of those residents who had fallen, those with any other fracture	2%	3%
Of those residents, those with a head injury	2%	5%

Figure 8 - Injuries related to a fall



Immunizations

Influenza (flu) is a viral infection that is easily spread from person to person. The flu leads to nearly 200,000 hospitalizations and an average of 23,607 deaths annually in the United States. In a typical flu season, up to 90 percent of flu-related deaths are in people over the age of 65 (CDC, *Epidemiology and Prevention of Vaccine-Preventable Diseases*, 2012).

Pneumococcal pneumonia is a common bacterial infection, resulting in approximately 175,000 hospitalizations each year in the United States. The overall death rate for pneumococcal pneumonia is an estimated five to seven percent; however, in older adults the fatality rate can reach over 50 percent (CDC, 2012).

Nursing facility residents should receive the flu vaccine on an annual basis and the pneumococcal vaccine (PPV-23) at least once after the age of 65. In 2014, the Advisory Committee on Immunization Practices (ACIP) released additional recommendations for the pneumococcal vaccine to include a second vaccine (Pneumovax 23) for individuals over the age 65 (CDC, *Use of the 13-Valent Pneumococcal Conjugate Vaccine and the 23-Valent Pneumococcal Vaccine Among Adults Aged ≥ 65 Years*, 2014).

Findings

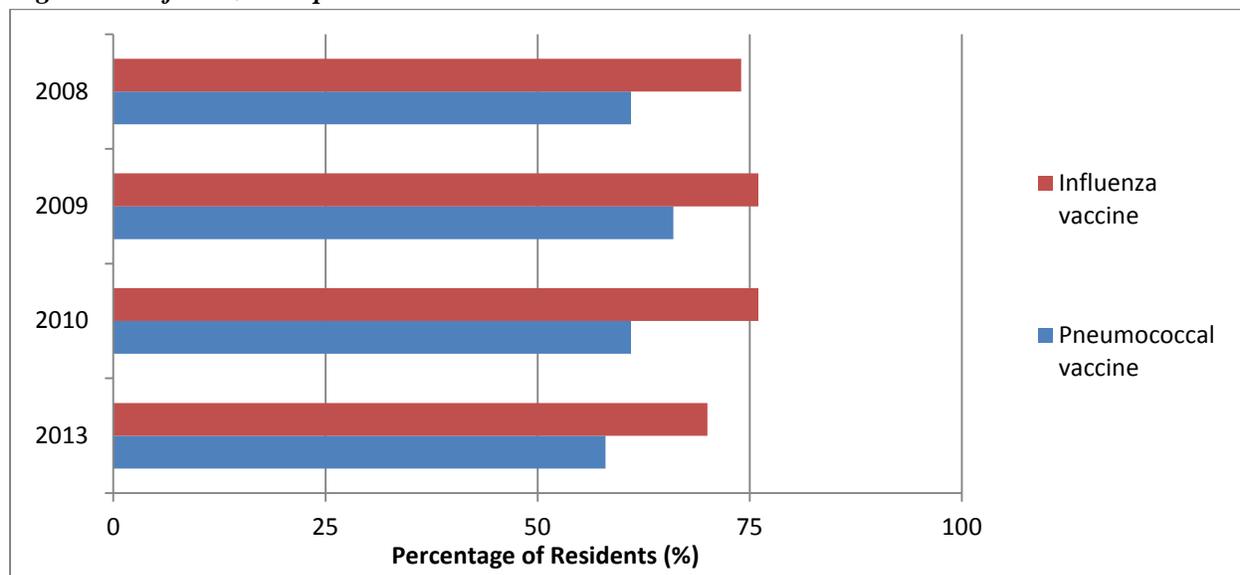
- Residents were less likely to receive the influenza vaccine than in previous years.¹¹
- Residents were less likely to receive the pneumococcal vaccine than in previous years.¹²

¹¹ Statistically significant linear trend at $p < 0.1$.

¹² Statistically significant linear trend at $p < 0.1$.

	2008	2009	2010	2013
Residents who received the influenza vaccine	74%	76%	76%	70%
Residents who received the pneumococcal vaccine	61%	66%	61%	58%

Figure 9 - Influenza and pneumococcal vaccines



Medication Practices and Safety

In the United States, people over the age of 65 make up approximately 13 percent of the population, but account for around 30 percent of medication use. Nationally, the cost of medications for people 65 years of age and older was over \$76 billion dollars in 2010 (CMS, *National Health Expenditure Data: Health Expenditures by Age and Gender*, 2010).

As people age, they may not be able to metabolize medications as well as younger adults. Changes in muscle mass and percentage of body fat and impairments in liver and kidney function can affect the way medications are metabolized and excreted from the body. Since older adults often take multiple medications, they are also at higher risk for drug interactions.

When making the decision to prescribe a medication, the physician should consider the resident’s clinical condition and the goals of therapy. The physician should also conduct an evaluation of the risks and benefits of the medication (AMDA, *Multidisciplinary Medication Management*, 2011).

Findings

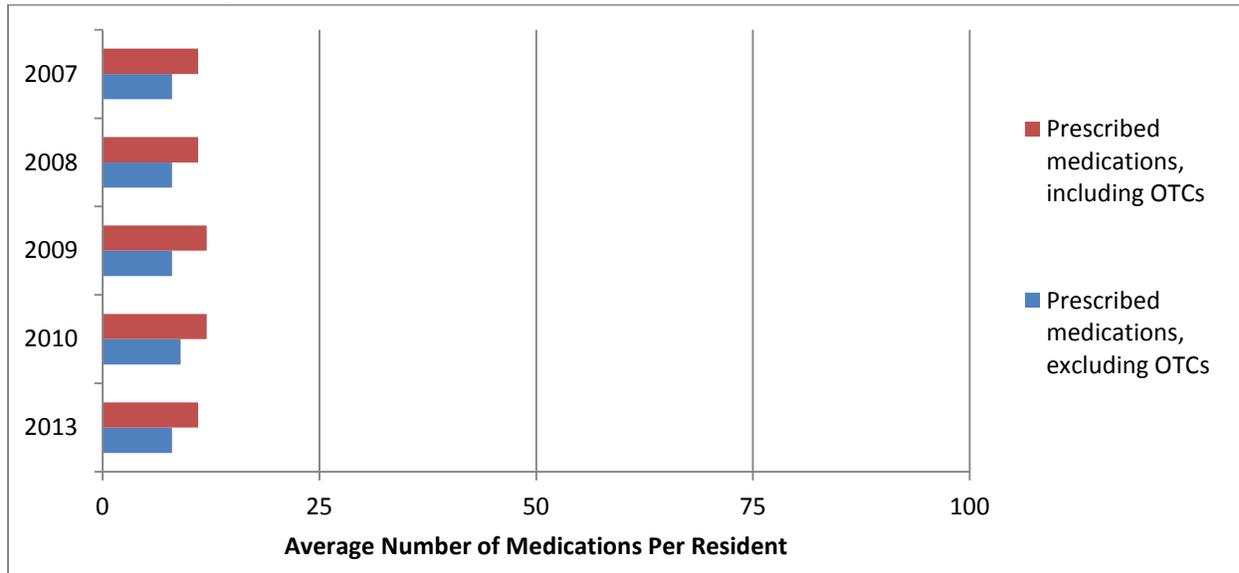
- The average number of prescribed medications per resident, including over the counter medications (OTCs), decreased.¹³
- The average number of prescribed medications per resident, excluding OTCs, decreased.¹⁴

¹³ Statistically significant linear trend at $p < 0.1$.

¹⁴ Statistically significant linear trend at $p < 0.1$.

	2007	2008	2009	2010	2013
Average number of prescribed medications per resident, including OTCs	11	11	12	12	11
Average number of prescribed medications per resident, excluding OTCs	8	8	8	9	8

Figure 10 - Average number of prescribed medications



In 1991, Dr. Mark Beers and a panel of experts developed the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (Beers List), with updates published in 1997 and 2001. In 2012, the American Geriatrics Society (AGS) published an updated version of the Beers List. When medications on the Beers List are prescribed to anyone over the age of 65, close monitoring is necessary (AGS, *Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*, 2012).

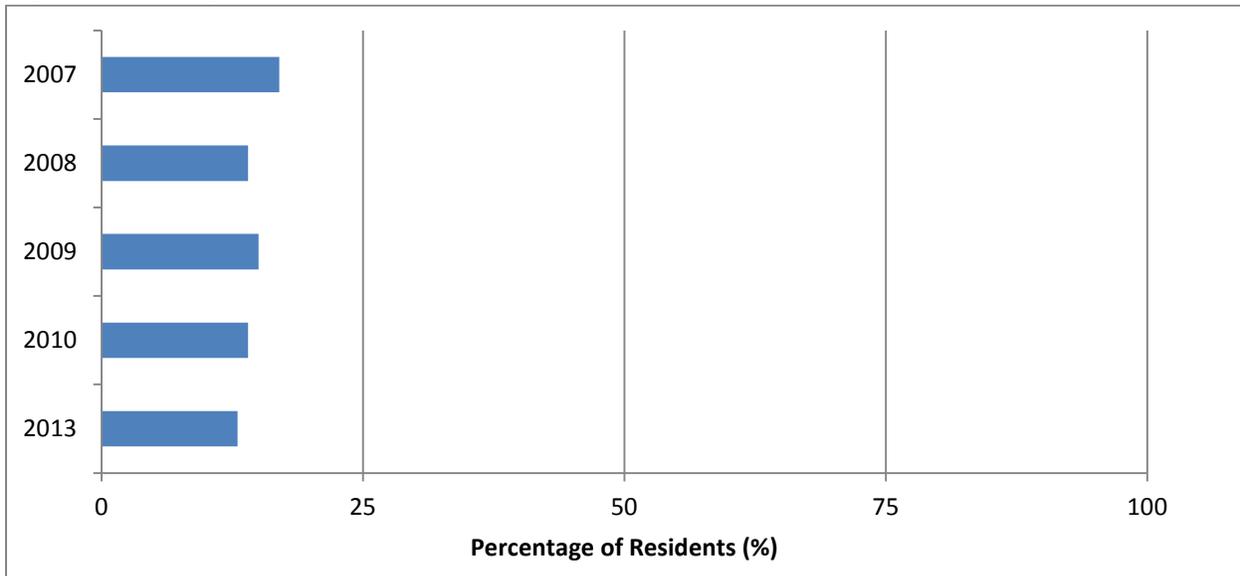
Findings

- Residents aged 65 or older were less likely to receive a medication on the Beers List than in previous years.¹⁵

	2007	2008	2009	2010	2013
Residents aged 65 years and older who received at least one medication on the Beers List	17%	14%	15%	14%	13%

¹⁵ Statistically significant linear trend at $p < 0.1$.

Figure 11 - Use of medications on the Beers List



Nutrition, Unintended Weight Loss and Hydration

Unplanned weight loss in an older adult is often the result of an underlying condition such as diabetes, cancer, advanced dementia or swallowing problems. Restrictive diets and some medications can also increase the risk for unintended weight loss. Unplanned weight loss is associated with a number of poor outcomes, including loss of muscle tissue, poor wound healing and cognitive decline (AMDA, *Altered Nutritional Status in the Long-Term Care Setting*, 2010).

Risk factors for dehydration are similar to those for weight loss, as well as acute illnesses such as fever, vomiting and diarrhea. Residents who need assistance with eating and drinking, and those who are on fluid restrictions are also at risk for dehydration (AMDA, *Dehydration and Fluid Maintenance in the Long-Term Care Setting*, 2010). Severe dehydration can lead to a decrease in blood pressure, rapid heartbeat, confusion, loss of consciousness and death.

Findings

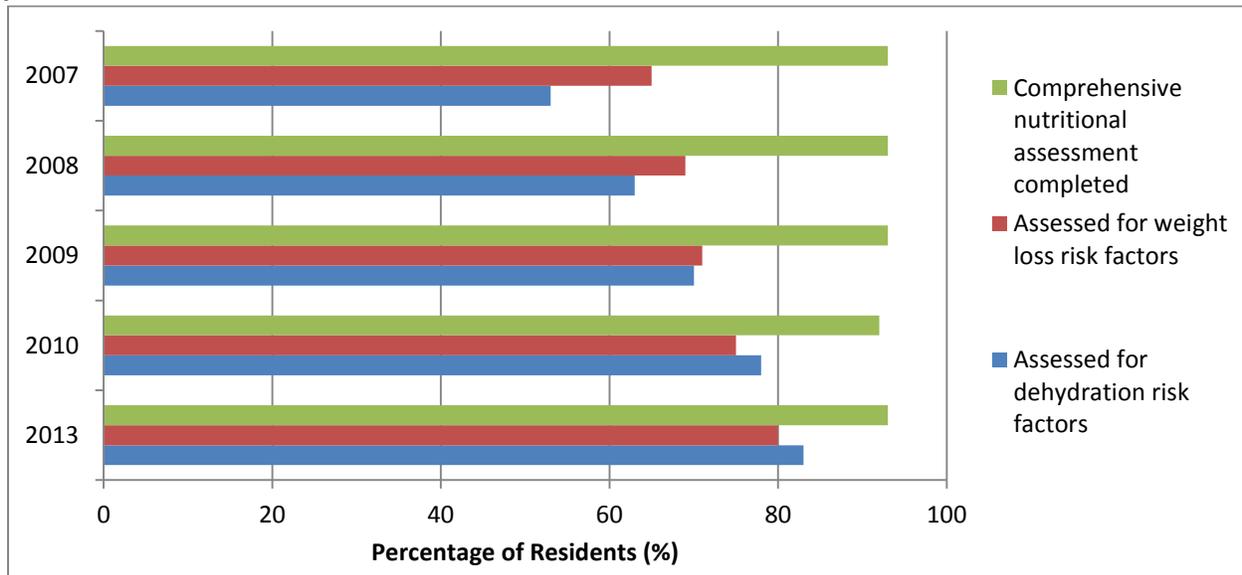
- Residents were as likely to have had a comprehensive nutritional assessment completed when compared to previous years.
- Residents were more likely to have been assessed for weight loss¹⁶ and dehydration¹⁷ risk factors than in previous years.

	2007	2008	2009	2010	2013
Residents who had a comprehensive nutritional assessment	93%	93%	93%	92%	93%
Residents who were assessed for weight loss risk factors	65%	69%	71%	75%	80%
Residents who were assessed for dehydration risk factors	53%	63%	70%	78%	83%

¹⁶ Statistically significant linear trend at p <0.1.

¹⁷ Statistically significant linear trend at p <0.1.

