6th Annual Forum on Post-Acute, Long-Term Care, and Assisted Living Facilities

Program Handouts

Friday, June 3, 2022 | 7:00 AM to 4:30 PM

DoubleTree by Hilton – Oak Brook
1909 Spring Road
Oak Brook, IL 60523

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6th Annual LIVE Forum on Post-Acute, LTC & ALF

Thank you to our sponsors. We encourage you to visit their booths and acknowledge their support of this conference. While at the Trade Show, make sure you enter the Raffle. Prizes will be drawn at the end of the program; winners must be present to claim their prizes.

Product Theater Sponsors

- Breakfast Product Theater: Neurocrine Biosciences
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Continuing Education Credits

Welcome to the 6th Annual LIVE Forum on Post-Acute, LTC & ALF. Enjoy a day of learning with quality programming, dynamic speakers, and a forum to exchange ideas, share information, and earn 6 free continuing education credits.

Nursing: This program has been approved for six hours of continuing education credit by The Illinois Board of Nursing, an approved sponsor of continuing education by the Illinois Department of Professional Regulation.

Administrators: This program has been approved for six hours of continuing education credit by the National Continuing Education Review Services (NCERS) of the National Association of Long-Term Care Administrator Boards (NAB) – Approval #20230602-6-A84172-IN.

Get your link/QR code for CE before you leave: A postcard will be distributed to each attendee at the close of the event that provides a link/QR code you can use to submit your CE request. Your license number and a valid email address are required.

Upon successful form submission, an email containing a link to download your certificate will be sent within 24 hours to the address provided. Note: if unable to locate in your inbox, please check spam/junk.

The Program

7:00 AM — **REGISTRATION OPENS**

7:30 AM – 8:25 AM — **BREAKFAST PRODUCT THEATER**

Recognition and Treatment of Tardive Dyskinesia with Focus on Older Population

Amber Hoberg
Neurocrine Bioscience, PMHNP

08:30 AM – 9:30 AM — ***Staff Retention in the New Normal***

Sheri Easton-Garrett
Belmont Village, Senior Vice President of Clinical Services

Thomas Annarella
Valley Hi, Administrator

Pamela Bryan Kramer
Forum Extended Care , Executive Vice President

Sara Champion
Forum Extended Care, Human Resources Manager

9:30 AM – 10:30 AM — ***Staying Safe and Secure in an Increasingly Hostile Cyber World***

Brian Kramer
Forum Extended Care Services, President & CIO

10:30 AM - 11:00 AM — **BREAK / VENDOR EXHIBITS**

11:00 AM – 12:00 PM — ***BRAIN ATTACK – Stroke Overview & Update***

Barb Bancroft
CPP Associates, Inc, Executive Director & President

12:00 PM – 12:55 PM — **LUNCH PRODUCT THEATER**

A Long-Term Care Resident with Hallucinations and Delusions Associated with Parkinson's Disease Psychosis: A Case for NUPLAZID

Dr Daniel Conone
Acadia Pharmaceuticals

1:00 PM – 2:00 PM — ***Survey After COVID***

Sheila Baker
Illinois Dept of Public Health, Bureau Chief of LTC

2:00 PM – 3:00 PM — ***Dealing with Difficult Families***

Benjamin Surmi
Koelsch Communities, Director of Education and Culture

3:00 PM – 3:30 PM — **BREAK / VENDOR EXHIBITS**

3:30 PM – 4:30 PM — ***Shampoos, Tattoos, and Bar-B-Ques: What's New in the World of Infectious Diseases***

Barb Bancroft
CPP Associates, Inc, Executive Director & President

4:30 PM — **CLOSING REMARKS**
DISTRIBUTION OF C.E. LINK
RAFFLE DRAWING
ADJOURNMENT

Learning Objectives

Staff Retention in the New Normal
Speakers: Sheri Easton-Garrett, MSN, RN, CDP, CMDCP; Thomas Annarella, BS, LNHA; Sara Champion, SHRM; & Pamela Bryan Kramer BA, LPhT
Learning Objectives:
- Learn how to attract and retain employees in the industry
- Recognize the impact of an effective onboarding process
- Understand what industry experts are doing to handle retention post-COVID

Survey After COVID
Speaker: Sheila Baker, RN, MBA, JD
Learning Objectives:
- Describe components to annual surveys and the focus for 2022
- Learn about survey changes since COVID-19 and how to prepare
- Recognize how to avoid top-cited deficiencies and common complaints from surveyors

Staying Safe and Secure in an Increasingly Hostile CyberWorld
Speaker: Brian Kramer, BS, BA, RPH, MBA
Learning Objectives:
- Explore data security and ways to mitigate risk in your organization
- Learn about HIPAA and rules for social media and the internet
- Understand how to protect your organizations and residents

Dealing with Difficult Families
Speaker: Benjamin Surmi, MSG
Learning Objectives:
- Outline ways to appropriately handle difficult family members
- Identify preventative steps to maintain escalating situations
- Adopt strategies to interact effectively with family members

Brain Attack – Stroke Overview and Update
Speaker: Barb Bancroft RN, MSN, PNP
Learning Objectives:
- Understand neuroanatomy and blood supply to the brain and spinal cord
- Recognize modifiable and non-modifiable risk factors for strokes, and prevention and treatment methods
- Learn about acute emergency treatment for strokes and chronic treatment protocols

Shampoos, Tattoos, and Bar-B-Ques: What's New in the World of Infectious Diseases?
Speaker: Barb Bancroft, RN, MSN, PNP
Learning Objectives:
- Understand food safety while at home, at your organization, and while traveling
- Learn about antibiotic stewardship and best practices to implement in your organization
- Recognize current and new diseases, their clinical manifestations, and treatments

Staff Retention in the New Normal

Sheri Easton Garrett, MSN, RN, CDP, CMDCP

Sheri is a strategic and driven healthcare executive within senior living and post-acute care and specializes in advanced healthcare delivery and gerontology. Sheri served as the Vice President of Clinical Services at Brookdale for more than eight years before joining Belmont Village in 2017 as the Senior Vice President of Clinical Services. Sheri is skilled at establishing an operating structure for small and large organizations that generates profitable results and exceeds business goals. She received her Master's degree in Nursing from Abilene Christian University.

Thomas Annarella, LNHA

A dedicated member of the long-term care profession for more than two decades, Tom served as the Administrator at Arbor of Itasca for nearly 10 years before joining Valley Hi as its Administrator in 2010. Tom holds a Bachelor's degree in Healthcare Administration from Southern Illinois University and has been a member of the Illinois Healthcare Association for most of his career. He was recognized as one of Provider magazine's "20 to Watch" and completed the AHCA/NCAL Future Leaders program. Tom joined the IHCA Board of Directors in 2011 and has served on various IHCA committees. He currently chairs the IHCA Nursing Facility Constituency Steering Committee and Illinois Leaders program.

Staff Retention in the New Normal

Pamela Bryan Kramer, BA, LPhT

With more than 35 years of experience in the pharmaceutical industry, Pam has created award-winning strategies and educational programs for industry leaders. She is responsible for developing and implementing Forum's mission and vision and optimizes Forum's infrastructure, approach, and services, based on her diverse background and expertise in strategic planning, customer relations, operational process development, and Lean Six Sigma. Pam is a seasoned speaker, presenting at conferences such as the American Society of Consultant Pharmacists, Illinois Health care Association, and Leading Age, Illinois. Pam holds a Bachelor's degree from New York University and is a Licensed Pharmacy Technician.

Sara Champion, BS, SHRM

Sara focuses on developing strategic and dynamic processes using technology and human capital to optimize benefits administration, talent management, recruitment, performance management, employee relations, training, and development. Sara served as the Human Resources Team Lead for Serrala US Corporation before joining Forum in 2021 as its Human Resources Manager. Her strong communication skills and ability to collaborate with global cross-functional teams have enabled her to develop exceptional levels of internal and external customer service and increase employee engagement and satisfaction. Sara received a Bachelor's degree in Leadership Studies from DePaul University and is currently working on her Master's in Human Resources from DePaul.

Staff Retention in the New Normal

Sheri Easton - Garrett
Belmont Village
Sr Vice President of Clinical Services

Thomas Annarella
Valley Hi Nursing & Rehabilitation
Administrator

Pamela Bryan Kramer
Forum Extended Care Services
Executive Vice President

Sara Champion
Forum Extended Care Services
Human Resources Manager

Forum 50 YEARS+ EXTENDED CARE SERVICES

Learning objectives

- Learn how to attract and retain employees in the industry
- Recognize the impact of an effective onboarding process
- Understand what industry experts are doing to handle retention post-COVID

The Skilled Nursing Perspective

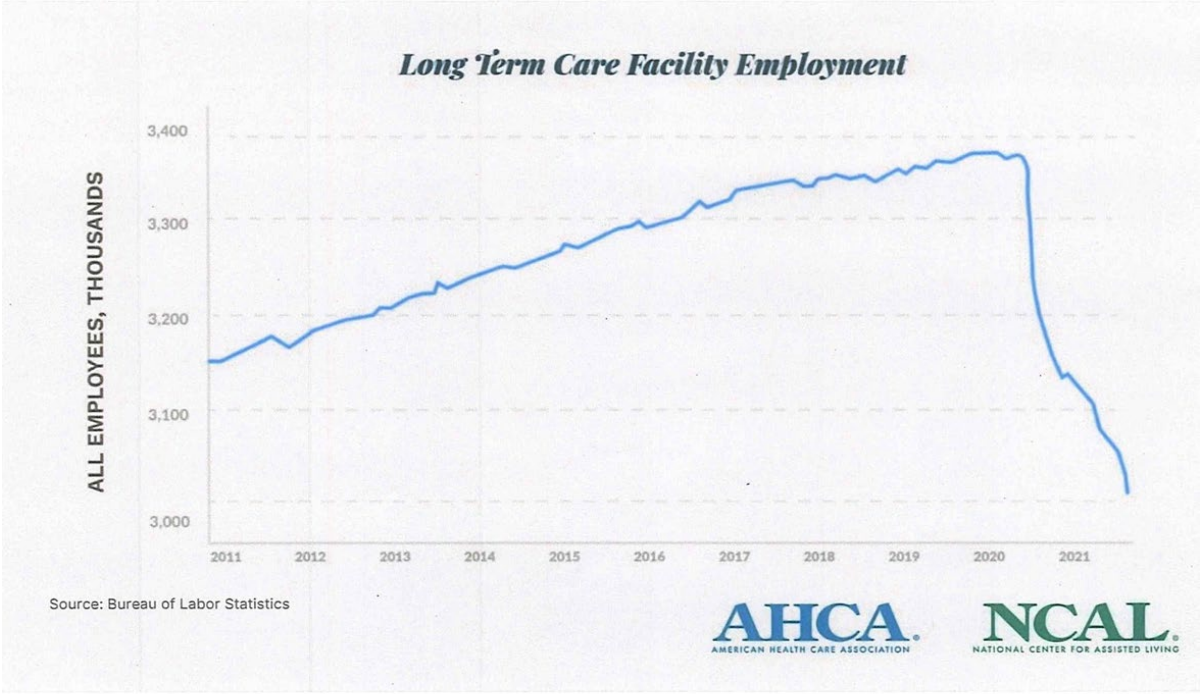
Thomas Annarella
Valley Hi Nursing & Rehabilitation
Administrator

Forum 50 YEARS+ EXTENDED CARE SERVICES

Objectives

- Understanding post-COVID employment trending
- Impact on applicants and interest in health care jobs – census, agency, and available resources
- Competition with non-health care hobs for the same skill set
- Importance of retention focus
- Organizational health's role in retention

Understanding post -COVID employment trending



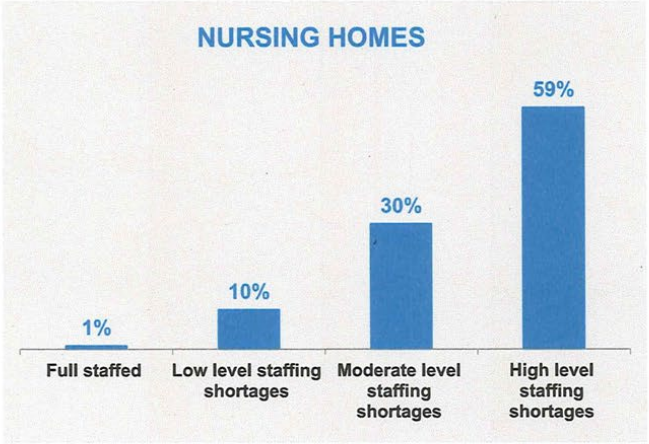
380,000 workers lost since 2020

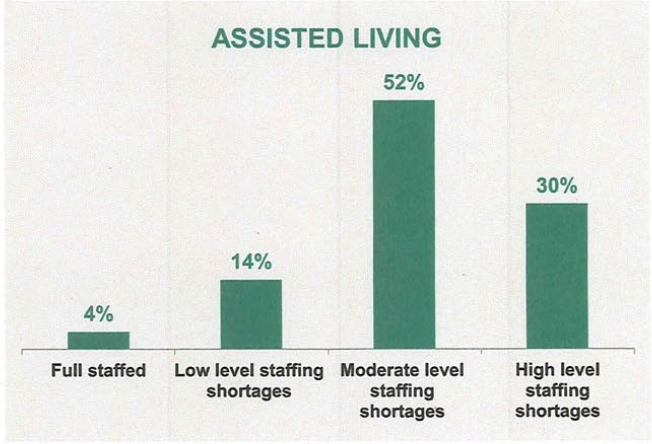
Understanding post -COVID employment trending

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

Nearly every nursing home (99%) and assisted living community (96%) in the U.S. is facing a staffing shortage.

Q: What is your current staffing situation?





Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

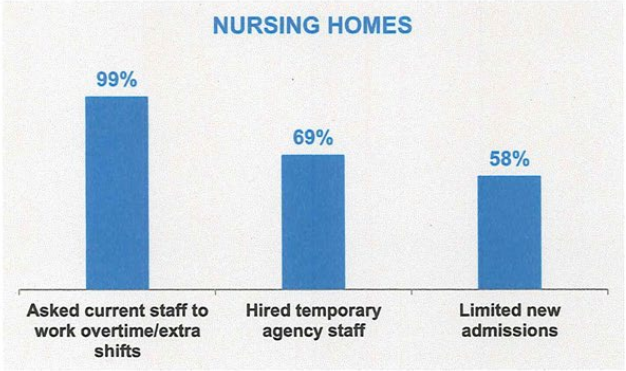
Understanding post -COVID employment trending

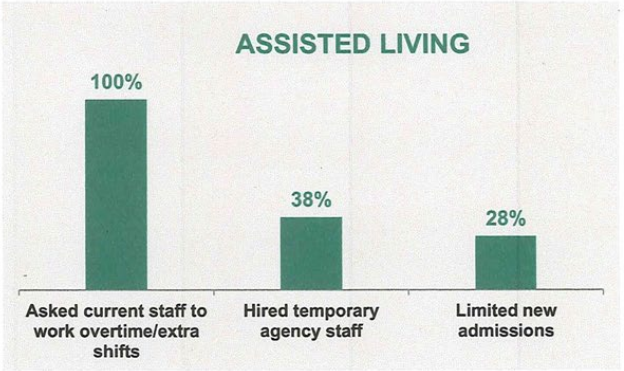
AHCA AMERICAN HEALTH CARE ASSOCIATION

NCAL NATIONAL CENTER FOR ASSISTED LIVING

Nearly every nursing home and assisted living community is asking staff to work overtime or extra shifts.
58% of nursing homes are limiting new admissions due to staffing shortages.

Q. What adjustments have you made due to staffing shortages?





Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

Impact on applicants & interest in health care jobs

Census, agency & available resources

- Applicants for job openings have declined significantly in the past year
  - Competition with non-health care jobs
  - Minimum wage laws creating wage compression for lower-skilled jobs
  - Rapidly rising labor costs without equivalent raising funding (although new Medicaid reimbursement system will help)
- Agency pricing and poaching
  - New agency regulations will help but not stop the issue

Impact on applicants & interest in health care jobs

Census, agency & available resources

- Follow the math
- Increased costs of supplies
  - Inflation impact
  - Commodities
  - Delays
- Increased costs of labor and benefits
  - Over-time
  - Bonuses
  - Benefits
- Increased costs of everything

- Decreased census due to staffing
- Decreased overall revenues due to lower census
  - Impact of fixed costs regardless of census levels

  - Equals – Extreme pressure on an organizations financial picture and workforce

Competetion with non-health care jobs for the same skill set

- What jobs does health care directly compete with the non-healthcare sector?
  - Housekeeping
  - Laundry
  - Dietary
  - Activities
  - All administrative support type services
- With all the COVID protocols, mandates, testing, and required mask wearing; why would someone who works in any of these fields go into health care?

It clearly is not because the pay is better!

Importance of retention focus

- Now, more than ever, hyper-focus on employee retention must be every leader's priority
- Why do people leave their jobs?
  - Don't let them get away with telling you it's about the money. That may be why they made the decision, but that is not what caused them to start looking. It all comes down to the work environment.
- What are you doing to engage your teams?
- What are leaders in the building doing to show appreciation; beyond pizza and bonuses?
- How present are the leaders?
- How do you measure employee engagement and how often?

Organizational health's role in retention

- There is no single greatest predictor of success than organizational health – NONE
- It is everyone's responsibility to create & maintain organizational health
- Healthy organizations have far less issues and much higher employee retention
  - Healthy companies are far less susceptible to ordinary problems than unhealthy ones
  - NO ONE BUT THE LEADERS OF AN ORGANIZATION CAN MAKE IT HEALTHY
  - **Organizational health is often neglected because it involves facing realities of human behavior that even the most committed leader is tempted to avoid – it requires a level of discipline and courage**

The Assisted Living Perspective

Sheri Easton -Garrett
Belmont Village Senior Living
Senior Vice President of Clinical Services

Forum 50 YEARS+
EXTENDED CARE SERVICES

In-training programs & career ladders

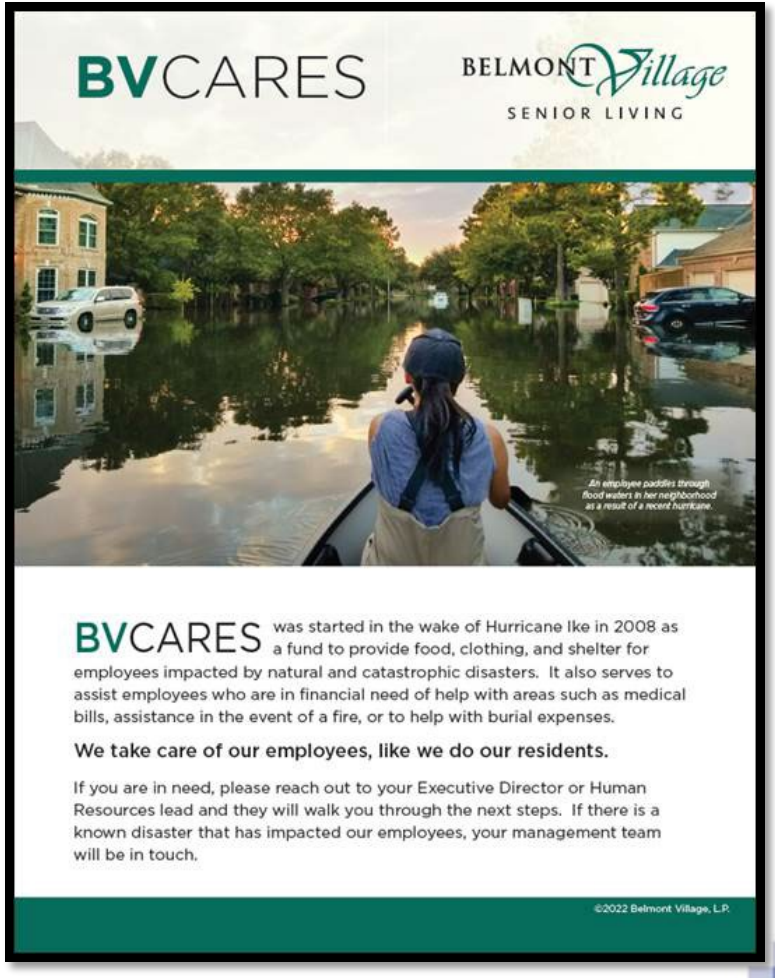
- **IT Program**
  - 6 month program
  - Various leadership positions
  - Application/Approval process
  - Mentor/Program Project
- **Career Ladder**
  - Paraprofessional Ladder
  - Paraprofessional to Professional Ladder
  - Professional Ladder

Leadership skills (BVLEAD)

- Jhana – Franklin Covey
  - Virtual mentor for leadership skills
  - Effective hiring & interviewing
  - Team Performance
  - Coaching & developing others
  - Employee engagement & retention
  - Self-development
- 6 Critical Practices

BVCARES

- Belmont Signature Program
- Employee assistance
- Way to give back
- Matching events



Nursing tuition reimbursement

- Tuition reimbursement policy & application
- FT employee - 6 months minimum
- One-time $2,500 payment
- Submit proof of payment
- One year commitment

BELMONT Village
SENIOR LIVING

TUITION REIMBURSEMENT REQUEST

Location Name: _____

I. EMPLOYEE INFORMATION

Last Name	First Name:	Date of Hire
Dept. Name	STD Hours Per Week	Job Title
Employee Street Address	State	Zip

II. NURSING EDUCATION PROGRAM DESCRIPTION:

Name of School/Program:					
Address:					
Course/Certification Name	Course #	# of Credits	Begins	Ends	Est. Cost

III. NURSING EDUCATION PROGRAM OBJECTIVES

Certificate in Vocational Nursing: ❑ Yes ❑ No
Associate Degree in Nursing: ❑ Yes ❑ No
Baccalaureate Degree in Nursing: ❑ Yes ❑ No
Graduate Degree in Nursing: ❑ Yes ❑ No

Credits Completedto Date:

My Reason for taking this Course(s): *(Check ALL that apply)*

❑ 1. To comply with community/department request
❑ 2. Is REQUIRED by the Company or the law to remain in my current position
❑ 3. Is necessary to prepare me for a promotion or specific new position with the Company
❑ 4. Is part of a curriculum necessary to remain in myposition
❑ 5. Will be REQUIRED as part of my job responsibility within the next 12 months
❑ Other: _____

In filing this application for Tuition Reimbursement, I certify that I have read and understand the provisions of the Belmont Village Tuition Reimbursement Policy. Within 30 days of course completion, I shall submit satisfactory evidence of course completion, grade, and a paid tuition receipt.

I understand that under Belmont Village's Tuition Reimbursement Policy, I agree to remain an employee of the Company and work at least 30 hours per week for a period of one (1) year following the date of any tuition reimbursement payment or to repay any and all tuition reimbursement amounts received during the prior 12-month period. I understand and agree that if I voluntarily leave the Company or change my status prior to the expiration of the one (1) year period, I authorize the Company to deduct from my final paycheck the full amount of the tuition reimbursement money that reimbursed within the 12-month period prior to my separation date, up to and including the maximum amount of $2,500.