Figure 12 - Comprehensive nutritional assessment, assessments for weight loss and dehydration risk factors



Pain Assessment and Control

While pain is a common problem for many older adults, it is not a normal part of aging. Pain is usually related to underlying conditions such as arthritis, shingles or neurological disorders. Pain affects up to 55 percent of all nursing facility residents (AMDA, *Pain Management in the Long-Term Care Setting*, 2012), and around 80 percent of nursing home residents diagnosed with cancer experience pain (AGS, *Pharmacological Management of Persistent Pain in Older Persons*, 2009). Pain that is not adequately treated can lead to negative outcomes including depression, difficulty sleeping and falls (AMDA, 2012). Residents with dementia can have trouble reporting pain, increasing the risk for under-treatment of pain and inappropriate use of antipsychotic medications to manage behaviors that could be related to pain.

A comprehensive pain assessment, using a standardized and validated pain scale, is an important part of any successful pain management program. A number of valid and reliable pain scales are available, including several for use with residents who have dementia or other cognitive impairments.

Findings

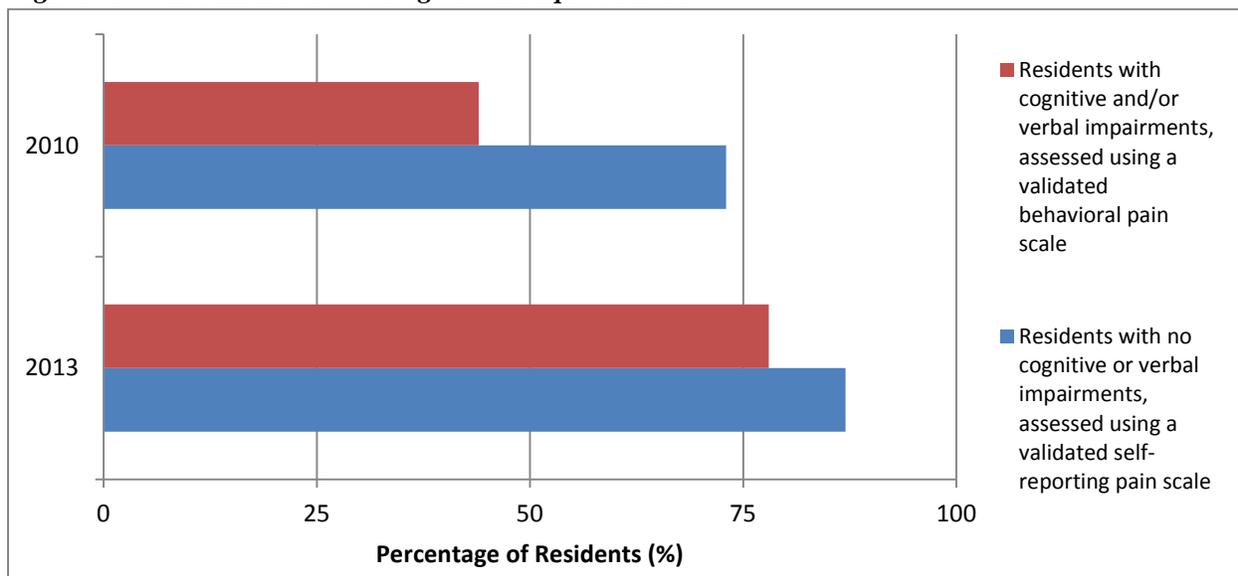
- Residents with cognitive and/or verbal impairments were more likely to have been assessed for pain using a validated behavioral pain scale than in 2010.¹⁸
- Residents with no cognitive or verbal impairments were more likely to have been assessed for pain using a validated self-reporting pain intensity scale than in 2010.¹⁹

¹⁸ Statistically significant linear trend at $p < 0.1$.

¹⁹ Statistically significant linear trend at $p < 0.1$.

	2010	2013
Residents with cognitive and/or verbal impairments who were assessed for pain using a validated behavioral pain scale	44%	78%
Residents who were cognitively and verbally intact who were assessed for pain using a validated self-reporting pain scale	73%	87%

Figure 13 - Pain assessments using validated pain scales



When conducting reassessments, facility staff should use the same pain scale consistently unless there has been a change in cognition or in the resident’s ability to self-report pain. Using the same pain scale each time increases the accuracy of the assessments, since pain scales are not interchangeable and their rating systems are not comparable.

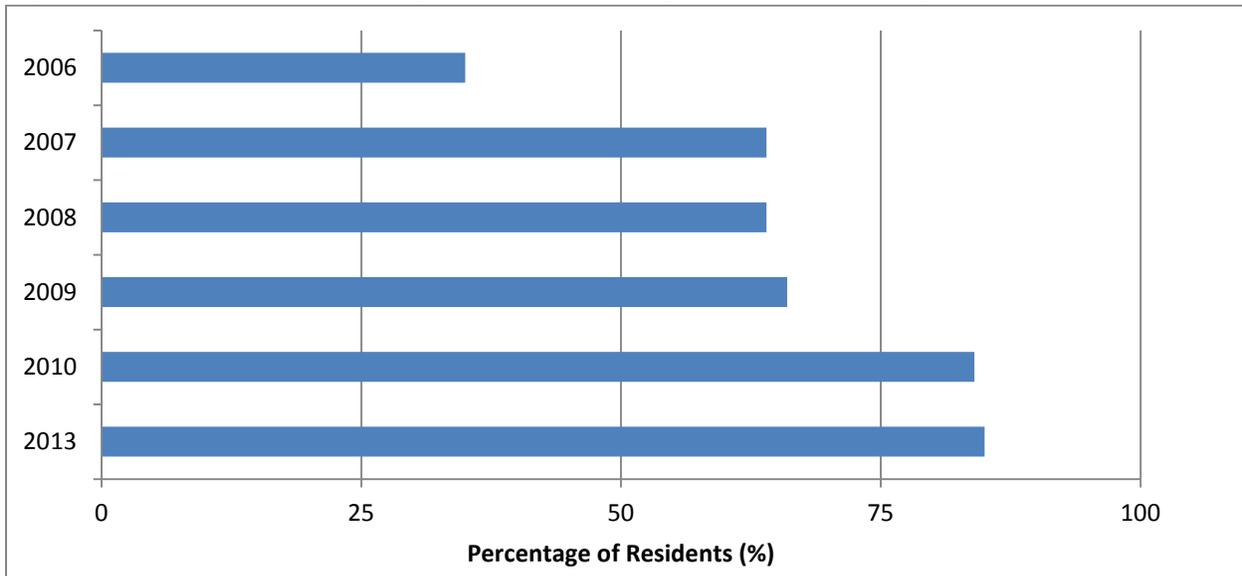
Findings

- Reassessments for pain were more likely to be conducted using the same validated scale consistently than in 2010.²⁰

	2006	2007	2008	2009	2010	2013
Residents whose pain assessments were conducted using the same validated pain scale consistently	35%	64%	64%	66%	84%	85%

²⁰ Statistically significant linear trend at p < 0.1.

Figure 14 - Pain assessments using the same validated pain scale consistently



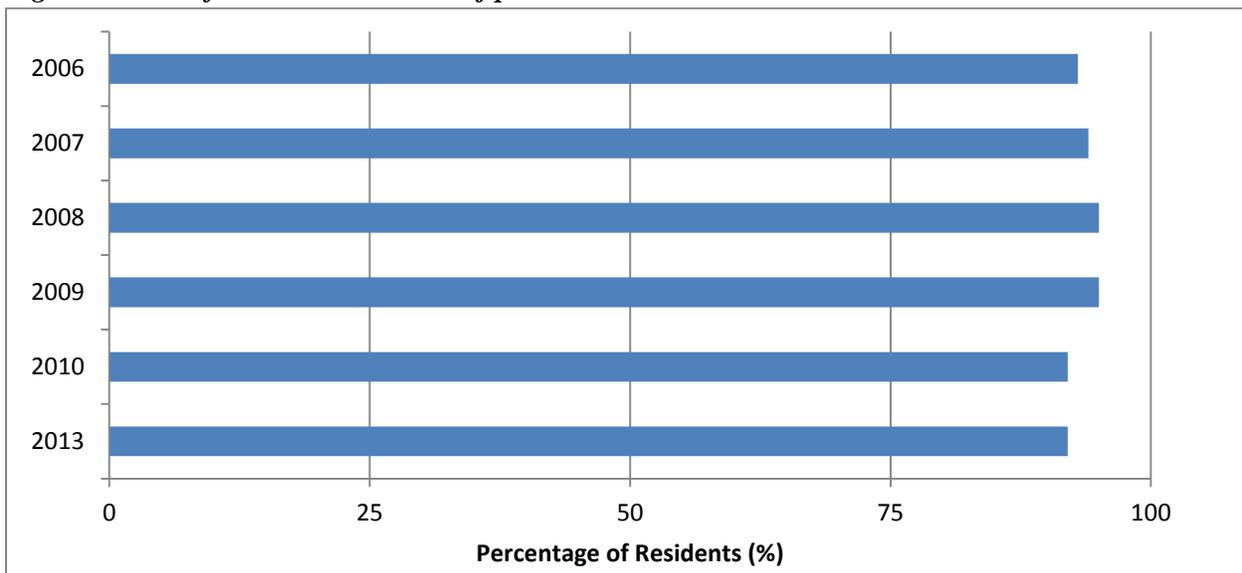
The goal of any pain management program is to provide residents with a level of pain control that meets their expectations. The individual goals of therapy will vary from person to person and may include achieving a certain acceptable level of discomfort or the ability to perform certain tasks and activities.

Findings

- The majority of residents in the sample expressed satisfaction with their level of pain control.

	2006	2007	2008	2009	2010	2013
Residents who expressed satisfaction with their level of pain control	93%	94%	95%	95%	92%	92%

Figure 15 - Satisfaction with the level of pain control achieved



Pressure Ulcers

Pressure ulcers, also called pressure sores or bed sores, are caused by unrelieved pressure or pressure in combination with shear. Shear occurs when the upper layer of skin is pulled in the opposite direction from the lower layers, causing damage to the underlying blood vessels and increasing the potential for damage from prolonged pressure. Pressure ulcers usually occur over bony areas, such as the tailbone, hips or shoulders and can develop within a matter of hours if preventive measures are not taken. Residents who have pressure ulcers can develop serious complications, including infections, pain and depression (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, *Prevention and Treatment of Pressure Ulcers*, 2014).

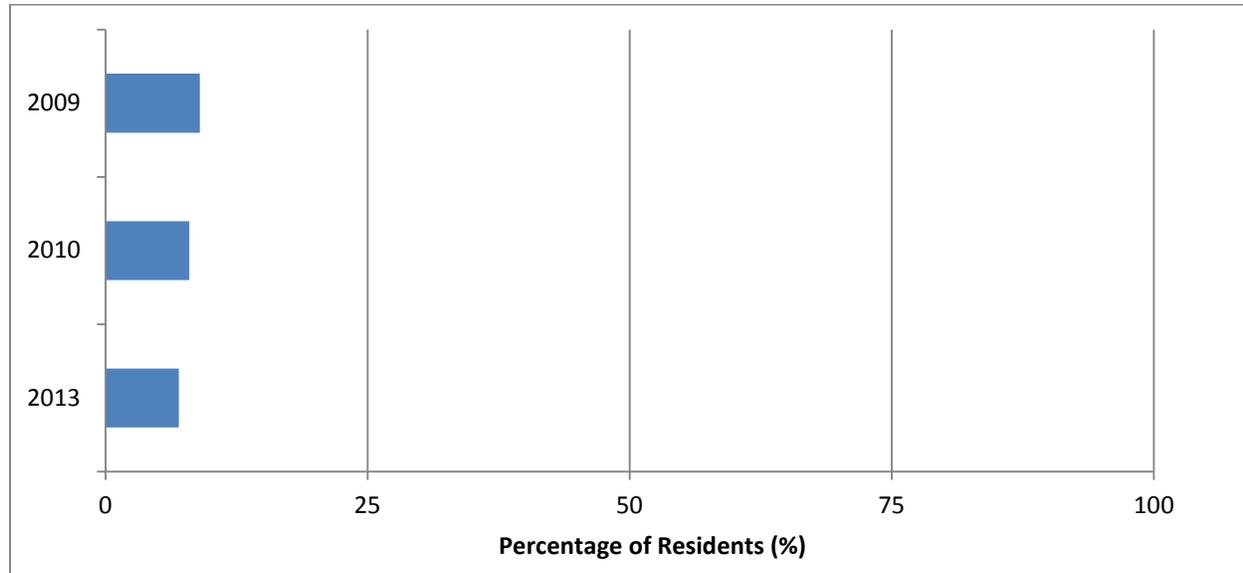
Nationwide, the incidence of pressure ulcers in nursing facilities is between 2.2 and 23.9 percent (Lyder & Ayello, *Pressure Ulcers: A Patient Safety Issue*, 2008). Over \$355 million dollars is spent treating pressure ulcers in nursing facilities each year, about 2.5 times the cost of prevention.

Findings

- Residents were less likely to have developed a pressure ulcer than in previous years.

	2009	2010	2013
Residents with a pressure ulcer	9%	8%	7%

Figure 16 - Any pressure ulcer, regardless of stage



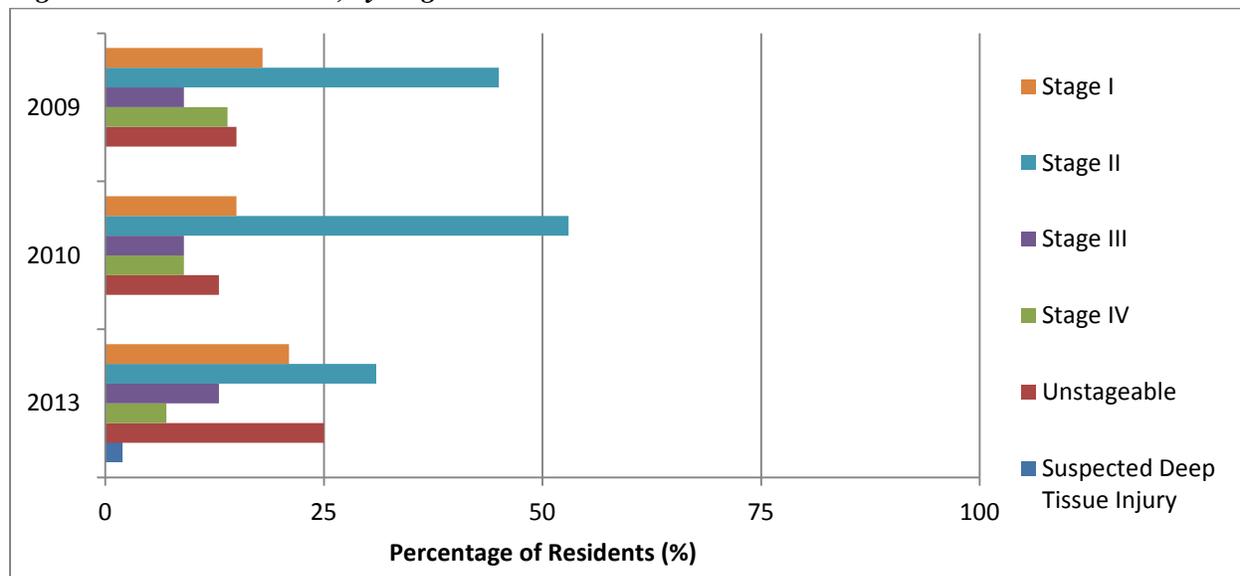
Pressure ulcers are staged or categorized by the degree of injury to the skin and underlying tissues, ranging from reddened, but intact skin (Stage I) to an open wound that exposes bone and or cartilage (Stage IV). In some situations, the degree of injury may be difficult to assess; those wounds are categorized as Unstageable or as Suspected Deep Tissue Injury.