Employee Signature/Date

Signature of Department Manager/Date

Signature of Executive Director/Date

Signature of Sr. Regional Vice President/Date

IV. APPROVAL

Status:	Reimb.Amt:	School Yr.:	Reimbursement Amt. UsedPrior:

Corporate Benefits Representative

V. REIMBURSEMENT AUTHORIZATION

Official Grade:	Verified Current Employment Status:	Verified DOH:	Receipt of paid Tuition amount:

Recognition & celebration

- Annual Awards
- Extra Mile Cards
- Rising Stars
- Employee of the Month
- Employee Holiday Parties
- Employee Summer Picnics
- President's Club
- Nurses Week

Life coaching

- 2022 Nursing Leadership Program
  - Development based from survey
  - 2x Month Sessions
  - Initial Session
  - Follow-up Huddle (Application)
- Geriatric Nursing Journal Article – May 2022

The Why, What And How Behind Resilience, A Comprehensive Approach To Manage Burnout

The Human Resources Perspective

Sara Champion
Forum Extended Care Services
Human Resources Manager

Forum 50 YEARS+ EXTENDED CARE SERVICES

Recruiting outside of the box

YouTube

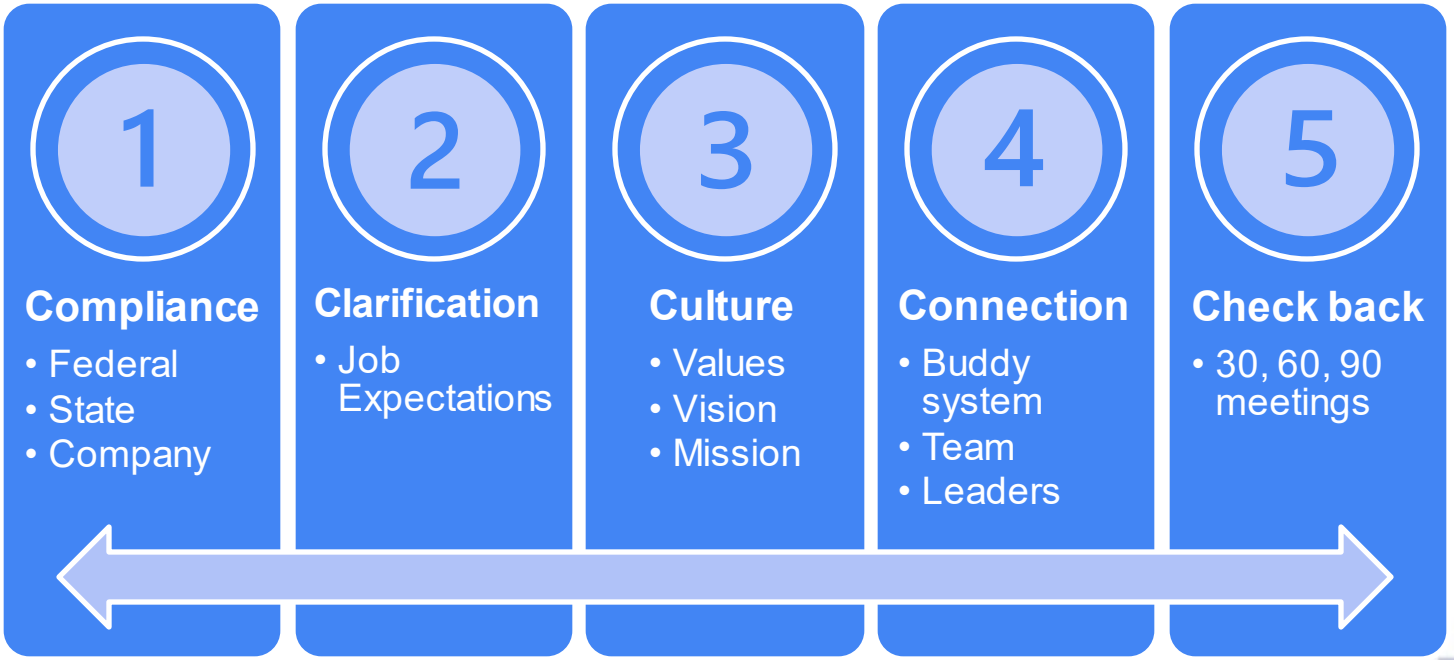
Instagram

TikTok

- Alternate channels
- Sign-on bonuses
- Internships
- Employee referrals
- Modernize the candidate experience
- Targeting millennials
- Diversifying your pipeline

Revamping on -boarding

The 5 C's of on -boarding



Retaining employees beyond compensation

- Learning & development
- Opportunities for advancement
- Fair scheduling
- Remote work options
- Opportunities for feedback
- Retention incentives
- Recognition for service & milestones

The Employer Perspective

Pamela Bryan Kramer
Forum Extended Care Services
Executive Vice President

Attracting top talent

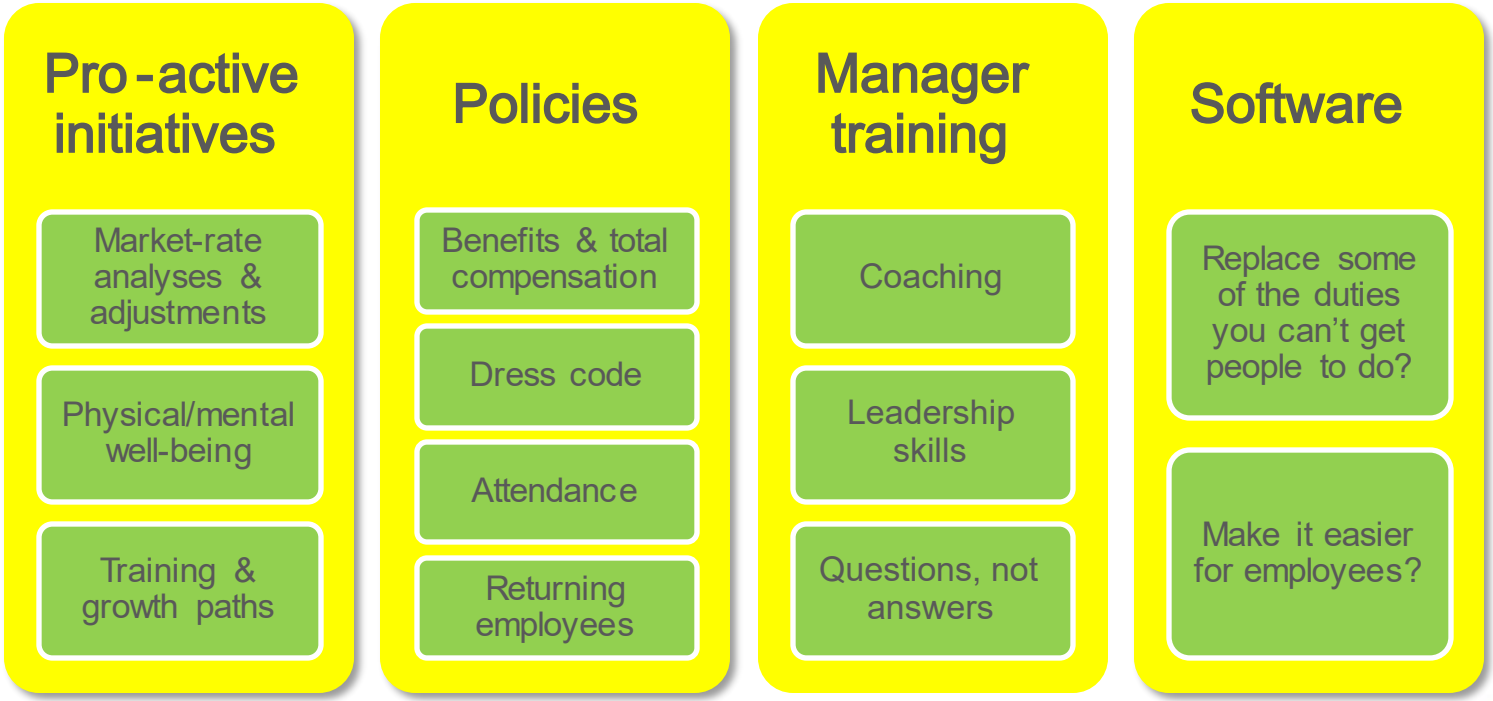
Looking beyond $$$:

- Company values
- Positive work culture
- Finding a purpose
- Meaningful work
- Learning & developing

Changing culture & engaging staff

- **Our actions speak louder than words**
  - **Actively seek feedback (suggestions, idea boards) & follow up**
  - **Include line staff in projects & QI**
- Being transparent; sharing our whys, wins & losses
- Maintaining relationships with others: what does our staff need/want?
- Support of staff: accommodation of special situations, ways to show appreciation

Changing our thinking



Final thoughts

"At the end of the day, you spend most of your life working. It sucks to be miserable."

Staying Safe and Secure in an Increasingly Hostile CyberWorld

Brian Kramer, BS, BA, MBA, RPh

Brian joined Forum in 1993, serving as Director of Operations before becoming the company's President in 2002. His experience includes hands-on work in LTC as a licensed Nursing Home Administrator. His career as a Registered Pharmacist spans more than 35 years in hospital, retail, and LTC pharmacy consulting and dispensing. He has a Bachelor of Arts degree in Biology and Chemistry from Knox College, a Bachelor of Science degree in Pharmacy from the University of Illinois-Chicago, and holds a Master's in Business Administration, with a concentration in Information Systems, from Roosevelt University.

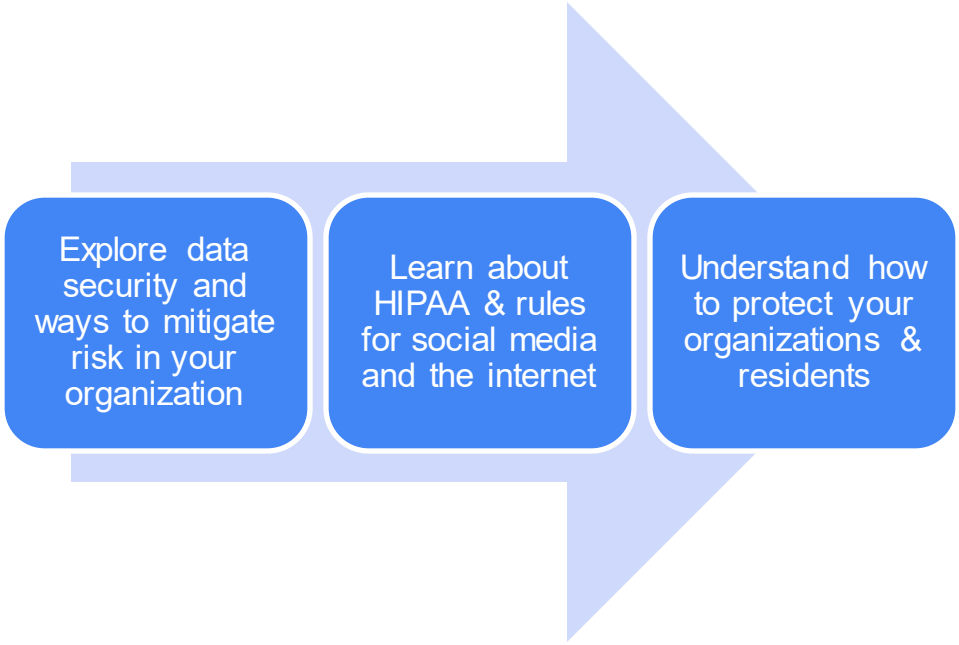
Brian served on the Illinois Governor's Advisory Committee on Electronic Healthcare Records (EHR) and is a member of the American Society of Consultant Pharmacists, the American Society of Hospital Pharmacists, the Illinois Pharmacist Association—LTC section, the National Council for Prescription Drug Programs (NCPDP), and the American Society for Automation in Pharmacy. Currently, Brian is the President and Director of the Illinois Association of LTC Pharmacy Providers and is a Founding Board Member and Vice Chair of the Board of the Senior Care Pharmacy Coalition.

Staying Safe & Secure in an Increasingly Hostile Cyber World

Brian Kramer
Forum Extended Care Services
President & Chief Information Officer

Forum 50 YEARS+ EXTENDED CARE SERVICES

Learning objectives



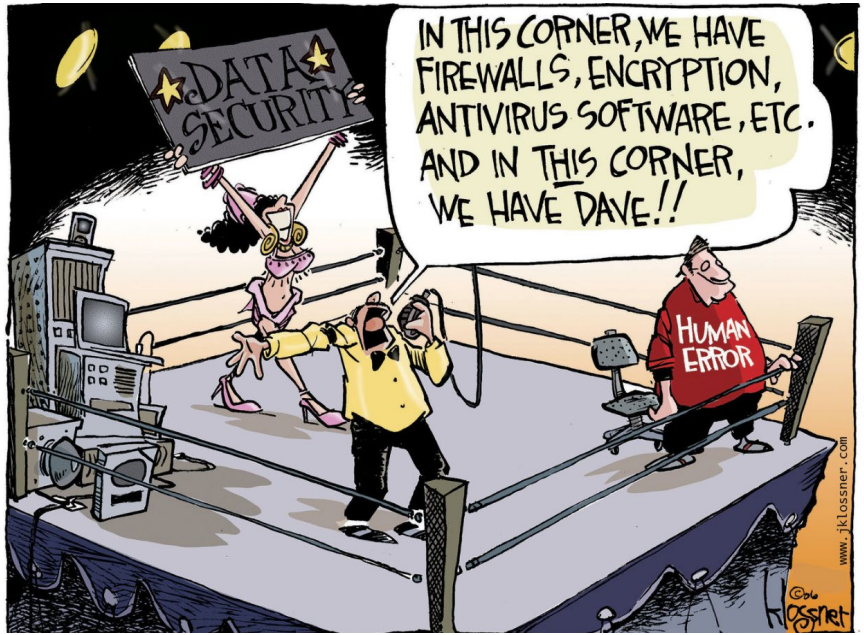
I have residents/clients/patients to take care of!

Does IT hate me?