Findings

- In 2013, the most frequently identified pressure ulcers were Stage II.²¹
- More residents had Stage I and Stage III pressure ulcers than in previous years.
- Residents were less likely to have a Stage IV pressure ulcer than in previous years.
- More residents had an Unstageable pressure ulcer than in previous years.²²
- In 2013, a few residents had areas of suspected deep tissue injury. Information on suspected deep tissue injury was not gathered prior to 2013.

	2009	2010	2013
Of residents with a pressure ulcer, percentage with Stage I pressure ulcers	18%	15%	21%
Of residents with a pressure ulcer, percentage with Stage II pressure ulcers	45%	53%	31%
Of residents with a pressure ulcer, percentage with Stage III pressure ulcers	9%	9%	13%
Of residents with a pressure ulcer, percentage with Stage IV pressure ulcers	14%	9%	7%
Of residents with a pressure ulcer, percentage with Unstageable pressure ulcers	15%	13%	25%
Of residents with a pressure ulcer, percentage with suspected deep tissue injury	n/a	n/a	2%

Figure 17 - Pressure ulcers, by stage



Psychoactive Medications

Psychoactive medications act on the central nervous system, causing changes in mood, behavior, cognition or consciousness. Antipsychotics, anti-anxiety medications (anxiolytics), sedatives and hypnotics are all examples of psychoactive medications.

²¹ Statistically significant linear trend at $p < 0.1$.

²² Statistically significant linear trend at $p < 0.1$.

Antipsychotic Medications

Antipsychotic medications include:

- Typical or first generation antipsychotics, such as haloperidol, chlorpromazine and loxapine.
- Atypical or second generation antipsychotics, such as risperidone, olanzapine and quetiapine.

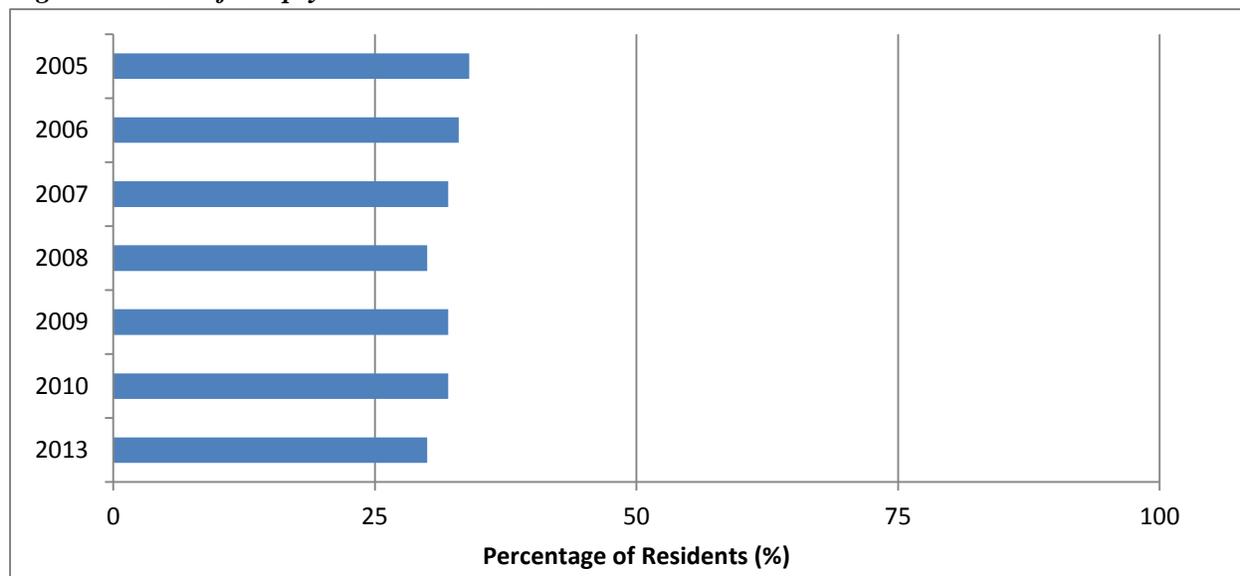
Antipsychotic medications have been approved by the U.S. Food and Drug Administration (FDA) for the treatment of psychiatric disorders such as schizophrenia and bipolar disorder. In 2005, the FDA issued a “black box warning” (the strongest FDA warning) noting an increased risk of death in older adults with dementia when taking atypical antipsychotics. In 2008, the warning was expanded to include typical antipsychotics as well.

Findings

- Fewer residents were receiving an antipsychotic medication than in previous years.

	2005	2006	2007	2008	2009	2010	2013
Residents who were receiving at least one antipsychotic medication	34%	33%	32%	30%	32%	32%	30%

Figure 18 - Use of antipsychotic medications



In March 2012, CMS launched the National Partnership to Improve Dementia Care, a coalition of providers across the nation working to reduce the inappropriate use of antipsychotic medications and improve the care provided to residents with dementia. While Texas has seen a reduction in antipsychotic use since the partnership was introduced, it is ranked 51st in the nation for the inappropriate use of antipsychotic medications in nursing homes (CMS, *Fact Sheets: Data Show National Partnership to Improve Dementia Care Exceeds Goals to Reduce Unnecessary Antipsychotic Medications in Nursing Homes*, 2014).

Antipsychotic medications are not an appropriate intervention for treating the behavioral or psychological symptoms of dementia and have never been an FDA-approved therapy for managing dementia-related behaviors. Currently CMS recognizes the following diagnoses as the only appropriate indications for antipsychotic medication use in nursing facility residents:

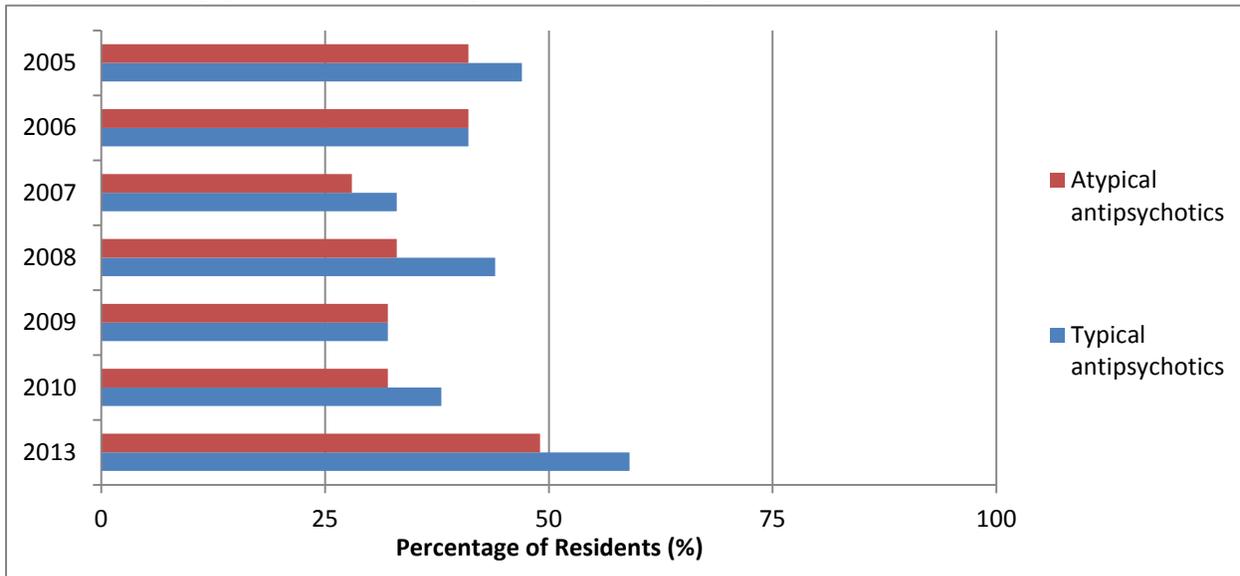
- Schizophrenia, schizo-affective disorder or schizophreniform disorder
- Delusional disorder
- Mood disorders, including bipolar disorder
- Psychosis, in the absence of dementia
- Medical illness with psychotic symptoms
- Huntington’s disease
- Tourette’s syndrome
- Hiccups, not brought on by other medications
- Nausea and vomiting associated with cancer or chemotherapy

Findings

- Of those residents who were prescribed atypical antipsychotic medications, nearly half were given those medications to manage dementia-related behavior.
- Of those residents who were prescribed typical antipsychotic medications, over half were given those medications to manage dementia-related behavior.

	2005	2006	2007	2008	2009	2010	2013
Of residents who were prescribed antipsychotics, those who were given atypical antipsychotics to manage dementia-related behavior	41%	41%	28%	33%	32%	32%	49%
Of residents who were prescribed antipsychotics, those who were given typical antipsychotics to manage dementia-related behavior	47%	41%	33%	44%	32%	38%	59%

Figure 19 - Antipsychotic medications prescribed to manage dementia-related behavior



Anti-anxiety Medications

Anxiety is a general term that covers a number of psychiatric disorders, including generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder and specific phobias. Over 15 percent of adults 60 years of age or older are diagnosed with an anxiety disorder in any given year, with women more likely to be affected than men (National Institutes of Mental Health [NIMH], *Statistics: Prevalence of Any Anxiety Disorder Among Adults*, 2014).

Findings

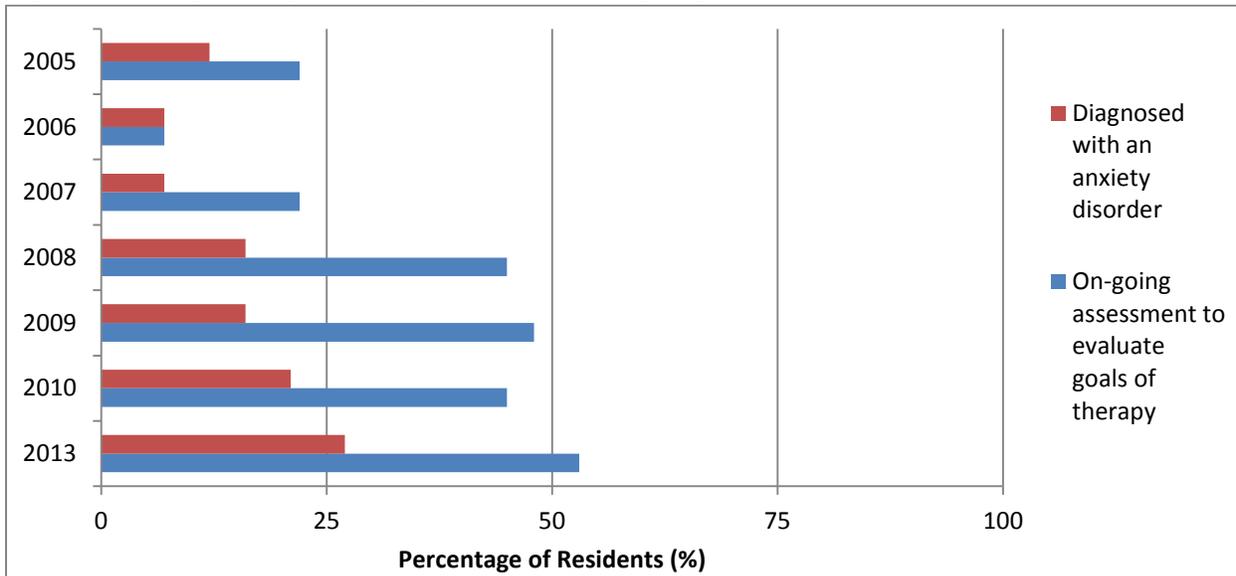
- Residents were more likely to be diagnosed with an anxiety disorder than in previous years.²³
- Of those residents who had been diagnosed with an anxiety disorder, more than half were reassessed at least every two weeks to evaluate the goals of therapy.²⁴

	2005	2006	2007	2008	2009	2010	2013
Residents diagnosed with an anxiety disorder	12%	7%	7%	16%	16%	21%	27%
Residents with an anxiety disorder who had on-going assessment to evaluate goals of therapy	22%	7%	22%	45%	48%	45%	53%

²³ Statistically significant linear trend at $p < 0.1$.

²⁴ Statistically significant linear trend at $p < 0.1$.

Figure 20 - Diagnosis of an anxiety disorder and on-going assessment



Anti-anxiety medications are often prescribed, but may not always be the best choice as the first line treatment for an anxiety disorder. Nursing facility residents tend to have multiple medical conditions and receive a number of medications, increasing the potential for adverse drug reactions. Non-pharmaceutical treatments, including psychotherapy, have been found to be useful in treating anxiety disorders (NIMH, *Anxiety Disorders*, 2014).

The percentage of residents diagnosed with an anxiety disorder was based on NFQR 2013 data, while the percentage receiving anti-anxiety medications was based on self-reported CMS data from nursing facilities. The data, methodology and sample population were different for the percentage diagnosed with an anxiety disorder and those receiving anti-anxiety medications. Given the different methodology and sampling techniques used by each, no inferences should be drawn between Figures 20 and 21.

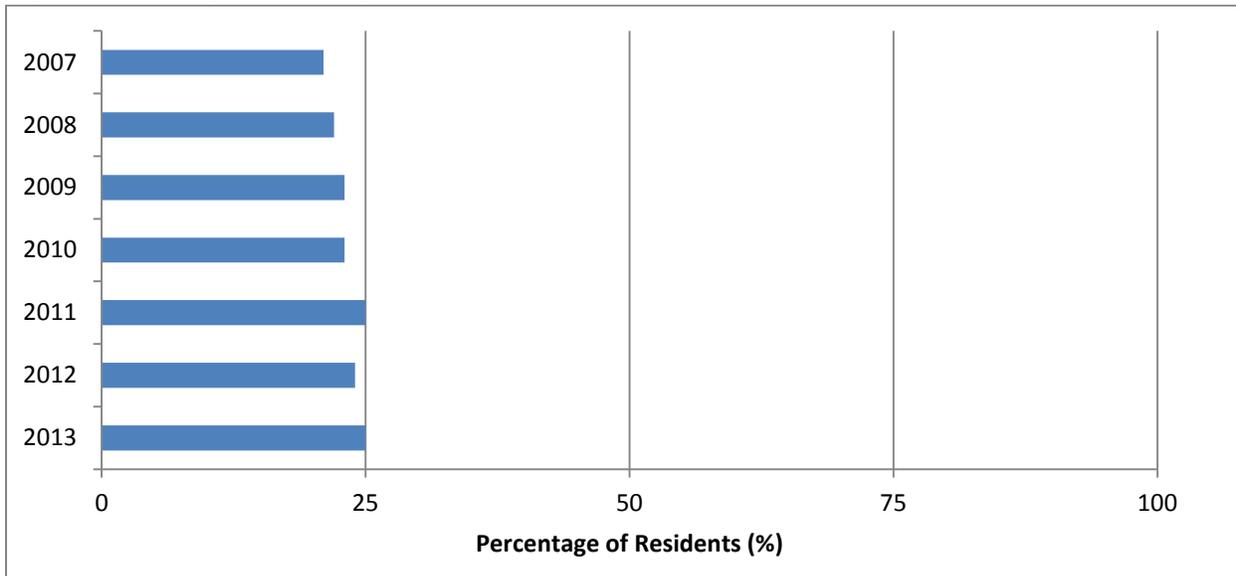
Findings

- Residents were more likely to be receiving anti-anxiety medications than in previous years.²⁵

	2007	2008	2009	2010	2011	2012	2013
Residents receiving anti-anxiety medications	21%	22%	23%	23%	25%	24%	25%

²⁵ Statistically significant linear trend at $p < 0.1$.

Figure 21 - Use of anti-anxiety medications



Sedative and Hypnotic Medications

With aging, complaints of sleep disturbances become more common. Over 50 percent of adults 65 years of age or older report problems with sleep, including difficulty getting to sleep, trouble staying asleep and feeling tired after waking (Subramanian & Surani, *Sleep Disorders in the Elderly*, 2007). A number of factors can contribute to sleep disturbances in older adults, including pain, depression, dementia, certain medications and stimulants such as caffeine.

Sedative and hypnotic medications are frequently prescribed for residents who have problems with sleep, but these drugs can have undesirable side effects and increase the risk of falls and fractures. Sedatives and hypnotics should be used only for short periods of time, and at lower doses than those given to younger adults. Non-drug interventions should be attempted first, including managing environmental and other factors that could interfere with sleep (e.g., sleep hygiene).

Findings

- Residents were more likely to have trouble sleeping than in previous years.²⁶
- Residents were more likely to be evaluated for sleep hygiene than in previous years.²⁷
- Residents were more likely to have an active prescription for sleep medication than in previous years.²⁸

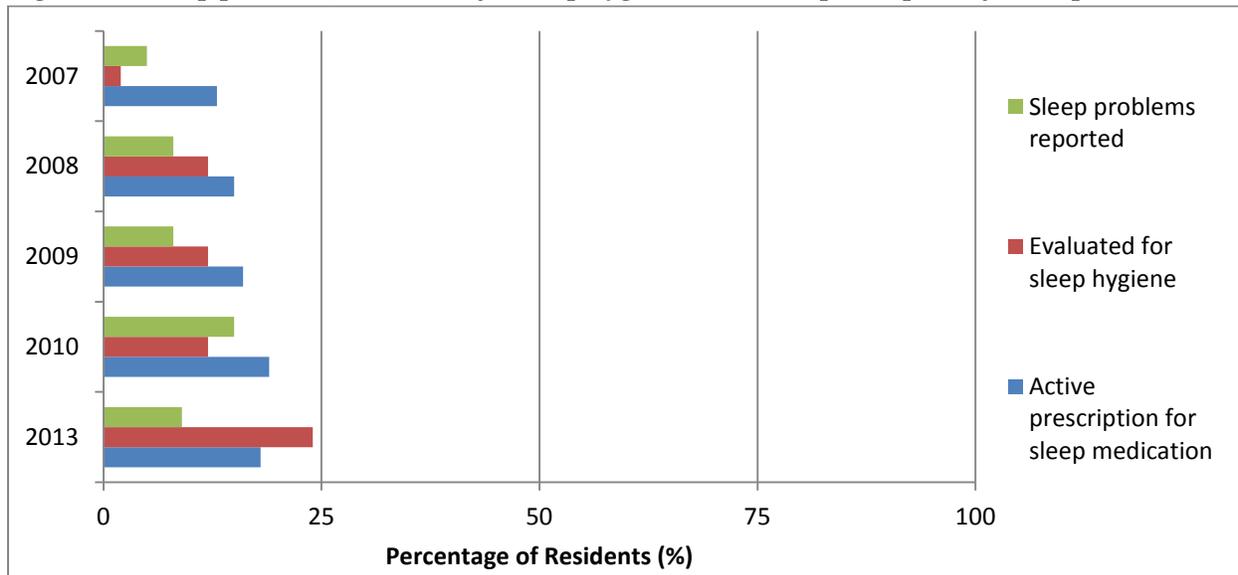
	2007	2008	2009	2010	2013
Residents who reported sleeping problems	5%	8%	8%	15%	9%
Residents who were evaluated for sleep hygiene	2%	12%	12%	12%	24%
Residents who had an active prescription for sleep medication	13%	15%	16%	19%	18%

²⁶ Statistically significant linear trend at $p < 0.1$.

²⁷ Statistically significant linear trend at $p < 0.1$.

²⁸ Statistically significant linear trend at $p < 0.1$.

Figure 22 - Sleep problems, evaluation for sleep hygiene and active prescriptions for sleep medication



Restraints

Physical restraints are any device or practice that restrict a resident’s freedom of movement or that prevents the resident from accessing any part of his or her body, and that the resident cannot easily remove without assistance (CMS, *State Operations Manual, 2014*). Devices that can be used as physical restraints include seat belts or other waist restraints; tray tables attached to wheel chairs; wrist restraints or hand mitts; and bed rails.

Chemical restraints are psychoactive medications used to manage behavioral symptoms that are distressing to the resident, other residents or facility staff without addressing the underlying cause of the behavior (CMS, *State Operations Manual, 2014*).

Findings

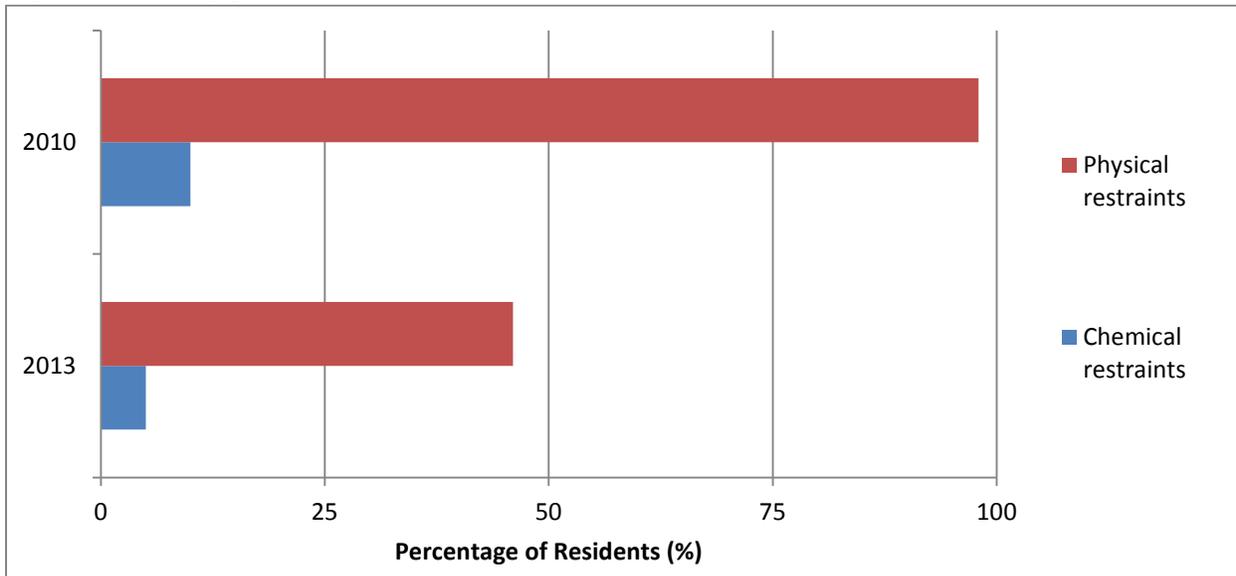
- Residents were less likely to be physically restrained than in previous years.²⁹
- Residents were less likely to be chemically restrained than in previous years.³⁰

	2010	2013
Residents who were physically restrained in some manner, including use of bed rails	98%	46%
Residents who were chemically restrained	10%	5%

²⁹ Statistically significant linear trend at $p < 0.1$.

³⁰ Statistically significant linear trend at $p < 0.1$.

Figure 23 - Use of physical or chemical restraints



Physical restraints have been used for many years, generally for safety purposes, including prevention of falls, management of wandering and assistance with positioning. More recently, research has shown that restraints do not prevent falls and that residents are more likely to be seriously injured if they fall while restrained. Other, more appropriate interventions are available to manage these issues. A number of poor outcomes have been linked to the use of physical restraints, including depression, agitation, incontinence, pressure ulcers and even death.

Findings

- Bedrails were the most frequently used physical restraint in 2013; however fewer residents had full bedrails in use than in previous years.³¹
- Other types of bedrails (i.e., partial bedrails) were used more frequently than in previous years.³²
- The use of trunk and limb restraints decreased from previous years.
- Fewer residents were placed in a chair that prevented rising.³³

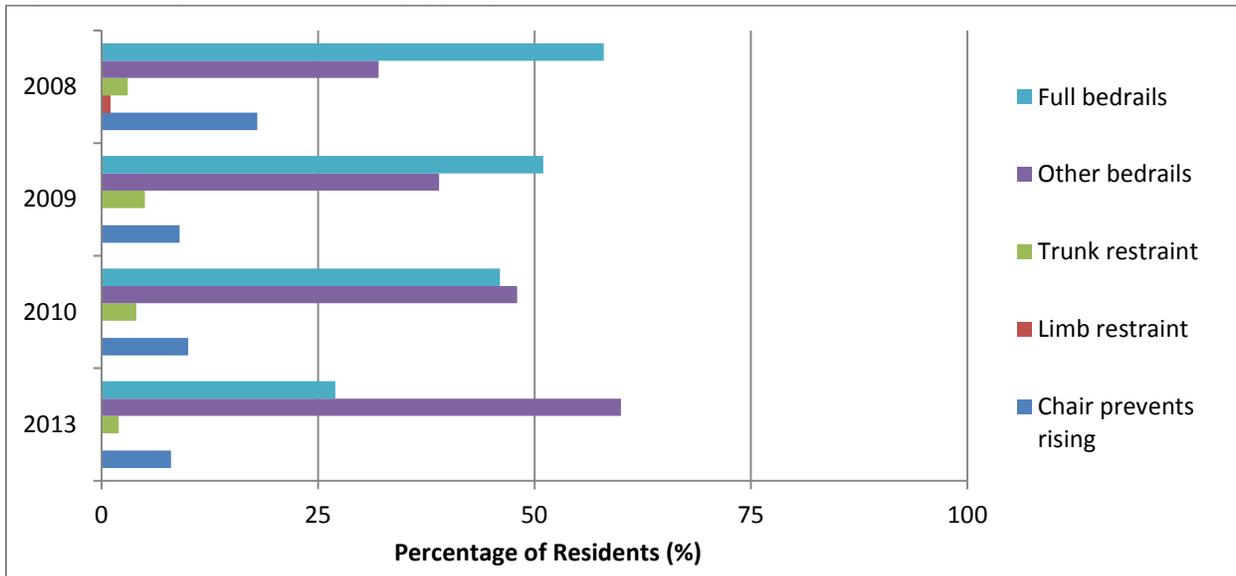
	2008	2009	2010	2013
Residents with full bed rails in use	58%	51%	46%	27%
Residents with other bedrails in use	32%	39%	48%	60%
Residents with trunk restraints in use	3%	5%	4%	2%
Residents with limb restraints in use	1%	<1%	<1%	<1%
Residents placed in a chair that prevents rising	18%	9%	10%	8%

³¹ Statistically significant linear trend at $p < 0.1$.

³² Statistically significant linear trend at $p < 0.1$.

³³ Statistically significant linear trend at $p < 0.1$.

Figure 24 - Physical restraints, by type of device



Even if used to treat valid medical conditions, psychoactive medications can have serious side effects. When used as chemical restraints, the risks of these medications are not offset by any benefit to the resident. The risks associated with these medications can include increased agitation, confusion, excessive sedation, loss of appetite, social isolation and a higher potential for falls.