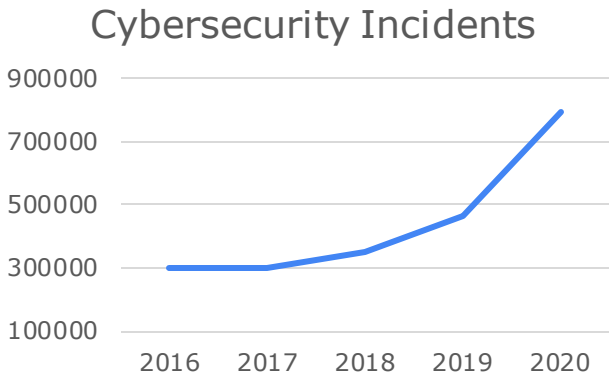
No!

Cybersecurity is a TEAM effort.

We cannot afford to think of it as something for the IT department to handle. Investing in the best security systems won't help if someone leaves the door wide open.



The threat is real



Fine, but why is it so complicated?

Technology has allowed for increased communication, easier access, and faster processing.

However, each new technology also introduces security and privacy concerns.

Evolution of technology

HIPPA

Health Insurance Portability and Accountability Act

HITECH Act

The Health Information Technology for Economic and Clinical Health Act

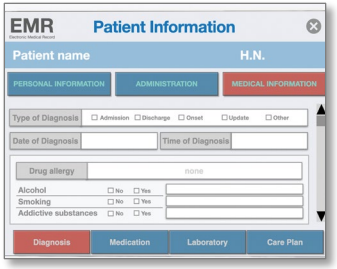
How do we implement cybersecurity?

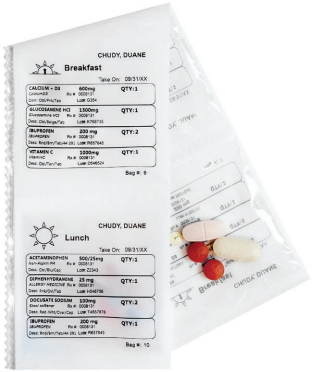
Several approaches can be used to mitigate security and privacy concerns in healthcare. We currently use the NIST [National Institute of Standards and Technology] Cybersecurity Framework.

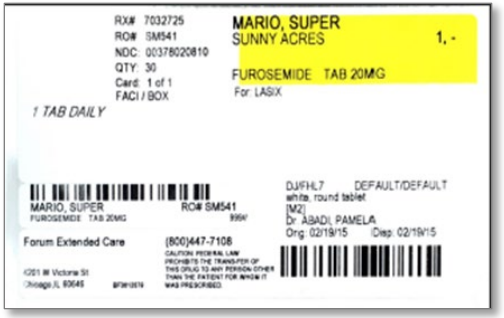
1. Identify

What data are we obligated to protect?

Once we know WHAT we are protecting, we need to determine WHERE it is created, stored, and transmitted.







2. Protect

The “CIA Triad” is an important way to understand the different but interconnected security measures we need to take to protect data.

2. Protect: common safeguards

- Technical
- Physical
- Administrative

3. Detect

- How will we detect a cybersecurity incident?
- Who's responsible for checking?
- Where is it documented?

4. Respond

- If and when an incident happens, what's the plan?
- Are the different responsibilities documented?
- Who's in charge of communicating the response, both internally and externally?

5. Recover

- Is there a disaster recovery / business continuity plan?
  - Has it been tested in the last year / ever?
- What's the expected time to recover from backups?
- What's the off-site capability?
- How can we improve?

Practical tips: passwords

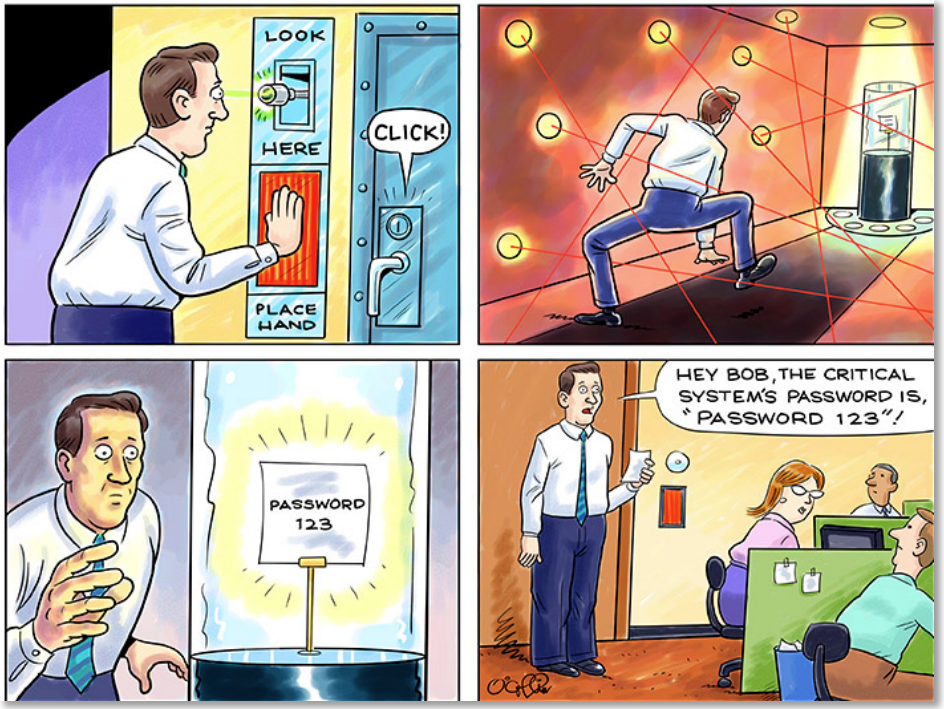
We all have too many passwords! Best practice is to use a password manager and multi -factor authentication wherever available. If that's not possible, make sure you do the following:

Hard to guess

Don't share

Don't write down

Practical tips: passwords



Practical tips: password managers

App	Notes
Bitwarden	Free & paid
LastPass	Free & paid
1Password	Free trial & paid
Dashlane	Limited free & paid
Keeper	Limited free & paid
KeePassXC	Free

https://www.cnet.com/tech/services -and-software/best -password -manager/

Practical tips: phishing

Email is critical BUT it's also the most likely source for data loss.

Attackers use psychology to tailor their attacks:

- Intimidation
- Impersonation
- Urgency

PREVENT phishing by:

- ✓ Limiting social media
- ✓ Double-checking links / content / senders
- ✓ Using MFA
- ✓ Taking it seriously

Questions?

Forum 50 YEARS+
EXTENDED CARE SERVICES

Brain Attack — Stroke Overview and Update

Barb Bancroft, RN, MSN, PNP

Barb is an industry professional with more than 40 years of experience in healthcare as a nurse, author, editor, educator, and speaker. She is a passionate and informative speaker on clinical topics such as pathophysiology, physical assessment, and pharmacology. Barb has taught more than 2,800 continuing education seminars on health-related topics and has served as the keynote speaker for professional associations and corporations, including the American Association of Practitioners for Infection Control, the American Academy of Nurse Practitioners, and the National Association of Orthopedic Nurses. Currently, Barb is the Executive Director and President of CPP Associates, Inc., a continuing education provider. Barb holds a Bachelor's degree in Nursing from East Carolina University and a Master's degree in Nursing from the University of Virginia.

Brain Attack: Stroke…10 FAST FACTS

Barb Bancroft
CPP Associates, Inc
Executive Director and President

Forum 50 YEARS+ EXTENDED CARE SERVICES

FAST FACT #1—the number one risk factor

- YOUR AGE…
- Most strokes occur in people over the age of 65
- The risk of having a stroke more than doubles each decade after the age of 55.
- Between 2000-2010 -- 44 percent increase in the number of young Americans (ages 18-54) hospitalized due to stroke.
- Lifestyle risk factors among younger people, including: hypertension (2nd most common cause of stroke); diabetes; obesity, and hyperlipidemia.

FAST FACT #2 – Act FAST

- Know the signs and symptoms of stroke and teach everyone else you know about the signs and symptoms of stroke…the FASTER we act, the better the outcome!
- In the first minute of a stroke, your brain loses an estimated **1.9** million cells, resulting in the loss of **14** billion synapses and **7.5** miles of pathways—what you would lose in **three** weeks of normal aging. (January 2006 *Stroke*)
- But the loss continues every minute the stroke is left untreated. If a stroke runs its usual **10**-hour course, it can kill **1.2** billion nerve cells—what a normal brain loses over the course of **36** years. (UCLA neurologist Jeffrey Saver) (Interview) 2007:34(2).
- **TIME IS BRAIN!!**

TIME IS BRAIN—Act FAST— "classic" signs and symptoms of a "brain attack"

- **F**acial symmetry — ask the patient to smile. Does one side droop?
- **A**rms — raise both arms…does one arm drift downward
- **S**peech — can a person repeat a single sentence? Is the speech slurred?
- **T**ime — call 911 immediately (U.S., Canada, Mexico) (New Zealand it's 111)(Australia? 000; Lots of 112's—most of Europe including Italy and France and the UK; UK? 999 or 55 or 112; Mexico? CHAD? (HUH?) **2251-4242—seriously?**)
- If you suspect a stroke; note the time the symptoms began

Get the patient to a major stroke center ASAP

- As we retire, we need to MOVE next door to a major stroke center not out in the country “to raise cows”…
- Next door won’t take so long to get to the ER

Act FAST for other stroke symptoms as well…

- Weakness or numbness in 1 side – arm, leg or both
- Dimness, blurring vision, “shade pulled down over my eye”-- especially one eye
- Severe headache…”bolt out of the blue”, ”worst headache I have ever had” — no cause found
- Unexplained dizziness, sudden drop or fall, especially with other signs
- **Note when symptoms started—When was your husband last seen as “normal?”**  (LKN…last known normal)
- Treatment protocols are guided by the time from onset of the stroke…the severity of the neurologic deficit, and findings on neuroimaging

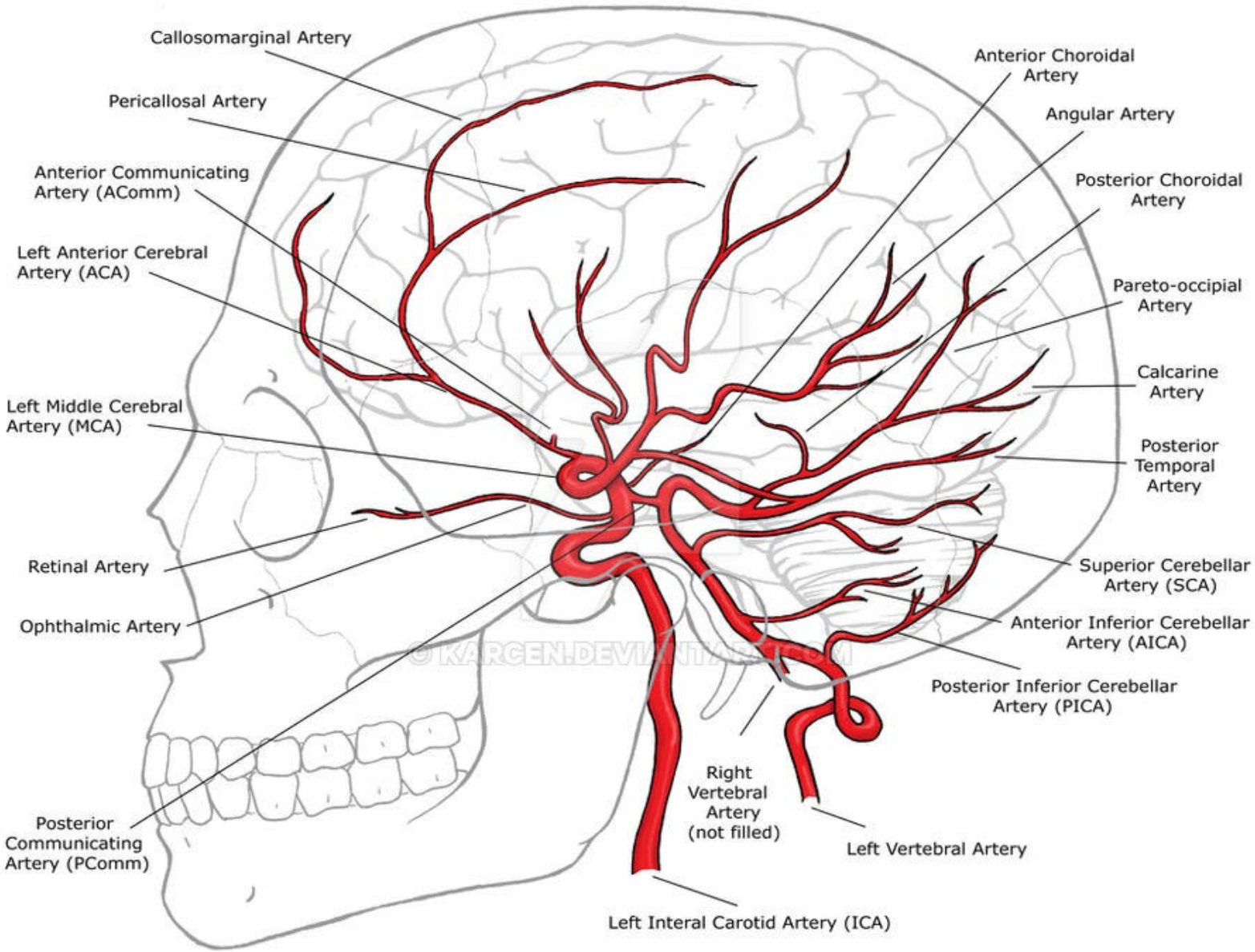
Time is BRAIN!! Act FAST

- In one survey, most respondents—93%—recognized sudden numbness or weakness on one side as a symptom of stroke.
- Only **38%** were aware of all major symptoms and knew to call 9-1-1 when they thought someone was having a stroke.
- ***How many Americans are living under a rock?***