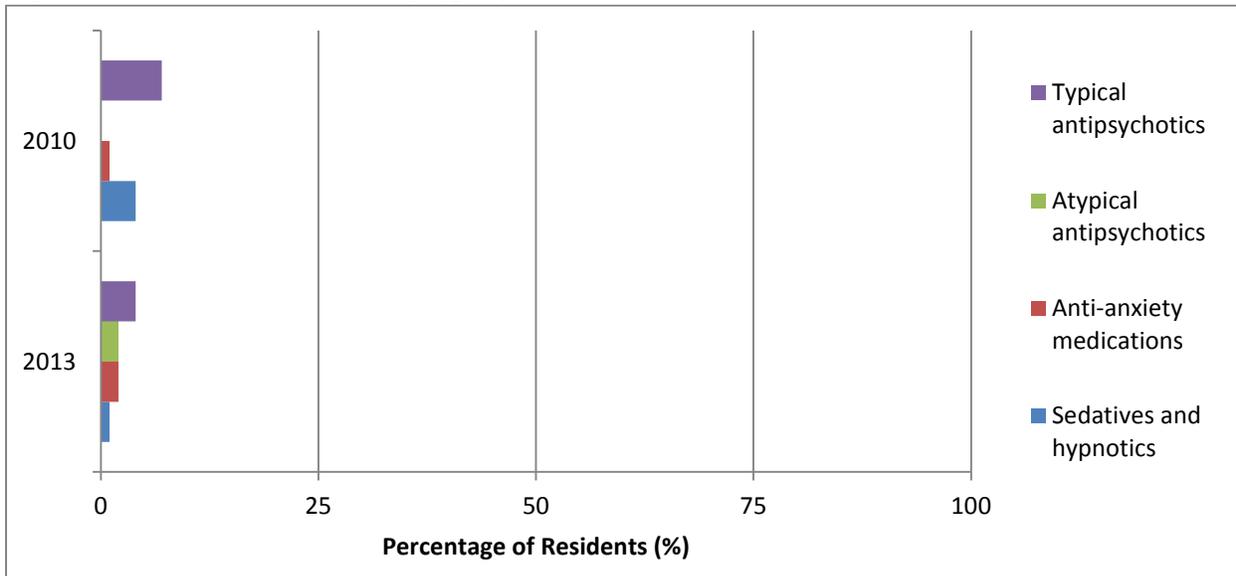
Findings

- Typical antipsychotics were the medications most frequently used as chemical restraints in 2013; however residents were less likely to be given a typical antipsychotic as a chemical restraint than in 2010.
- Residents were more likely to receive an atypical antipsychotic or an anti-anxiety medication as a chemical restraint than in 2010.
- Fewer residents were given a sedative or hypnotic medication as a chemical restraint than in 2010.³⁴

	2010	2013
Residents who were given typical antipsychotics as a chemical restraint	7%	4%
Residents who were given atypical antipsychotics as a chemical restraint	<1%	2%
Residents who were given anti-anxiety medications as a chemical restraint	1%	2%
Residents who were given sedatives or hypnotics as a chemical restraint	4%	1%

³⁴ Statistically significant linear trend at $p < 0.1$.

Figure 25 - Chemical restraints, by type of medication

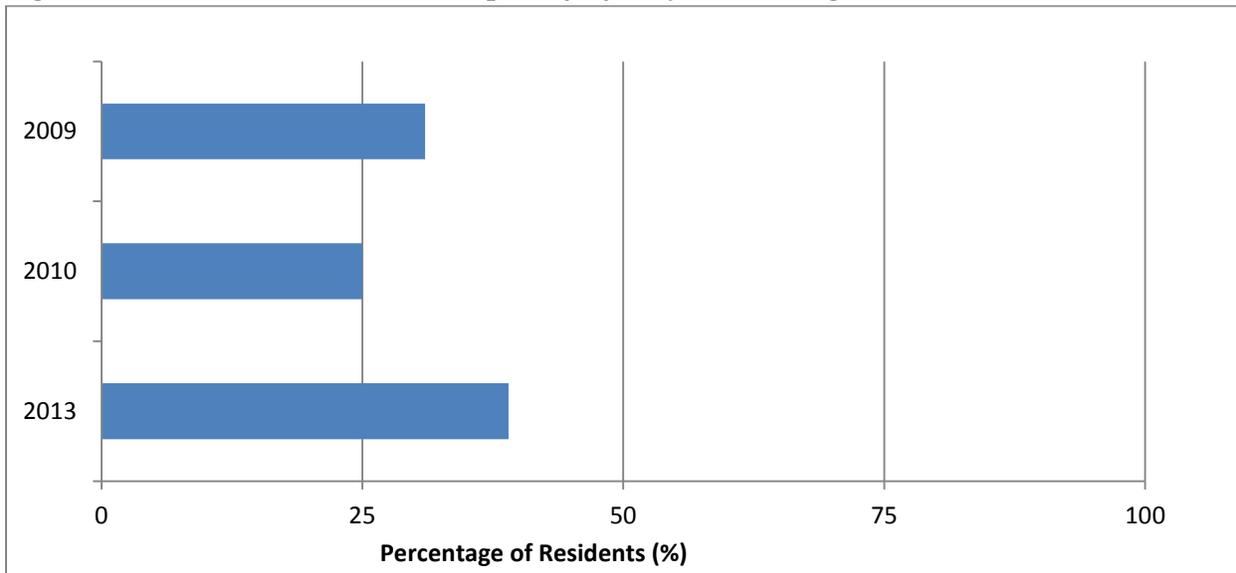


Findings

- Residents were more likely to be restrained at the request of a family member or guardian than in previous years.³⁵

	2009	2010	2013
Residents restrained at the request of a family member or responsible party	31%	25%	39%

Figure 26 - Restraints initiated at the request of a family member or guardian



³⁵ Statistically significant linear trend at $p < 0.1$.

Urinary Continence

Urinary incontinence, or loss of bladder control, affects nearly 60 percent of all nursing facility residents in the United States (AMDA, *Urinary Incontinence in the Long Term Care Setting*, 2012). Incontinence is not a normal part of the aging process, but is often related to underlying issues including chronic medical conditions, dementia, mobility impairments and some medications.

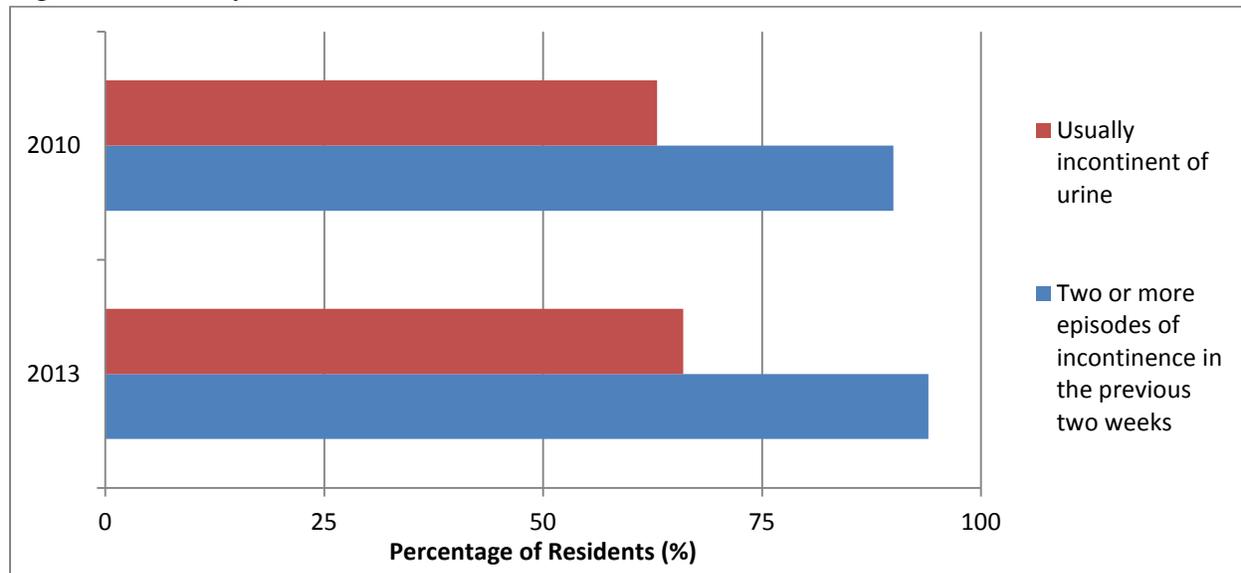
Incontinence often plays a part in the decision to pursue nursing facility placement and can increase the risk of falls, fractures and skin breakdown. Residents with incontinence are often reluctant to participate in activities, leading to social isolation (AMDA, 2012).

Findings

- The majority of residents in the sample were usually incontinent.
- Of those residents who were usually incontinent, most had two or more episodes in the previous two weeks.³⁶

	2010	2013
Residents who were usually incontinent of urine	63%	66%
Residents who were incontinent of urine and had two or more episodes of incontinence in the previous two weeks	90%	94%

Figure 27 - Urinary incontinence



Any plan for treating incontinence should be based on a thorough assessment of the resident, identifying any underlying problems. Continence promotion plans must be individualized and have measurable goals, such as a complete reversal of incontinence or a decrease in the number of incontinent episodes. The primary goal of any continence promotion plan is to improve the resident's quality of life (AMDA, 2012).

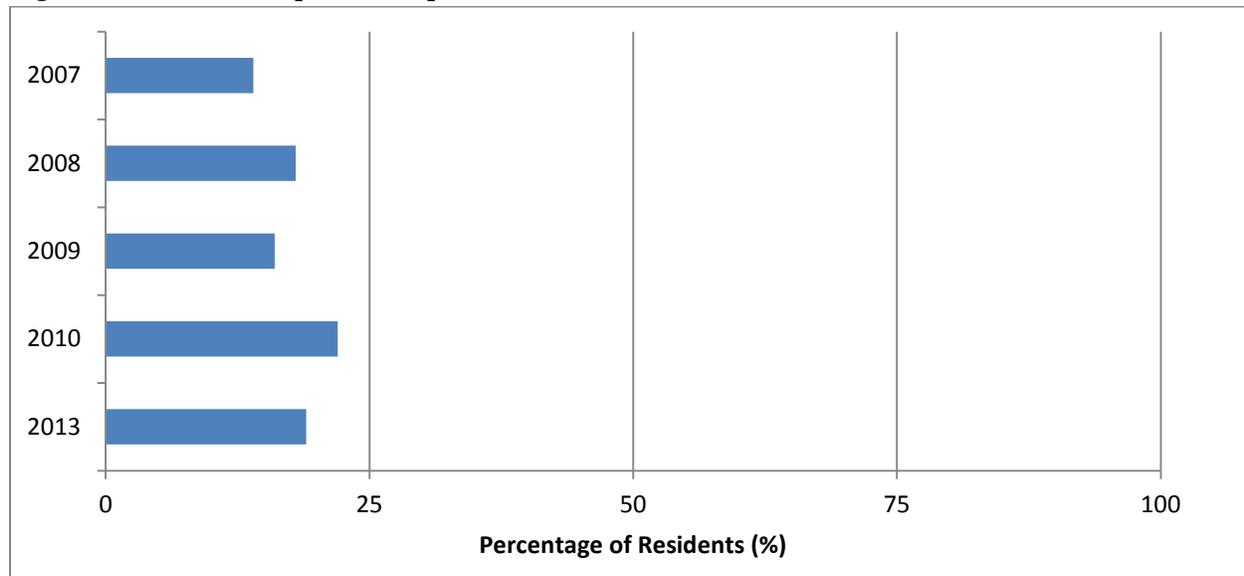
³⁶ Statistically significant linear trend at $p < 0.1$.

Findings

- Residents were more likely to have a continence promotion (toileting) plan than in previous years.³⁷

	2007	2008	2009	2010	2013
Residents with a continence promotion plan	14%	18%	16%	22%	19%

Figure 28 - Continence promotion plans



Quality of Life/Consumer Satisfaction

Quality of life is a subjective measurement of residents' experiences in the nursing facility and their ability to enjoy the normal activities of life. Quality of life addresses not only concerns regarding health status and medical treatment, but also the residents' satisfaction with relationships, activities, autonomy, privacy, dining and feelings of safety/security at the facility.

Information for this section of the survey was gathered from the residents through a face-to-face interview. If the resident was unable to participate, a family member or guardian was contacted to complete the questions regarding overall satisfaction with their experience in the facility and the health care services received. In some cases, neither the resident nor a family member/guardian was able to complete this portion of the survey.

Findings – Food and Dining Services

- Most of the residents stated they liked the food served at the facility.³⁸
- Over half of the residents stated their favorite foods were available at the facility.
- Most of the residents stated they enjoyed mealtimes at the facility.³⁹

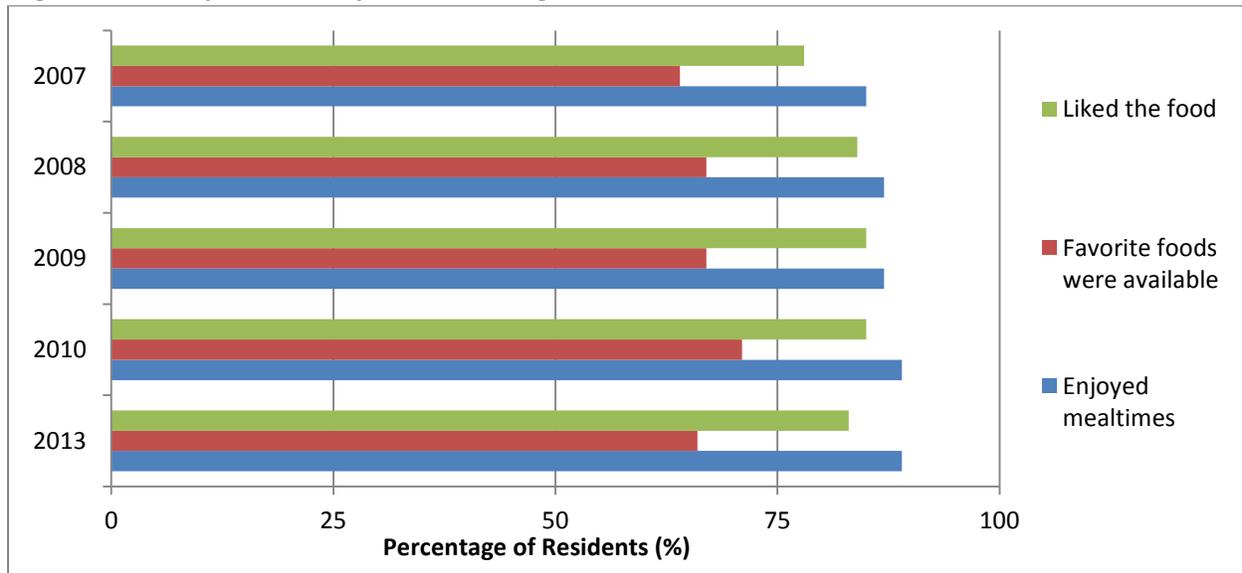
³⁷ Statistically significant linear trend at $p < 0.1$.

³⁸ Statistically significant linear trend at $p < 0.1$.

³⁹ Statistically significant linear trend at $p < 0.1$.