FAST FACT #3—TWO TYPES OF STROKE

- Broadly divided into **ischemic** (87%) and **hemorrhagic** strokes (13%)
- 46% of all ischemic strokes are caused by the sudden occlusion of a **large** cerebral vessel (greater than 2 mm in diameter) (examples: internal carotid artery, the proximal middle cerebral artery, the anterior cerebral arteries, the basilar artery, the vertebral arteries, and the posterior cerebral arteries)
- One **large** vessel ischemic stroke occurs every 90' in the U.S.
- Worse prognosis in untreated **large** vessel ischemic strokes vs. small-vessel ischemic strokes (tributaries of the large vessels)
- **The operative word here is LARGE…GET IT? ☺**

ANTERIOR AND POSTERIOR CIRCULATION LATERAL VIEW



ISCHEMIC STROKES (87% of all strokes)—two types (coronal view and superior view)

Thrombotic -- atherosclerosis is the underlying culprit; fatty plaque in major vessel will rupture or "fissure" + thrombus forms on top of the plaque decreasing blood flow to the brain—internal carotid arteries are a favorite place for this type of stroke

Embolic – caused by clots; 20% of all ischemic strokes are caused by atrial fibrillation—an emboli from the left atrium; 90% of these emboli come from the left atrial appendage…so what can we do about that?

The Watchman procedure closes off the left atrial appendage

- LAAC (left atrial appendage closure) with Watchman provides stroke prevention in nonvalvular atrial fibrillation comparable to warfarin, with a decreased risk of major bleeding, particularly hemorrhagic stroke, and mortality.
- Anti-coagulants can usually be stopped within 45 days after the procedure

(Reddy VY, et al. 5-Year Outcomes After Left Atrial Appendage Closure: From the PREVAIL and PROTECT AF Trials. *J Am Coll Cardiol*. 2017 Dec 19;70(24):2964-2975. doi: 10.1016/j.jacc.2017.10.021. Epub 2017 Nov 4. PMID: 29103847)

Clinical profile of a thrombotic stroke (40% of all strokes)

- Older w/Hx of high cholesterol, atherosclerosis and HTN (diabetics w/all 3)
- gradual, stuttering (fluctuating) onset or in a stepwise progression of neurological signs over a longer period of time vs. an embolic stroke (instant)—
- carotid artery distribution (FACE, ARM, TRUNK, LEG) is the most common presentation;
- may hear a carotid bruit (stethoscope on neck)
- Only 5% with mental status changes
- MRI/CT shows ischemic infarction
- ~25% of the time there is a preceding Transient Ischemic Attack (TIA)

The temporal sequence of a thrombotic "full-blown" stroke

- 35% to 40% occur during sleep; may wake up with a thrombotic "stroke in progress" aka "wake-up" stroke. It's preferable to know WHEN the stroke symptoms started (but this is not always possible)—in other words, when was the patient last seen or known as normal? (LKN)
- *"Mrs. Toke, we think your husband has had a stroke…can you tell me when you last saw him behaving normally?"* 
- Bed at 11? Woke up at 7 with symptoms? Bed at 11? Woke up at 5, perfectly fine to go to the bathroom? Woke up again at 7 with symptoms?
- Treatment protocols are guided by the time from onset of the stroke…the severity of the neurologic deficit, and findings on neuroimaging

Embolic strokes (30% of all strokes)

- Atrial fibrillation (Afib) is the #1 cause; mechanical valves, endocarditis*
- The middle cerebral artery is the main branch of the internal carotid artery that is most involved (Face, Arm)
- Fat emboli from long bone fractures or liposuction (butt lifts are especially dangerous)

*Endocarditis with clot formation in younger patients—such as IV drug users; use of COCs in young women with migraines with aura

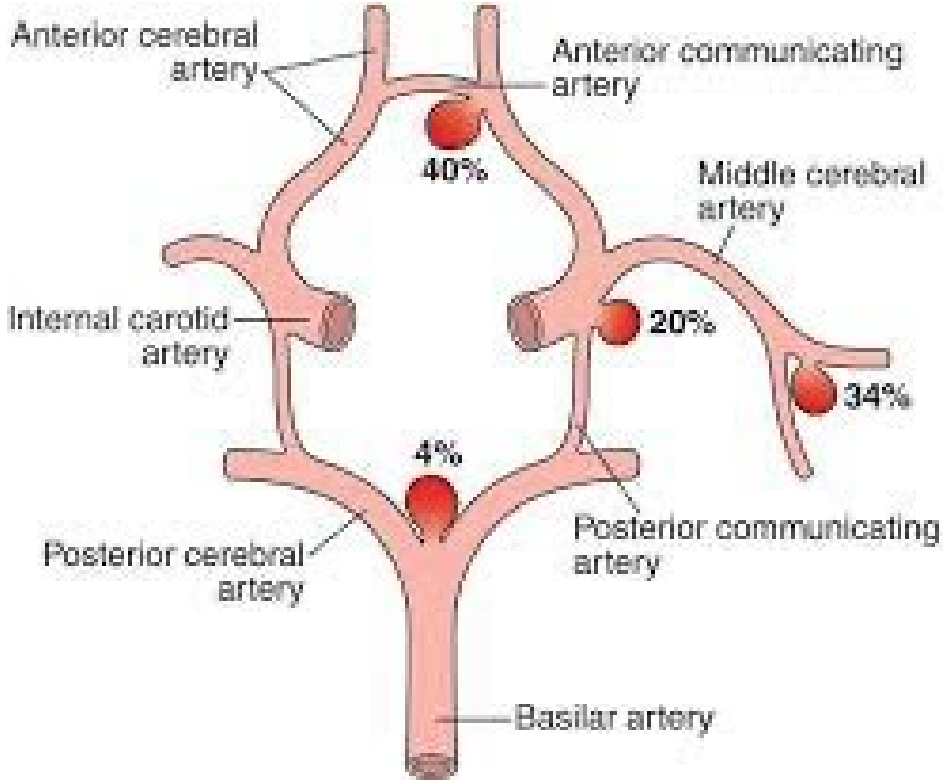
Clinical profile of an embolic stroke (30% of all strokes)

- Sudden onset, often during a usual daily activity;
- Onset may be associated with palpitations, initiation of a cardiac arrhythmia, or following the Valsalva maneuver, heavy lifting or voiding, trauma with fracture
- 10% with preceding TIAs;
- 1% with altered mental status
- 80% of patients reach their peak neurological deficits at or near onset, often with improvement shortly afterward as the embolus breaks up and portions travel farther out into more distal branches of the affected artery

HEMORRHAGIC STROKES (13% of all strokes)

4 major causes:

- Ruptured aneurysm with a subarachnoid hemorrhage—usually in the major arteries at the base of the brain that form the Circle of Willis
- Ruptured AV (arteriovenous) malformation (congenital)
- Hypertensive rupture of fragile penetrating arteries-lenticulostriate arteries off the middle cerebral artery
- The patient is on anti-coagulants



What is the clinical profile of a patient with a hemorrhagic stroke?

- Sudden onset— "OMG, this is the absolute worst headache I have ever had", along with a prominent decrease in or loss of consciousness early in the course or complete loss of consciousness at the beginning
- fluctuation of mental status is a common feature.
- Increased ICP with hypertension accompanied by bradycardia (Cushing reflex); vomiting

FAST FACT #4…In a perfect world the recommended stroke evaluation time would be…

- Door to Doc – 10 minutes
- Access to neuro expert – 15 minutes
- Door to CT scan completion – 25 minutes
- Door to CT scan interpretation – 45’
- Door to treatment – 60 minutes
- Admission to monitored bed for endovascular therapy (tPA) – 3 hours
- OR LESS…

FAST FACT #5. THE FUTURE is ALMOST HERE: Mobile stroke units – 20 in the U.S.

- Mobile stroke units are state-of-the-art ambulances equipped with a mobile CT scanner to provide stroke patients with an emergency diagnosis and treatment before they arrive at the hospital
- More than 50% of stroke patients treated by a mobile stroke unit made a complete recovery after three months, compared with less than 43% who underwent emergency care in a standard ambulance.

CT scan—rapidly ruling OUT hemorrhage (1-2 minutes once the patient is in the scanner)

- CT (without contrast) is available 24 hours a day and is the gold standard for ruling out an acute hemorrhage as the cause of the stroke. (White and gray matter of the brain have sufficient contrast to be differentiated without contrast)
- Ischemia on the top CT; hemorrhage on the bottom CT

FAST FACT #6: What can we do? We can breakdown the clot/thrombus…

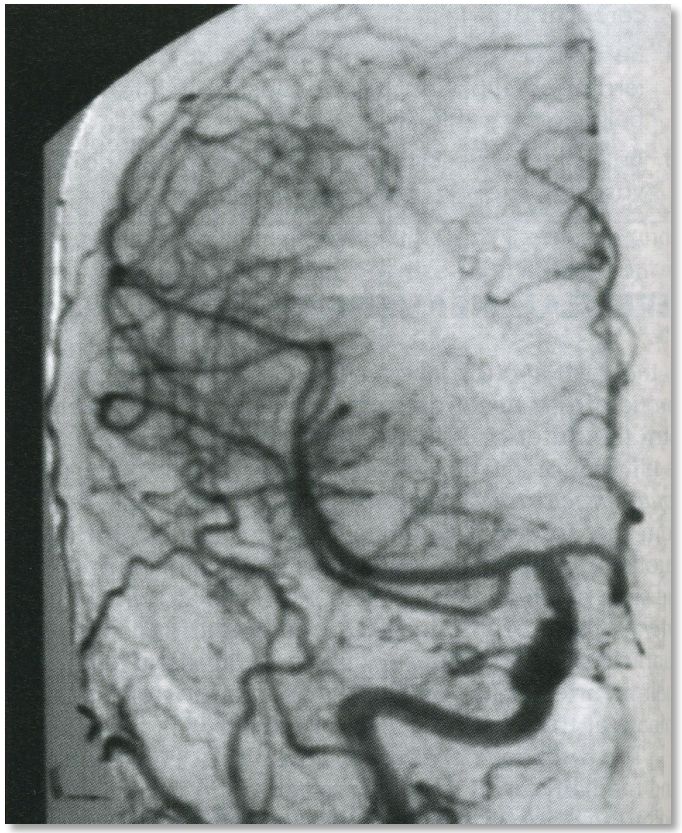
- Alteplase or tenecteplase—IV tissue plasminogen activase to breakdown the clot; “In a perfect world, given to all eligible patients within 4.5 hours” of last known normal and to a more select group meeting specific criteria after 4.5 – 9 hours
- **Give as soon as possible! For every 1000 patients treated 15 minutes earlier than 4.5 hours, there were 11 more patients with independent ambulation at discharge, 12 more discharged to home, and 9 more with functional independence.**

FAST FACT #7: OR we can pull out the clot via…

- mechanical thrombectomy (Endovascular thrombectomy—EVT)—improves outcomes over clot busting drugs—can be used with the "clot-busting" drugs or by itself
- retrieve and remove the clot in selected patients—early window (6 hours) plus an extended window for certain patients with **large** vessel occlusions (internal carotid artery or proximal middle cerebral artery) from 6 hours to 24 hours

Let's take a look…this is a normal angiogram of a major cerebral artery…the middle cerebral artery

- internal carotid artery branching into the anterior cerebral arteries (ACA) that goes straight up the middle between both lobes—and branches laterally through the middle cerebral artery…



Voilá! Mechanical thrombectomy success!