	2007	2008	2009	2010	2013
Residents who stated they liked the food at the facility	78%	84%	85%	85%	83%
Residents who stated their favorite foods were available	64%	67%	67%	71%	66%
Residents who stated they enjoyed mealtimes	85%	87%	87%	89%	89%

Figure 29 - Satisfaction with food and dining services



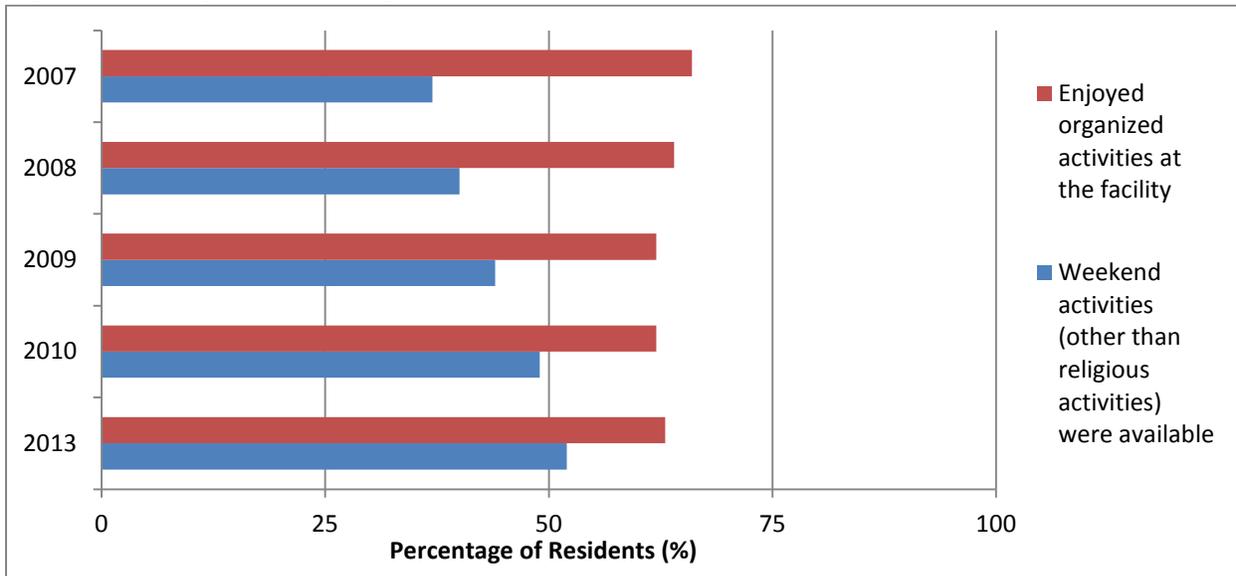
Findings – Activities

- The majority of residents stated they enjoyed the organized activities offered at the facility.
- More residents stated weekend activities (other than religious activities) were available at the facility than in previous years.⁴⁰

	2007	2008	2009	2010	2013
Residents who stated they enjoyed organized activities at the facility	66%	64%	62%	62%	63%
Residents who stated weekend activities (other than religious activities) were available	37%	40%	44%	49%	52%

⁴⁰ Statistically significant linear trend at $p < 0.1$.

Figure 30 - Satisfaction with organized activities

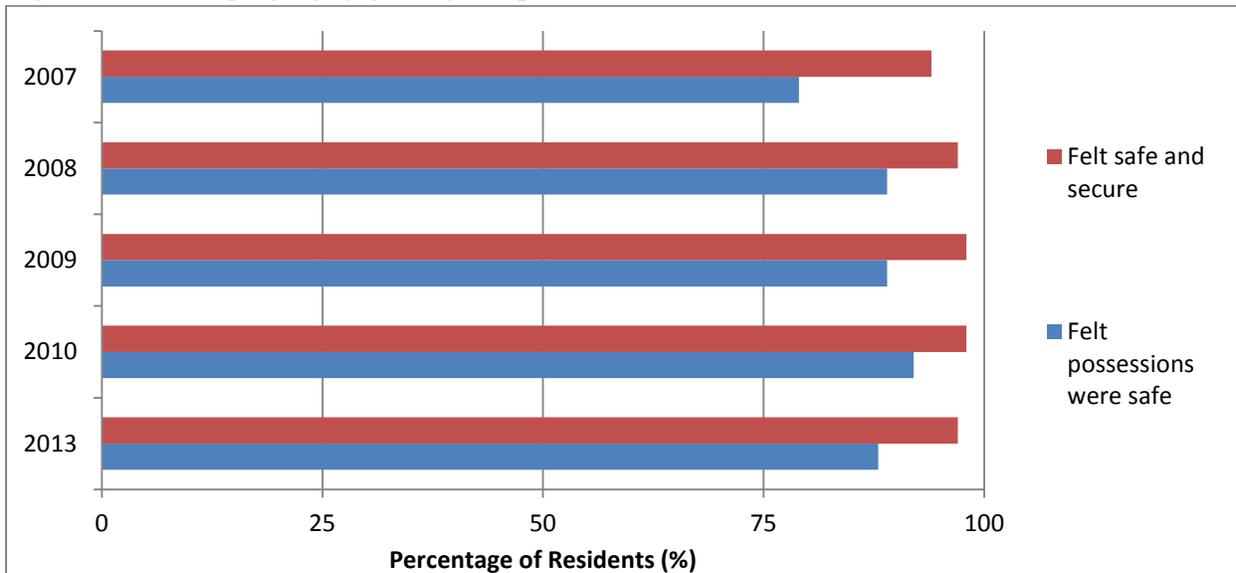


Findings - Safety

- Most residents stated they felt safe and secure at the facility.⁴¹
- Most residents stated they felt their possessions were safe at the facility.⁴²

	2007	2008	2009	2010	2013
Residents who stated they felt safe and secure	94%	97%	98%	98%	97%
Residents who stated they felt their possessions were safe	79%	89%	89%	92%	88%

Figure 31 - Feelings of safety, for self and possessions



⁴¹ Statistically significant linear trend at $p < 0.1$.

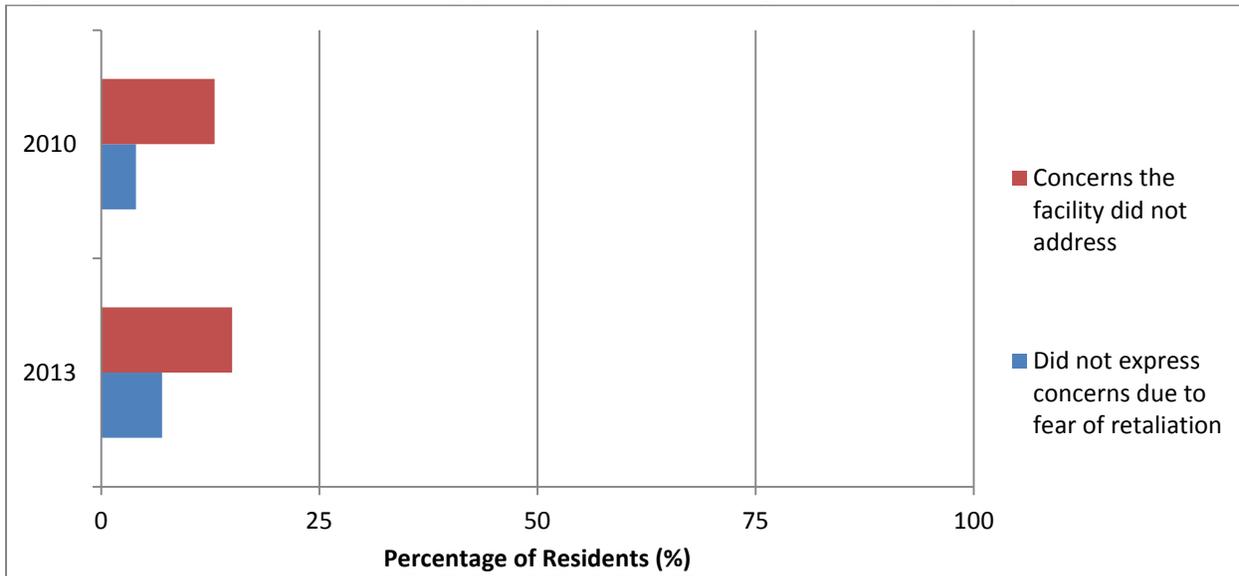
⁴² Statistically significant linear trend at $p < 0.1$.

Findings – Addressing Concerns

- Some of the residents interviewed stated they had concerns the facility did not address.
- More residents stated they did not express concerns due to a fear of retaliation than in 2010.⁴³

	2010	2013
Residents who had concerns the facility did not address	13%	15%
Residents who had concerns they did not express due to the fear of retaliation	4%	7%

Figure 32 - Concerns not addressed by facility, concerns not expressed due to fear of retaliation



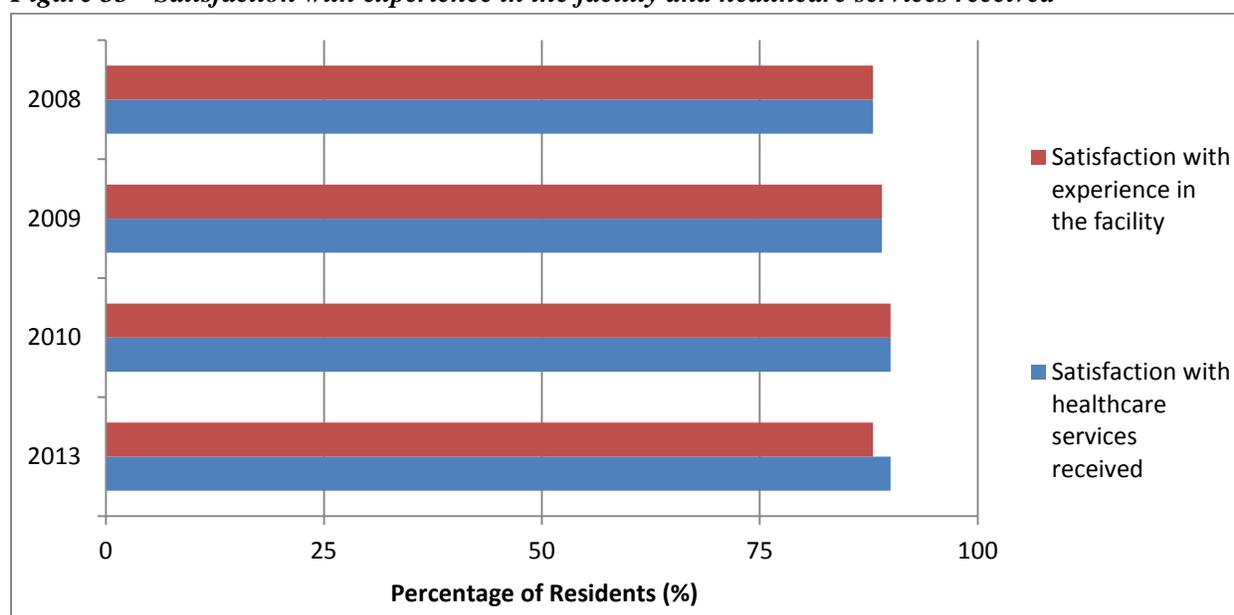
Findings – Overall Satisfaction

- Most of the residents expressed satisfaction with their experience in the facility.
- Most of the residents expressed satisfaction with the healthcare services they received.

	2008	2009	2010	2013
Residents who expressed satisfaction with their experience in the facility	88%	88%	90%	88%
Residents who expressed satisfaction with the healthcare services they received in the facility	88%	89%	90%	90%

⁴³ Statistically significant linear trend at $p < 0.1$.

Figure 33 - Satisfaction with experience in the facility and healthcare services received



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Appendix B - NFOR 2013 Survey Instrument with Results

**Department of Aging and Disability Services
2013
Nursing Facility Quality Review
Resident Assessment**

Instructions: CHOOSE ONLY ONE ANSWER FOR EACH QUESTION that offers a choice of responses. Please print clearly.

 -signifies the resident is asked the question.

Part 1. Identifying Information

1.1 Date of Assessment ____ / ____ / 2013
(M) (D)

1.2 Facility ID Number _____

1.3 Quality Review Nurse's Identifier Number _____

1.4 Resident's DADSID Number _____

1.5 Admission Date ____ / ____ / ____ (Average days in facility 452)
(M) (D) (Year)

1.6 Resident's Date of Birth ____ / ____ / ____ (Average age 79 years)
(M) (D) (Year)

1.7 Resident's Gender ¹ Male (31.8%) ² Female (68.2%)

1.8 What is the resident's race/ethnicity?

- ¹ Hispanic/Latino (17%)
- ² White (69%)
- ³ Black or African-American (13%)
- ⁴ Asian (<1%)
- ⁵ American Indian/Alaska Native (<1%)
- ⁶ Native Hawaiian/Other Pacific Islander (<1%)
- ⁷ Other (<1%)

1.9 What is the resident's height? ____ feet ____ inches (Mean 64.8 inches/5 ft 4.8 in)

1.10 What is the resident's weight? _____ pounds (Mean 159.43 lbs)

BMI Categories (Mean 26.6522)
Underweight (9.0%) Overweight (25.8%)
Normal (38.8%) Obese (26.4%)

1.11 What is the resident's blood pressure? ____/____. (Mean 128.05/71.31)

1.12 What is the resident's most recent serum glucose (2013)? _____ mg/dl (Mean 106.30)

1.13 What is the resident's most recent lipid profile (2012-2013)?

Cholesterol _____ mmol/L or _____ no test done (Mean 150.63)

LDL _____ mmol/L or _____ no test done (Mean 83.11)

HDL _____ mmol/L or _____ no test done (Mean 43.13)

Triglycerides _____ mmol/L or _____ no test done (Mean 125.61)

1.14 Is this resident receiving hospice or palliative services?

¹ Yes (11%)

² No (89%)

1.15 Does this resident have a diagnosis of Alzheimer's Disease, dementia or cognitive impairment?

¹ Yes (67.7%)

² No (32.3%)

NOTE:

For all questions in Parts 2 through 16, with a few exceptions that are noted explicitly in the guidance, each question is meant to be answered independently of all other questions.

Part 2. Assessment of Urinary Continence

NOTE: Perform a continence check (ITEM 2.1) on every resident in the sample prior to collecting the remaining data items for any resident.

2.1 Did you find (see, smell, or feel) evidence of urinary incontinence?

¹ Yes (39.8%)

² No (60.2%)

2.2 Is the resident usually continent *without needing* a toileting plan, incontinence products or a catheter?

¹ Yes (34.3%)

² No (65.7%)

----- If item 2.2 was answered YES, then skip to Part 3 -----

2.3 Have there been two or more episodes of urinary incontinence each week in the last two weeks?

¹ Yes (94.4%)

² No (5.6%)

2.4 Does the resident have a terminal condition or palliative plan of care and declines to participate in a continence promotion plan (toileting)?

- ¹ Yes (12.1%) ² No (87.9%)

2.5 Is a continence promotion plan (toileting plan) (prompted voiding-PV, scheduled voiding-SV or bladder retraining-BR) specifically documented as part of the resident's care plan?