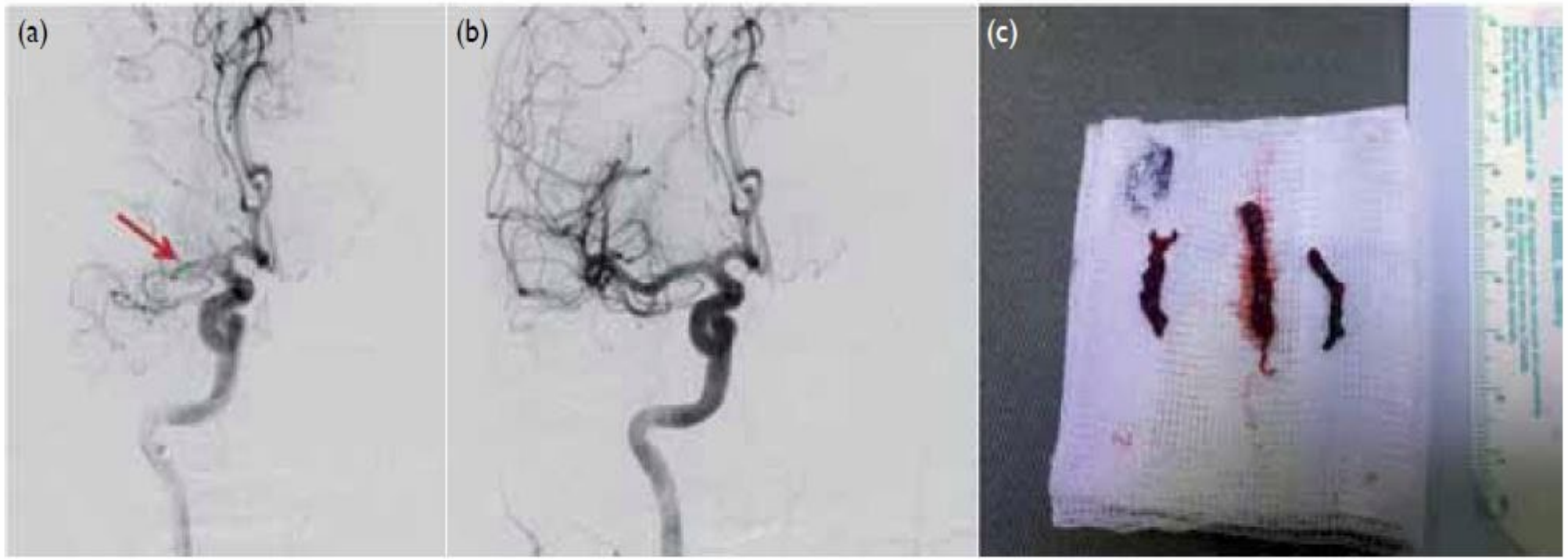


FIG 1. (a) Angiogram showing acute occlusion of the right middle cerebral artery (arrow). (b) Post-thrombectomy angiogram showing revascularisation of the right middle cerebral artery territory. (c) Thrombus removed by endovascular thrombectomy

FAST FACT #8—New definition of a TIA (transient ischemic attack)("mini-stroke")

- DEFINITION: a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia, **without** acute infarction. (AHA/ASA; 2019; Amarenco P. Transient Ischemic Attack. N Engl J Med 2020;382:1933-42)
- Tissue-based definition as well: no visible tissue damage on brain imaging studies; if a minor ischemic brain lesion (white dot) is found it's called a minor ischemic stroke
- Clinical presentation: neurologic manifestations that **last for no more than one hour** (most last for seconds or a few minutes and less than one hour—average time? 5 minutes)

MOST COMMON NEUROLOGICAL PRESENTATIONS OF A TIA

- Temporary loss of vision (amaurosis fugax—a transient monocular blindness) *("Feels like a curtain was pulled down over my eye…")* (Ophthalmic artery branch of the internal carotid)
- Aphasia
- Hemiparesis
- Paresthesia's (numbness/tingling) (unilateral)

TIAs (transient ischemic attacks) or “mini-strokes”

- ~30% of people who have a TIA and don’t get treatment have a major stroke within 1 year. 10% to 15% of people will have a major stroke within 3 months of a TIA. (American Heart Association/American Stroke Association.. Accessed October 6, 2016)
- Recognition of the TIA provides a critical opportunity to quickly find and treat the cause – ischemic strokes and TIA’s are treated the same...consider for urgent revascularization
- Immediate treatment can reduce the risk of stroke within 3 months by 80% -- antiplatelet drugs, anticoagulants, reduce BP, HbA1C, and high lipids
- $ABCD^2$ score—Age (greater than 60 – 1 pt), BP (greater than 140/90—1 pt) Clinical weakness/speech disturbance (weakness 2 pts, speech disturbance 1 pt), Duration (longer than 10 minutes—1 pt; greater than 60 minutes—2 pts)/Diabetes (1 pt)--total points = 7; higher the score the greater the risk of more serious ischemic event

FAST FACT #9—PREVENTION is the BEST MEDICINE!!

- ***The incidence of stroke increases directly in relation to the degree of elevation of systolic and diastolic blood pressure.***
- **Hypertension** accounts for 35-50% of stroke risk.
- 180/120 is a hypertensive URGENCY—may experience stroke symptoms with BP this high
- 30 to 40% reduction in stroke risk with lowering of blood pressure.
- TOP 3 classes to prescribe?
  1. Thiazide diuretics (HCTZ) or thiazide-like diuretics (Chlorthalidone)—first choice for monotherapy for hypertension
  2. ACE inhibitors— "the prils"—
  3. ARBs—the "sartans"

FAST FACT #9—PREVENTION is the BEST MEDICINE!! Lose weight!

- Weight loss decreases blood pressure
- Particularly those who have “central obesity” where extra weight is carried around the belly.
- Men with waist circumference of 101.6 cm (40 inches) or more and women with waist circumference of 88.9 cm (35 inches) or higher are at particularly high risk of stroke.
- 85% of weight loss is ***portion control***; 15% exercise

FAST FACT #9—PREVENTION is the BEST MEDICINE!! Stop smoking!

- Current smokers who smoke 20 or more cigarettes per day have a 2 to 4x greater stroke risk
- Quitting will significantly reduce the risk within two years
- Within five years, your risk will be the same as someone who never smoked

FAST FACT #9—PREVENTION is the BEST MEDICINE!! Decrease cholesterol…

- The link between high cholesterol and stroke isn't as clear cut as the link between high cholesterol and acute coronary syndromes.
- However, high blood cholesterol increases the risk of atherosclerosis in the carotid arteries that supply the brain subsequently reduce blood flow to the brain
- In addition, a ‘ruptured’ (fissured plaque) in those large arteries can expose collagen and attract clotting factors…causing a “thrombotic” stroke

Say “YES” to the “statins” to lower LDL cholesterol and decrease fat in the large cerebral arteries

High-intensity (higher dose) statins—daily dose lowers LDL by greater than or equal to 50%--reducing LDL-c to 70 mg/dL or even lower

The top 2 statins are:

- atorvastatin (Lipitor)—40-80 mg
- rosuvastatin (Crestor)—20-40 mg

Moderate-intensity statins—lower LDL by 30- 50%; best choice for the elderly

- Atorvastatin – 10-20 mg
- Rosuvastatin – 5-10 mg
- pravastatin (Pravachol)—40-80 mg
- simvastatin (Zocor)—20-40 mg (not a good choice—too many drug interactions)

FAST FACT #9—PREVENTION is the BEST MEDICINE!! Treat Diabetes Mellitus

- **Diabetes:** Diabetics are 2 to 3 times more likely to develop stroke. Almost 20% of people who have a stroke are diabetic.
- Diabetes is a **proatherosclerotic** disease
- 70-80% of diabetics also have hypertension ("the deadly duo")
- Treat the hypertension, treat the elevated lipids, and, of course, treat the hyperglycemia—HbA1C to less than 7
- Metformin + another drug to start—GLP-1 agonist (glutides) or Metformin + SGLT2 inhibitor (flozin); may add a basal insulin (insulin glargine for example)

FAST FACT #10…We're DONE! QUESTIONS?

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Survey After COVID

Sheila Baker, RN, MBA, JD

Sheila joined the Illinois Department of Public Health (IDPH), Office of Healthcare Regulation, as the Bureau Chief of Long-Term Care in 2021. She is responsible for long-term care Federal, State and licensure surveys in Illinois as well as the Special Investigations Unit, Compliance Assurance, and Certification and Licensures. Before joining IDPH, Sheila served as the Vice President of Operations for Cigna and as the Director of the Post-Acute Preferred Provider Network for Presence Health, where she developed quality care criteria for skilled and long-term nursing care providers.

Sheila is a member of the Illinois State Bar and practiced law for several years, focusing on employee/labor relations, contracts, and healthcare compliance. Sheila holds a Juris Doctorate from the University of Illinois Champaign Urbana, a Master of Business Administration from Saint Xavier University, and a Bachelor of Science in Nursing from Marquette University. She is a member of the American Health Lawyers Association, American College of Healthcare Executives, and the Medical Group Management Association.

IDPH Long Term Care Survey 2022

Sheila Baker
Bureau Chief, Long Term Care
Office of Healthcare Regulation
Illinois Department of Public Health

Forum 50 YEARS+ EXTENDED CARE SERVICES

Agenda

01

Most cited deficiencies and compliance issues

02

Navigation of IDPH guidance, waivers & emergency rules

03

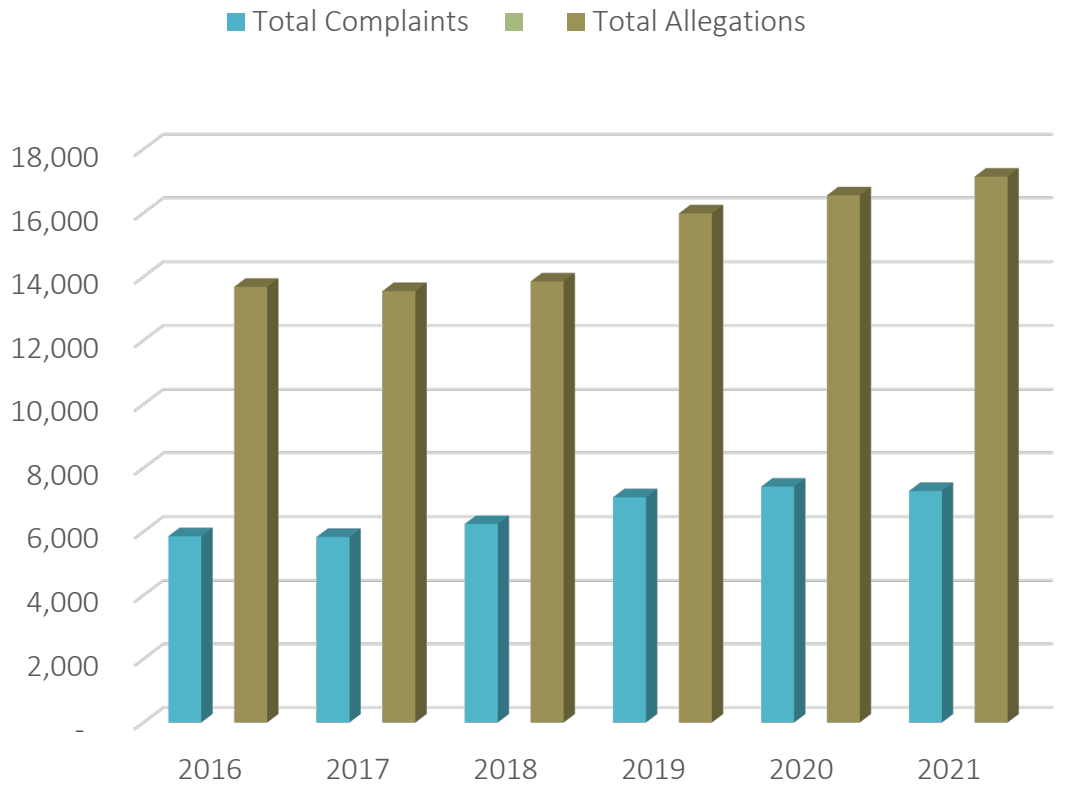
Understanding of the survey cycle

Most cited deficiencies and compliance issues

COMPLAINT INTAKE & ALLEGATIONS

	2016	2017	2018	2019	2020	2021
Total Complaints	5,849	5,826	6,237	7,073	7,409	7,272
Total Allegations	13,677	13,544	13,847	15,981	16,547	17,136