(NOTE: If more than one applies, answer with first answer from the list that applies to this resident)

- ¹ Yes-PV (6.5%) ² Yes-SV (11.4%) ³ Yes-BR (0.7%)
 ⁴ No (81.4%)

2.6 Is the plan based on the resident's voiding pattern and needs?

- ¹ Yes (15.8%) ² No (5.2%) ³ There is no plan (79.0%)

2.7 Does the resident refuse to follow their continence promotion plan?

- ¹ Most of the time (1.8%) ² Sometimes (3.9%)
 ³ Almost never (13.8%) ⁸ No plan (80.5%)

 **2.8 (Ask the resident) Do you ever refuse help to use the bathroom when you need to?**

- ¹ Yes (2.5%) ² No (43.2%) ³ No response (54.2%)

-----If item 2.8 was answered NO, then skip to Part 3 -----

 **2.9 (Ask the resident) Is this because help is offered when it's not convenient for you?**

- ¹ Yes (3.1%) ² No (11.6%) ³ No response (85.3)

Part 3. Pressure Ulcers

3.1 Does the resident have risk factors for a pressure ulcer? (Questions 3.1 and 3.3 MUST BE ANSWERED. Question 3.2 MUST BE ANSWERED when the answer to question to 3.1 is YES. Questions 3.4 through 3.7 MUST BE ANSWERED when the answer to question to 3.3 is 1 or more.)

- ¹ Yes (71.4%) ² No (28.4%)

-----If item 3.1 was answered NO, then skip to 3.3. -----

3.2 Does the resident have a treatment plan to address his/her risks for pressure ulcers? (check yes or no for each option):

- | | |
|--|--|
| 1 Bedridden and repositioned every 2 hours? | <input type="radio"/> ¹ Yes (31%) |
| | <input type="radio"/> ² No (69%) |
| 2 In chair and able to self shift weight every 15 minutes? | <input type="radio"/> ¹ Yes (40.3%) |
| | <input type="radio"/> ² No (59.7%) |
| 3 In chair and repositioned by staff every 1 hour? | <input type="radio"/> ¹ Yes (17.9%) |
| | <input type="radio"/> ² No (82.1%) |

- | | |
|--|--|
| 4. Pressure-reducing mattress on bed | <input type="radio"/> ¹ Yes (72.6%) |
| | <input type="radio"/> ² No (27.4%) |
| 5. Pressure-reducing device in chair | <input type="radio"/> ¹ Yes (49.9%) |
| | <input type="radio"/> ² No (50.1%) |
| 6. Heels floated off mattress surface | <input type="radio"/> ¹ Yes (21.8%) |
| | <input type="radio"/> ² No (78.2%) |
| 7. Incontinence care protocol | <input type="radio"/> ¹ Yes (73%) |
| | <input type="radio"/> ² No (27%) |
| 8. Other _____ | <input type="radio"/> ¹ Yes (16.9%) |
| | <input type="radio"/> ² No (83.1%) |
| 9. There is no plan (not in chart or treatment book) | <input type="radio"/> ¹ Yes (26.7%) |
| | <input type="radio"/> ² No (73.3%) |

3.3 How many pressure ulcers does the resident have? _____

-----If 3.3 is 0 (zero), then skip to Part 4-----

3.4 How many pressure ulcers have a treatment plan? _____

3.5 When was a pressure ulcer first noticed (If there are multiple pressure ulcers, check all that apply)?

- | | |
|--|--|
| <input type="radio"/> ¹ Admission (36.3%) | <input type="radio"/> ² Readmission (10%) |
| <input type="radio"/> ³ Developed while in facility (52.5%) | |

3.6 What is the highest stage pressure ulcer present?

- | | |
|--|--|
| <input type="radio"/> ¹ Stage 1 (21.2%) | <input type="radio"/> ⁴ Stage 4 (7.1%) |
| <input type="radio"/> ² Stage 2 (31.4%) | <input type="radio"/> ⁵ Unstageable (25%) |
| <input type="radio"/> ³ Stage 3 (13.5%) | <input type="radio"/> ⁶ Suspected Deep Tissue Injury (1.9%) |

3.7 How long has the resident had the highest stage pressure ulcer?

_____ days (Mean 68.23 days)

Part 4. Infectious Illnesses

4.1 Has the resident had a urinary tract infection at any time in the last 30 days?

- | | |
|--|--|
| <input type="radio"/> ¹ Yes-MRSA (0.2%) | <input type="radio"/> ⁴ Yes-Other (11.8%) |
| <input type="radio"/> ² Yes-VRE (0.1%) | <input type="radio"/> ⁵ No (88.2%) |
| <input type="radio"/> ³ Yes-CRE (0.1%) | |

4.2 Has the resident had a skin or wound infection at any time in the last 30 days?

- | | |
|--|---|
| <input type="radio"/> ¹ Yes-MRSA (1.1%) | <input type="radio"/> ⁴ Yes-Other (2.5%) |
| <input type="radio"/> ² Yes-VRE (0%) | <input type="radio"/> ⁵ No (94.8%) |
| <input type="radio"/> ³ Yes-CRE (0%) | |

4.3 Has the resident had pneumonia at any time in the last 30 days?

- ¹ Yes-MRSA (0.1%) ⁴ Yes-Other (2.5%)
 ² Yes-VRE (0%) ⁵ No (99.3%)
 ³ Yes-CRE (0%)

4.4 Has the resident had bacterial diarrhea at any time in the last 30 days?

- ¹ Yes-MRSA (0%) ⁴ Yes-Other (0.2%)
 ² Yes-VRE (0%) ⁵ Yes-C.Diff (0.5%)
 ³ Yes-CRE (0%) ⁶ No (99.3%)

4.5 Was a culture and sensitivity obtained prior to initiating antibiotics?

- ¹ Yes (12%) ² No (88%)

4.6 Was the organism identified by C&S susceptible to the antibiotic ordered?

- ¹ Yes (12%) ² No (88%)

-----If item 4.6 was answered YES, then skip to Part 5. -----

4.7 If question 4.6 is “no”, was the antibiotic changed based on the C&S findings?

- ¹ Yes (2%) ² No (98%)

Part 5. Pain Assessment

All questions in this Section MUST BE ANSWERED.

5.1 Is a validated behavioral pain scale being used by the facility staff to assess the cognitively and/or verbally impaired resident’s pain? (e.g., PAINAD, DS-DAT [Discomfort Scale for Dementia of the Alzheimer’s Type] Pain Scale)

- ¹ Yes (78.4%) ² No (21.6%)

5.2 Is a self-reporting validated pain intensity scale used by the facility staff to assess the cognitively and verbally intact resident’s pain? (e.g., 0-10 or 0-5 verbal or numeric rating scale, 0-10 Pain thermometer; Iowa Pain thermometer; Faces Pain Scale-Revised)

- ¹ Yes (86.8%) ² No (13.2%)

5.3 According to the last 7 days of documentation in the clinical record, what has the resident’s most severe level of pain been? (Note: *Unable to determine* means that the clinical record does not show any evidence of a pain scale used to determine the level of pain.)

- Score _____ (Mean 1.74) Unable to determine

5.4 Is the same assessment tool used by the facility staff every time the resident is assessed for pain?

- ¹ Yes (69.7%) ² No (9.0%)
 ⁵ Yes, one of two tools is used depending on resident's mental status (21.2%)

 **5.5** (Ask the resident or the family) **Is the resident (or family) satisfied with his/her level of pain relief during the last 24 hours?** (Note: NA means that neither the resident nor family can tell you.)

- ¹ Yes (92.2%) ² No (7.8%) ⁸ NA

5.6 What type of pain management regimen is the resident receiving?

- ¹ PRN treatment only (56.8%) ³ Both are present (27.6%)
 ² Scheduled treatment only (4.6%) ⁴ None (11%)

5.7 Are non-pharmacological therapies ordered for pain management?

- ¹ Topical OTC analgesics (6.1%)
 ² Non-pharmacological treatment (5.7%)
 ³ None (88.2%)

5.8 If non-pharmacological therapies were ordered, has the resident received these therapies in the past 7 days?

- ¹ Yes (6.3%) ² No (93.7%)

Questions 5.9 and 5.10 ask the resident first. If the resident is unable to answer, look in the chart for answers.

 **5.9** (Ask the resident) **Was pain level assessed after pain medication was administered.** (Use drug guidelines if relevant).

- ¹ Yes (57.3%) ² No (93.7%)
 ⁸ NA (no pain medication administered)

 **5.10** (Ask the resident) **What usually helps your pain?** (Check all that apply)

- ¹ Pain medicine (92.2%)
 ² Repositioning (20.3%)
 ³ Environmental modifications (music, temperature, light, etc). (2.2%)
 ⁴ Alternative therapy (aromatherapy, massage, etc.) (0.9%)
 ⁵ Other: _____ (8.9%)
 ⁸ NA for no pain

5.11 Responses for 5.9 and 5.10 were provided by:

- ¹ resident (58.8%) ² chart (41.2%)

 **5.12** (Ask the resident) **How long does it take after you request pain medications to get the medication?**

___ ___ minutes (if unable to respond write in 0-9 [0 dash 9]) (Mean 17.39 minutes)

Part 6. Fall Risk Assessment

Questions 6.1a through 6.2 MUST BE ANSWERED. Question 6.3 through 6.6 MUST BE ANSWERED when the answer to 6.2 is YES.

6.1a Is there evidence that the resident was assessed for fall risks within 24 hours of admission?
(Use most recent event.)

- ¹ Yes (77.1%) ² No (22.9%)

6.1b If this resident had an acute change in condition, is there evidence that they have been assessed for fall risks within 14 days of onset of changes?

- ¹ Yes (50.6%) ² No (49.4%) ³ No acute change in condition

6.1c Is there evidence that the resident was assessed for fall risks in the last quarter?

- ¹ Yes (85.3%) ² No (14.7%)

6.2 Is there evidence that the resident fell in the past 30 days while under the care of the nursing facility?

- ¹ Yes (9%) ² No (91%)

----- If item 6.2 was answered NO, then skip to Part 7 -----

6.3 How many times in the last 30 days has the resident fallen while under the care of the nursing facility?

#___ (Mean 1.388)

6.4 If the resident fell in the last 30 days, and was not transferred to an ER or hospital, (did not leave the facility), is there documentation that the resident was reassessed for fall risks within 24 hours after the fall?

- ¹ Yes (56%) ² No (33.2%)
 ³ NA (fell and was transferred to hospital) (10.9%)

6.5 If the resident fell, were they injured (regardless of transfer to hospital)?

- ¹ Yes (38.9%) ² No (61.1%)

-----If item 6.5 was answered NO, then skip to Part 7. -----

6.6 If the resident was injured, what type of injuries did they sustain? (check all that apply)

- ¹ fractured hip (2.1%)
 ² fractured upper extremity (0%)

- ³ fractured pelvis (1%)
- ⁴ lacerations (8.8%)
- ⁵ contusions (8.8%)
- ⁶ head injuries (4.6%)
- ⁷ sprains (0%)
- ⁸ other fractures (specify locations) _____ (2.6%)
- ⁹ other (specify) _____

Part 7. Immunizations

7.1 Is there any documentation that the resident has ever received the polyvalent (including trivalent) Pneumococcal vaccine?

- ¹ Yes, proper documentation present (29.4%)
- ² Yes, no proper documentation (28.7%)
- ³ No (41.9%)

7.2 Is there evidence that the resident is allergic to the Pneumococcal vaccine?

- ¹ Yes (0.9%) ² No (99.1%)

7.3 Is there documentation that the resident (or family) was informed of the benefits and risks for the Pneumococcal vaccine?

- ¹ Yes (49.1%) ² No (50.9%)

7.4 Is there documentation that the resident (or family) REFUSED the Pneumococcal vaccine?

- ¹ Yes (23%) ² No (77%)

7.5 Is there documentation that Influenza vaccine for the 2012 (September 2012 through May 2013) Influenza Season was given? Any form of documentation is acceptable.

- ¹ Yes, proper documentation present (41.2%)
- ² Yes, no proper documentation (22%)
- ³ No (36.8%)

7.6 Is there evidence that the resident is allergic to either eggs or a previous Influenza vaccine or has had Guillain-Barré syndrome (GBS)?

- ¹ Yes (1%) ² No (99%)

7.7 Is there documentation that the resident (or family) was informed of the benefits and risks for the influenza vaccine?

- ¹ Yes (55.1%) ² No (44.9%)

7.8 Is there documentation that the resident (or family) REFUSED the influenza vaccine?

- ¹ Yes (18.6%) ² No (81.4%)

Part 8. Advance Care Planning

8.1 On first accessing the chart, were you able to find all of the existing advance directives and care limiting order documents within 30 seconds?

- ¹ Yes (88.1%) ² No (11.9%)

8.2 According to facility documents, when did the facility staff first discuss advance care planning with the resident or family?

- ¹ Prior to admission (23.4%)
 ² Within 14 days of admission (52.4%)
 ³ After 14 days of admission (14.4%)
 ⁴ Advance Care Planning has not been discussed with the resident or family (7.8%)

8.3 After a thorough search of the clinical record, which of the following ACP documents did you find?

- | | |
|---|--|
| 8.3a Out of Hospital DNR (OOHDNR) | <input type="radio"/> ¹ Yes (48.5%) |
| | <input type="radio"/> ² No (51.5%) |
| 8.3b Directive to Physicians | <input type="radio"/> ¹ Yes (21.2%) |
| | <input type="radio"/> ² No (78.8%) |
| 8.3c Durable Medical Power of Attorney | <input type="radio"/> ¹ Yes (27.8%) |
| | <input type="radio"/> ² No (72.2%) |

---- If all items in 8.3a, 8.3b and 8.3c were answered NO, then skip to Part 9 ----

8.4 Is the care being provided consistent with the instructions in the advance care planning documents?

- ¹ Yes (98.8%) ² No (1.2%)

8.5 Does the advance care plan address artificially administered nutrition and hydration?

- ¹ Yes (32.6%) ² No (67.4%)

Part 9. Tube Feeding

Question 9.1 MUST BE ANSWERED. Question 9.2 MUST BE ANSWERED when the answer to Question 9.1 is YES.

9.1 Does the resident have a feeding tube?

- ¹ Yes (7.7%) ² No (92.3%)

----- If item 9.1 was answered NO, then skip to Part 10 -----

9.2 Is the resident receiving tube feedings? (Includes NG tube, PEG, or other enteral tube providing artificial nutrition and/or hydration)

¹ Yes (94.1%)

² No (5.9%)

Part 10. Nutrition

10.1 Is there a comprehensive nutritional assessment completed for the resident? (This may be an initial assessment done on admission or an annual if the resident has been in the facility for a year. You need to review the most recent one.)