Leading Complaints by Allegation	2016	2017	2018	2019	2020	2021
Administration/Personnel Allegations	1,864	2,242	2,342	2,167	1,498	1,751
Nursing Services Allegations	684	438	445	977	1,044	1,488
Physical Environment Allegations	1,201	1,051	1,325	1,500	927	831
Quality of Care/Treatment Allegations	3,827	4,011	4,286	4,896	4,675	4,806
Resident/Patient/Client Abuse Allegations	921	925	878	1,090	1,134	1,016
Resident/Patient/Client Rights Allegations	935	943	1,000	1,398	1,637	1,796



483.15 Administration & Personnel: 17 F-tags including one substandard quality of care

483.35 Nursing Services: 8 F-tags most related to staffing, competency

483.90 Physical Environment: 21 F-tags

483.24 Quality of Care: 16 F-tags all potential for substandard quality of care

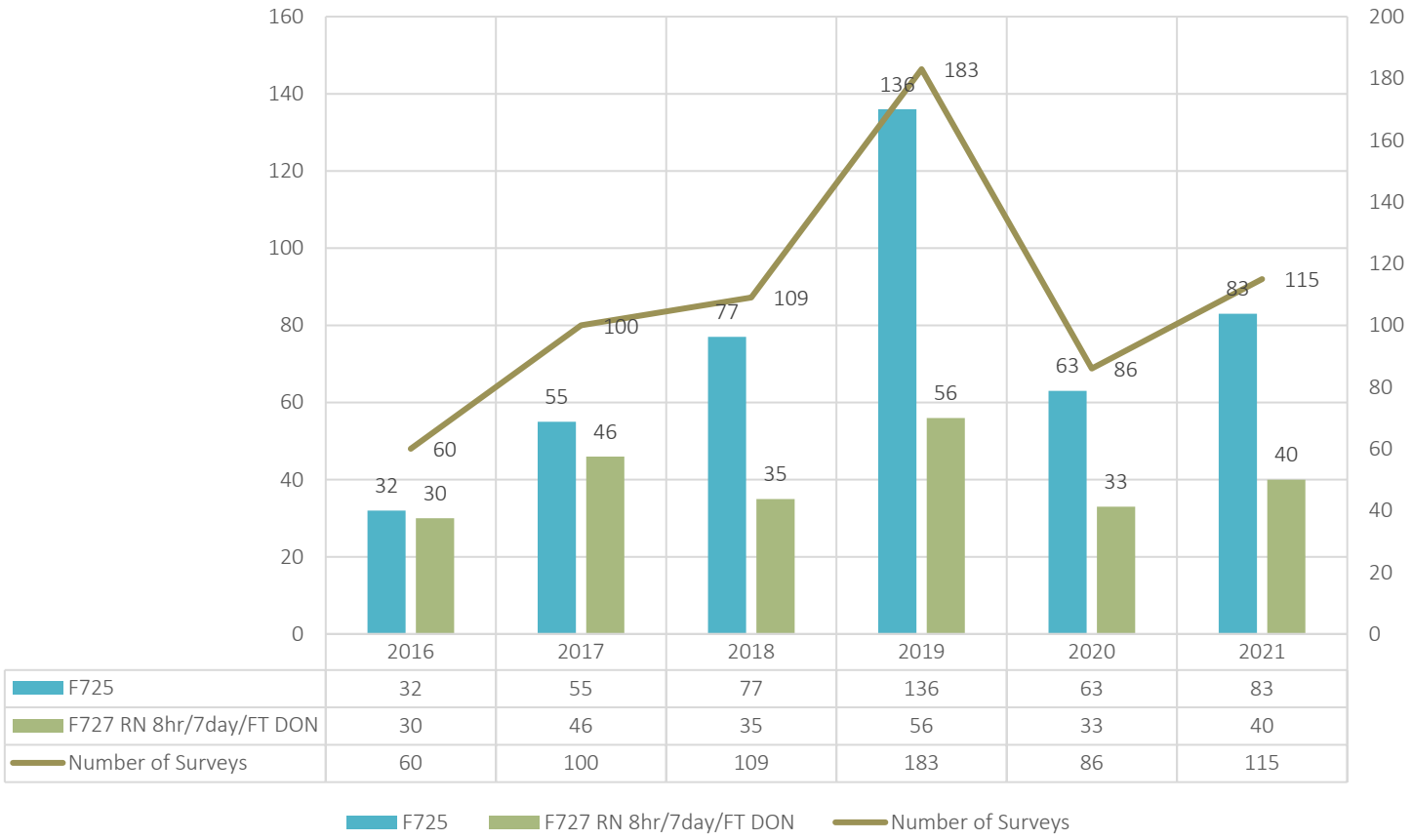
483.10 Resident Rights: 35 F-tags 6 potential substandard quality of care

483.12 Resident Abuse: 9 F-tags all potential substandard quality of care

Related CFR & F-tags

Administration/Personnel Allegations

- Failure to follow abuse policies and procedures
- Background checks not completed
- Unlicensed staff working in facility
- Failure to report serious injuries to IDPH
- Inappropriate staff behavior
- Failure to release medical records



	2016	2017	2018	2019	2020	2021
F725	32	55	77	136	63	83
F727 RN 8hr/7day/FT DON	30	46	35	56	33	40
Number of Surveys	60	100	109	183	86	115

Nursing Services Allegations

- Predominantly staffing related

Quality of Care Allegations

- Improper infection control practice
- Call lights not answered
- Medication not administered per physician's order
- Improper incontinent care
- Failure to prevent pressure ulcers
- Lack of MD notification change in condition

Resident Abuse & Rights Allegations

Retaliation	Visitation restricted/denied	Dignity issues
Staff refusing to provide care	Moving call lights out of reach	Facility took personal items/searched belongings

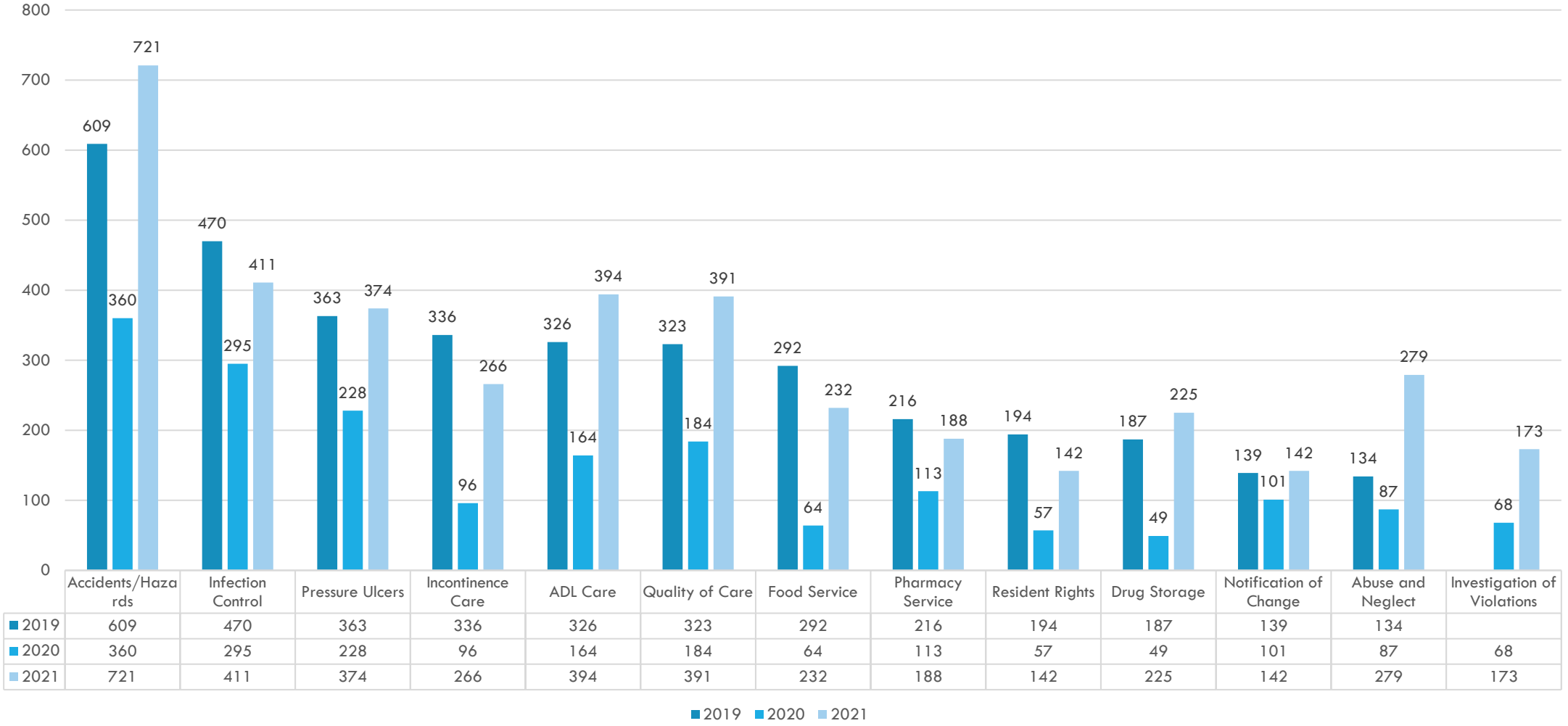
Top 10 Skilled Nursing/Nursing Facility Deficiencies Cited by IDPH in 2021

Tag	Tag Description	# Citations	% of Providers Cited
F689	Free of Accident/Hazards/Supervision/Devices	721	59.5
F880	Infection Prevention & Control	411	46.6
F677	ADL Care Provided for Dependent Residents	394	36.4
F684	Quality of Care	391	37
F686	Treatment/Services to Prevent/Heal Pressure Ulcers	374	37
F600	Free from Abuse or Neglect	279	27.1
F690	Incontinence/Catheter/UTI	266	29.7
F812	Food Procurement/Store/Prepare/Serve/Sanitary	232	30.4
F761	Label/Store Drugs and Biologicals	225	30.1
F755	Pharmacy services/procedures/records	188	21.7
Tag	**Notable Mention**		
F609	Reporting of alleged violations	181	18.80
F610	Investigating/preventing/correcting alleged violation	173	19.30
F758	Free from unnecessary psychotropic medications	138	19.00