¹ Yes (93.6%)

² No (6.4%)

10.2 Has the resident experienced an unintentional 10% weight change in the last six months?

¹ weight gain (> than 10%) (2.4%) ² weight loss (> than 10%) (8.2%)

³ No (89.3%)

10.3 Have risk factors for weight loss been assessed?

¹ Yes (80.1%)

² No (19.9%)

10.4 Have risk factors for dehydration been assessed?

¹ Yes (82.7%)

² No (17.3%)

Part 11 Diabetes Mellitus

Question 11.1 MUST BE ANSWERED. Questions 11.2 through 11.5 MUST BE ANSWERED when the answer to Question 11.1 is YES.

11.1 Does the resident have diabetes mellitus?

¹ Yes (34.1%)

² No (65.9%)

-----If item 11.1 was answered NO, then skip to Part 12-----

11.2 Does the resident have Type I (insulin dependent) diabetes mellitus?

¹ Yes (34.2%)

² No (65.8%)

11.3 What type of insulin order is present in the drug regimen?

¹ Sliding scale only (27.4%)

² Long-acting insulin only (14.3%)

³ Both are present (58.2%)

11.4 Has the resident received the following assessment/test within the past 12 months?

1. Foot assessment

¹ Yes (41.9%)

² No (58.1%)

2. Eye examination

¹ Yes (26.2%)

² No (73.8%)

- 3. Lipid profile ¹ Yes (**50.6%**)
 ² No (**49.4%**)
- 4. Urine protein test ¹ Yes (**46.2%**)
 ² No (**53.8%**)
- 5. HgB A1C ¹ Yes (**67.8%**)
 ² No (**32.2%**)

11.5 What is the latest Hemoglobin A1C test result? _____% (Mean 7.42)

Part 12. Use of Anti-anxiety Medications

All questions in this Section MUST BE ANSWERED. Each of these questions must be answered independently.

12.1 Is there documentation of a diagnosis of generalized anxiety disorder, panic disorder, social anxiety disorder, agoraphobia, PTSD, or anxiety due to a medical illness that is not dementia?

- ¹ Yes (**26.9%**) ² No (**73.1%**)

12.2 Is there documentation of one or more anxiety symptoms characteristic of the disorder identified in 12.1? (If item 12.1 is answered NO, then answer 12.2 NA. If 12.1 is answered YES, then refer to the symptom list in the guidance.)

- ¹ Yes (**67.3%**) ² No (**32.7%**) ⁸ NA

12.3 Is there documentation of ongoing anxiety symptom assessment (at least every 2 weeks) for the stated, measurable therapeutic goals of anti-anxiety therapy? (Answer NA if the resident has no anxiety symptoms and is not taking medications)

- ¹ Yes (**52.7%**) ² No (**47.3%**) ⁸ NA

12.4 What type of treatment is the resident receiving for anxiety? (Check all that apply).

- ¹ Individual psychological services/counseling (**9.7%**)
- ² Dietary changes (**0%**)
- ³ Relaxation therapy (**0.2%**)
- ⁴ Medications (**39.3%**)
- ⁵ Environmental modifications (**1.6%**)
- ⁶ Other _____ (**0.7%**)
- ⁷ None (**56.2%**)

Part 13. Depression

Question 13.1 MUST BE ANSWERED. Questions 13.2 and 13.4 through 13.6 MUST BE ANSWERED when the answer to Question 13.1 is YES. Question 13.3 MUST BE ANSWERED when the answer to Question 13.2 is YES.

13.1 Has the resident been diagnosed with a depressive disorder (major depression, clinical depression, bipolar disorder, seasonal-affective disorder or dysthymia)?

- ¹ Yes (53.7%) ² No (46.3%)

-----If item 13.1 is NO, then skip to Part 14-----

13.2 Have contributing factors been identified for this resident's depression?

- ¹ Yes (58.3%) ² No (41.7%) ⁸ NA

-----If item 13.2 is NO, then skip to 13.4-----

13.3 What contributing factors are documented? (Check all that apply)

- ¹ Grief and loss (12.1%)
 ² Medical illnesses (84.9%)
 ³ Anxiety disorder (34.8%)
 ⁴ Drugs that cause symptoms of depression (6.3%)
 ⁵ Resident/family history of depression (4.5%)
 ⁶ Other _____ (5.1%)

13.4 What type of treatment is the resident receiving for depression? (Check all that apply)

- ¹ Individual psychological services/counseling (27.2%)
 ² Group psychological services/counseling (0.3%)
 ³ Medications (88.6%)
 ⁴ Environmental modifications (3.2%)
 ⁵ Other _____ (1.2%)
 ⁶ None

13.5 Is there documentation of ongoing depression symptom assessment (at least every 2 weeks) for the stated, measurable therapeutic goals of depression therapy? (Answer NA if the resident has no depression symptoms and is not taking medications)

- ¹ Yes (51.6%) ² No (48.4%) ⁸ NA

13.6 Does the chart indicate that the resident has responded to treatment?

- ¹ Yes (59.4%) ² No (48.4%) ⁸ NA (no treatment)

Part 14. Use of Hypnotic Medications

Questions 14.1 through 14.4 MUST BE ANSWERED. Questions 14.5 and 14.6 MUST BE ANSWERED when the answer to Question 14.4 is YES.

14.1 Has the resident complained of sleep problems within the last 14 days? (See guidance)

- ¹ Yes (9%) ² No (91%)

14.2 Is there evidence that the resident has been evaluated for sleep hygiene including all of the following: medication changes, diet history, daytime habits, sleeping habits, and sleeping environment?

- ¹ Yes (24.3%) ² No (75.7%)

14.3 Does the MAR show an active prescription for sleep medication in last 14 days?

- ¹ Yes (18.2%) ² No (81.8%)

-----If item 14.3 is NO, skip to Part 15-----

14.4 Is there evidence that alternative interventions were attempted before sleep medications were given?

- ¹ Yes (12.3%) ² No (87.7%)
 ⁸ NA (no sleep hygiene problems)

14.5 Did the resident continue to have sleep problems after receiving sleep medications?

- ¹ Yes (10.7%) ² No (89.3%)

14.6 If 14.5 is yes, has the resident been reassessed for sleep difficulties?

- ¹ Yes (23.1%) ² No (76.9%) ⁸ NA

Part 15. Restraints

15.1 How many times has the resident been restrained in the last 30 days? (See guidance)
_____ (Mean 8.11)

---- If item 15.1 is answered 0, skip to Part 16 ----

15.2 What type(s) of restraints were used? (Check all that apply)

- ¹ Mechanical (45.8%)
 ^{1a} Full bed rails (27.3%)
 ^{1b} Other types of bed rails (60.4%)
 ^{1c} Trunk restraints (1.5%)
 ^{1d} Limb restraints (0.3%)
 ^{1e} Chair prevents rising (7.6%)
 ² Personal (1.3%)
 ³ Chemical (4.9%)
 ^{3a} Typical antipsychotics (4.4%)
 ^{3b} Atypical antipsychotics (1.5%)
 ^{3c} Anxiolytics (1.5%)
 ^{3d} Sedatives/hypnotics (1.2%)
 ^{3e} Others _____ (5.9%)

15.3 Why were restraints used? (Check all that apply)

- ¹ To control disruptive behavior (2.9%)
- ² To control physically aggressive behavior towards self (0.2%)
- ³ To control physically aggressive behavior towards others (0.7%)
- ⁴ To control resident from wandering (4.4%)
- ⁵ To control the resident from getting up at night (7.6%)
- ⁶ To prevent self-transfers from bed or chair (4.9%)
- ⁷ To prevent falls and fall-related injury (39.4%)
- ⁸ To assist with positioning in bed or chair (59.9%)
- ⁹ Other _____ (5.4%)
- ¹⁰ Evaluator unable to determine from record why restraint was used (2.5%)

15.4 Did the resident's family or guardian request the use of restraints?

- ¹ Yes (37.1%)
- ² No (59.2%)
- ⁸ NA (3.7%)

15.5 What alternatives were tried to prevent the use of restraints? (Check all that apply)

- ¹ Verbal de-escalation or redirection (2%)
- ² Interpersonal physical separation (0.2%)
- ³ Environmental modifications (1.7%)
- ⁴ Seclusion (0%)
- ⁵ Wanderguard (6.7%)
- ⁶ Bed alarm (18.9%)
- ⁷ Chair alarm (16.8%)
- ⁸ Other _____ (3.2%)
- ⁹ None (69.9%)

Part 16. Quality of Life/Consumer Satisfaction

Question 16.1 MUST BE ANSWERED. Questions 16.2 through 16.22 MUST BE ANSWERED if Question 16.1 is RESIDENT. Questions 16.2, 16.21 and 16.22 MUST BE ANSWERED if Question 16.1 is FAMILY MEMBER OR GUARDIAN.

If the resident is unable to answer, then only a family member or guardian may answer items 16.21 and 16.22.

16.1 Who is responding to this survey?

- ¹ Resident (63.9%)
- ² Family member or guardian (12.9%)
- ³ Neither (23.2%)

----- If item 16.1 was answered, "Neither" then STOP -----

16.2 Was a translator used for this survey?

- ¹ Yes (2.9%)
- ² No (97.1%)

-- If 16.1 was answered, "Family member or guardian" then SKIP to 16.21--

 **16.3 Can you find a place to be alone when you wish?**

- ¹ Always (61.6%)
- ² Sometimes (19.1%)
- ³ Rarely (4.0%)
- ⁴ Never (9.6%)
- ⁵ No answer (5.7%)

 **16.4 Can you make a private phone call?**

- ¹ Always (63%)
- ² Sometimes (12.7%)
- ³ Rarely (4.1%)
- ⁴ Never (13.4%)
- ⁵ No answer (6.7%)

 **16.5 When you have a visitor, can you find a place to visit in private?**

- ¹ Always (62.3%)
- ² Sometimes (19.4%)
- ³ Rarely (3%)
- ⁴ Never (9.2%)
- ⁵ No answer (6%)

 **16.6 Can you be together in private with another resident (other than your roommate)?**

- ¹ Always (46.4%)
- ² Sometimes (17.2%)
- ³ Rarely (5.6%)
- ⁴ Never (14.7%)
- ⁵ No answer (16.1%)

 **16.7 Do you participate in religious activities here?**

- ¹ Always (30.2%)
- ² Sometimes (21.3%)
- ³ Rarely (8.8%)
- ⁴ Never (36.3%)
- ⁵ No answer (3.4%)

 **16.8 Do the religious observances here have personal meaning for you?**

- ¹ Always (43.7%)
- ² Sometimes (15%)
- ³ Rarely (5.7%)
- ⁴ Never (29.4%)
- ⁵ No answer (6.2%)

 **16.9 Do you enjoy the organized activities here at the nursing facility?**

- ¹ Always (33.1%)
- ² Sometimes (27%)
- ³ Rarely (11.8%)
- ⁴ Never (23%)
- ⁵ No answer (5%)

 **16.10 Outside of religious activities, do you have enjoyable things to do at the nursing facility during the weekends?**

- ¹ Always (19.7%)
- ² Sometimes (27.5%)
- ³ Rarely (15.6%)
- ⁴ Never (28.2%)
- ⁵ No answer (9%)

 **16.11 Do you like the food here?**

- ¹ Always (41.1%)
- ² Sometimes (40.1%)
- ³ Rarely (8.3%)
- ⁴ Never (8.3%)
- ⁵ No answer (2.3%)

 **16.12 Do you enjoy mealtimes here?**

- ¹ Always (54%)
- ² Sometimes (32.1%)
- ³ Rarely (5%)
- ⁴ Never (5.3%)
- ⁵ No answer (3.6%)

 **16.13 Can you get your favorite foods here?**

- ¹ Always (22%)
- ² Sometimes (38.9%)
- ³ Rarely (14.7%)
- ⁴ Never (17.2%)
- ⁵ No answer (7.1%)

 **16.14 Can you get snacks and drinks when you want them?**

- ¹ Always (53.1%)
- ² Sometimes (24.6%)
- ³ Rarely (7.2%)
- ⁴ Never (7.6%)
- ⁵ No answer (7.5%)

 **16.15 Do you feel that your possessions are safe at this nursing facility?**

- ¹ Always (68.5%)
- ² Sometimes (17.1%)
- ³ Rarely (3.7%)
- ⁴ Never (7.6%)
- ⁵ No answer (3.1%)

 **16.16 Have your clothes gotten lost or damaged in the laundry in the last month?**

- ¹ Always (7.2%)
- ² Sometimes (21.3%)
- ³ Rarely (8.7%)
- ⁴ Never (55.2%)
- ⁵ No answer (7.6%)

 **16.17 Do you feel safe and secure?**

- ¹ Always (86.5%)
- ² Sometimes (8.6%)
- ³ Rarely (1.4%)
- ⁴ Never (1.5%)
- ⁵ No answer (2%)

 **16.18 Do you ever have concerns that the facility does not address?**

- ¹ Yes (15.3%)
- ² No (84.7%)

 **16.19 In the last month, have you had a concern that you did not express because you were afraid of retaliation?**

- ¹ Yes (6.9%)
- ² No (93.1%)

 **16.20 Have you been visited by an Ombudsman from the Long-Term Care Ombudsman Program in the last 12 months?**

- ¹ Yes (17.4%) ² No (82.6%)

 **16.21 Overall, how satisfied are you with your (or your family member's) experience in this nursing facility?**

- ¹ Very dissatisfied (2.8%)
 ² Dissatisfied (2.4%)
 ³ Somewhat dissatisfied (3.4%)
 ⁴ Neither (2.1%)
 ⁵ Somewhat satisfied (15%)
 ⁶ Satisfied (45.5%)
 ⁷ Very satisfied (28.7%)
 ⁸ NA (0%)

 **16.22 Overall, how satisfied are you with your (or your family member's) health care services?**

- ¹ Very dissatisfied (1.8%)
 ² Dissatisfied (1.9%)
 ³ Somewhat dissatisfied (3.4%)
 ⁴ Neither (1.9%)
 ⁵ Somewhat satisfied (13.9%)
 ⁶ Satisfied (50%)
 ⁷ Very satisfied (27%)
 ⁸ NA

I certify by my signature below that the *DADSID* number of the resident has been doubled-checked for accuracy, and that the information in this document is an accurate assessment of the resident.

QR Nurse Signature _____ **Date** _____