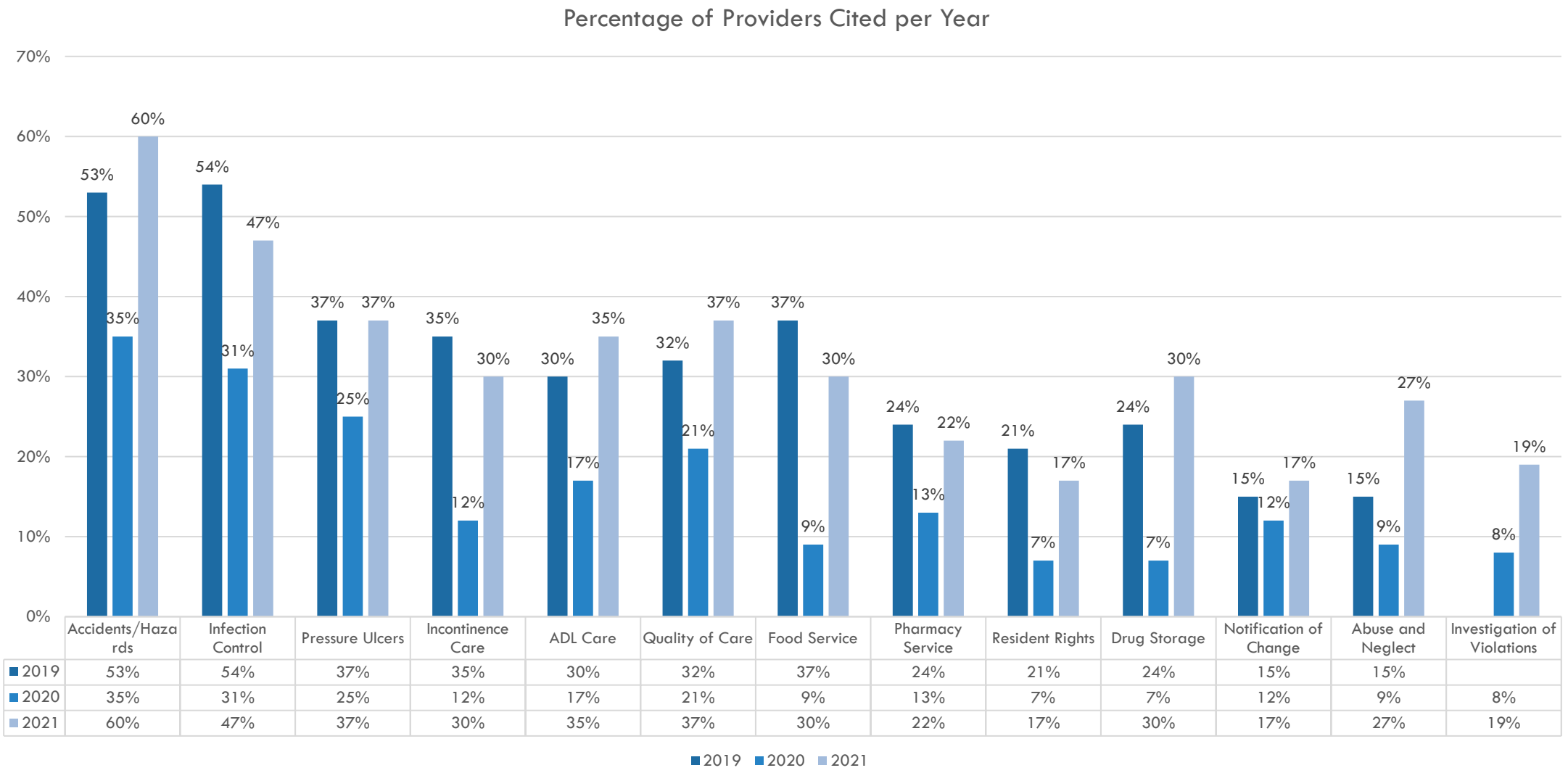
LOOK BACK TOP 10 DEFICIENCIES

Tag	Tag Description	2021 Citations	2020 Citations	2019 Citations
F689	Free of Accident/Hazards/Supervision/Devices	721	360	609
F880	Infection Prevention & Control'	411	295	470
F677	ADL Care Provided for Dependent Residents	394	164	326
F684	Quality of Care	391	184	323
F686	Treatment/Services to Prevent/Heal Pressure Ulcers	374	228	363
F600	Free from Abuse or Neglect	279	87	134
F690	Incontinence/Catheter/UTI	266	96	336
F812	Food Procurement/Store/Prepare/Serve/Sanitary	232	64	292
F761	Label/Store Drugs and Biologicals	225	49	187
F755	Pharmacy services/procedures/records	188	113	216
	Notable Mention			
F609	Reporting of alleged violations	181	66	128
F610	Investigating/preventing/correcting alleged violation	173	68	116
F758	Free from unecssary psychotropic medications	138	48	167

Most Cited Deficiencies by Year



	Accidents/Hazards	Infection Control	Pressure Ulcers	Incontinence Care	ADL Care	Quality of Care	Food Service	Pharmacy Service	Resident Rights	Drug Storage	Notification of Change	Abuse and Neglect	Investigation of Violations
2019	609	470	363	336	326	323	292	216	194	187	139	134	
2020	360	295	228	96	164	184	64	113	57	49	101	87	68
2021	721	411	374	266	394	391	232	188	142	225	142	279	173



	Accidents/Hazards	Infection Control	Pressure Ulcers	Incontinence Care	ADL Care	Quality of Care	Food Service	Pharmacy Service	Resident Rights	Drug Storage	Notification of Change	Abuse and Neglect	Investigation of Violations
2019	53%	54%	37%	35%	30%	32%	37%	24%	21%	24%	15%	15%	
2020	35%	31%	25%	12%	17%	21%	9%	13%	7%	7%	12%	9%	8%
2021	60%	47%	37%	30%	35%	37%	30%	22%	17%	30%	17%	27%	19%

Tag	Tag Description	2022 Projected*	2022 Citations	2021 Citations
F689	Free of Accident/Hazards/Supervision/Devices	588	196	721
F880	Infection Prevention & Control'	366	122	411
F677	ADL Care Provided for Dependent Residents	384	128	394
F684	Quality of Care	351	117	391
F686	Treatment/Services to Prevent/Heal Pressure Ulcers	315	105	374
F600	Free from Abuse or Neglect	252	84	279
F690	Incontinence/Catheter/UTI	177	59	266
F812	Food Procurement/Store/Prepare/Serve/Sanitary	222	74	232
F761	Label/Store Drugs and Biologicals	171	57	225
F755	Pharmacy services/procedures/records	195	65	188

LOOKING AHEAD TOP 10 DEFICIENCIES

Examples of Non-Compliance

Failed to keep cleaning supplies out of reach, resident with dementia ingests, hospitalized with esophageal damage

Failed to apply a smoke apron and resident suffered 3rd degree burns

Failed to move bed away from radiating heater causing 3rd degree burns on physically impaired resident

Failed to use two persons to transfer/mechanical lift, fall and subdural hematoma, death

Failed to supervise while toileting, falls with injuries

Accidents, Hazards & Supervision

CMS Enforcement Actions for Deficiencies

Types of Enforcement Actions

- Plans of Correction (including Directed)
- Discretionary Denial of Payment for New Admissions (DOPNA)
- Denial of Payment for all Residents
- Directed In-Service Training
- Civil Money Penalties

Total Enforcement Actions

- 2021: 1,535
- 2020: 1,285
- 2019: 246
- 2018: 244

State Violations

Licensure Findings & Violations separate from Federal enforcement cycle and may include:

- Plans of Correction
- Money penalties


QUESTIONS

Navigation of IDPH guidance, waivers & emergency rules

The Regulatory Maze

Secretary of State Index

Illinois Register (ilsos.gov)

Illinois Register 2020 Yearly Index (ilsos.gov)

SIREN

SIREN (illinois.gov)

Advisory Boards

Long-Term Care Facility Advisory Board(illinois.gov)

Joint Committee on Administrative Rules Joint Committee on Administrative Rules

TITLE 77: PUBLIC HEALTH : Parts Listing

Centers for Medicare & Medicaid

Policy & Memos to States and Regions | CMS

Vaccine requirements CMS Certified Facilities

Enforcement actions triggered by Scope & Severity of non-compliance

Plans of correction (including directed)
Directed in-service training
Civil money penalties
Denial of payment for new admissions

State licensure violations may apply based on Scope & Severity of non-compliance

Vaccine Requirements Licensed Facilities

Skilled Nursing: Automatic high-risk designation (generally doubles fines) and imposes an “A” violation

- Conditional license
- Plan of correction
- Up to $12,500 fine per violation

Assisted Living: Type 1 $2,000 initial, up to $10,000 repeat

Community Living: Licensure revocation

Sheltered Care: Type A

SMHRF/ICFDD: Type A

Federal and State Waivers

CMS Waivers: Coronavirus Waivers | CMS

CMS Compliance Group: CMS Ending COVID-19 PHE-related Blanket Waivers | CMS Compliance Group

State of Illinois Executive & Administrative Orders: Executive & Administrative Orders (illinois.gov)

RN Waivers & Staffing Rules


QUESTIONS

Understanding of the survey cycle

CMS Waivers Expiring in May

- Resident Groups
- Physician Delegation of Tasks in SNFs/ Physician Visits –
- QAPI
- Information Sharing for Discharge Planning Clinical Records

CMS Waivers Expiring in June 2022

- Outside Doors and Windows,
- Life Safety Code (LSC), and Health Care Facilities
- Paid Feeding Assistants
- In–Service Training for Nurse Aides
- Training and Certification Nurse Aides

- Onsite survey: observation, interview, record review
- Writing the statement of deficiencies
- Supervisor review
- Transmittal to compliance assurance
- Initiating enforcement
- Compliance
- Appeals

Survey Process

SURVEY EXIT DATE OPENS AN ENFORCMENT CYCLE

State issues the SOD to Facility within 10 business days

30-45 DAYS OPPORTUNITY TO CORRECT if only Level 2 deficiencies (45 days)) or a G tag that the facility does not have a history of G or higher back to and including the last annual survey and the tag is not in a SQC category (30 days).

As a courtesy, the State provides a 70 DAY notice of mandatory DOPNA

3 MONTHS is mandatory Denial of Payment for New Admissions

6 MONTHS mandatory Termination of Medicare and Medicaid Certification

TIMELINE

Enforcement Process

"D" or above begins survey (enforcement) cycle

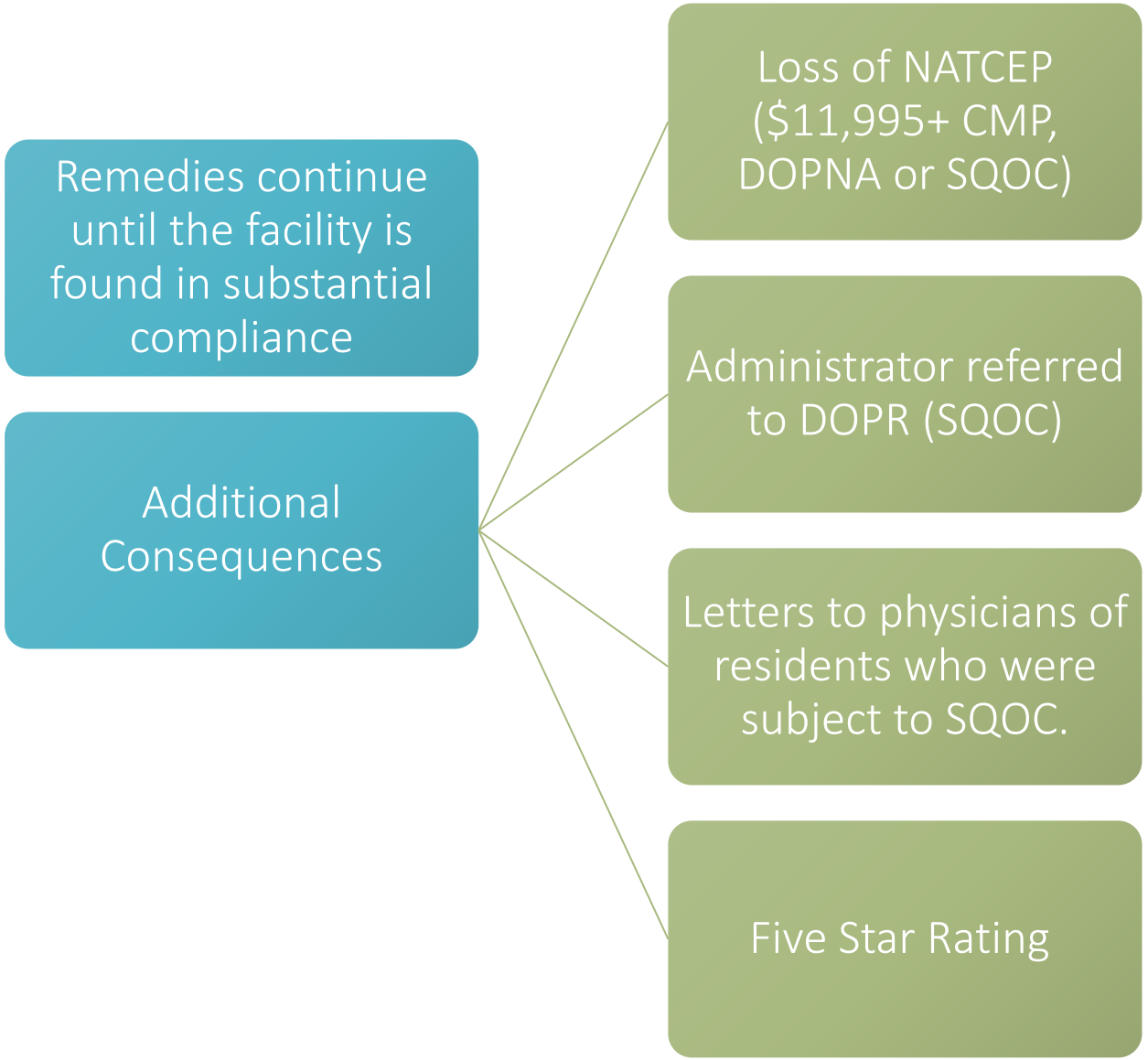
DPNA in 3 months or Discretionary Denial of Payment for New Admissions (DDOPNA) in less time

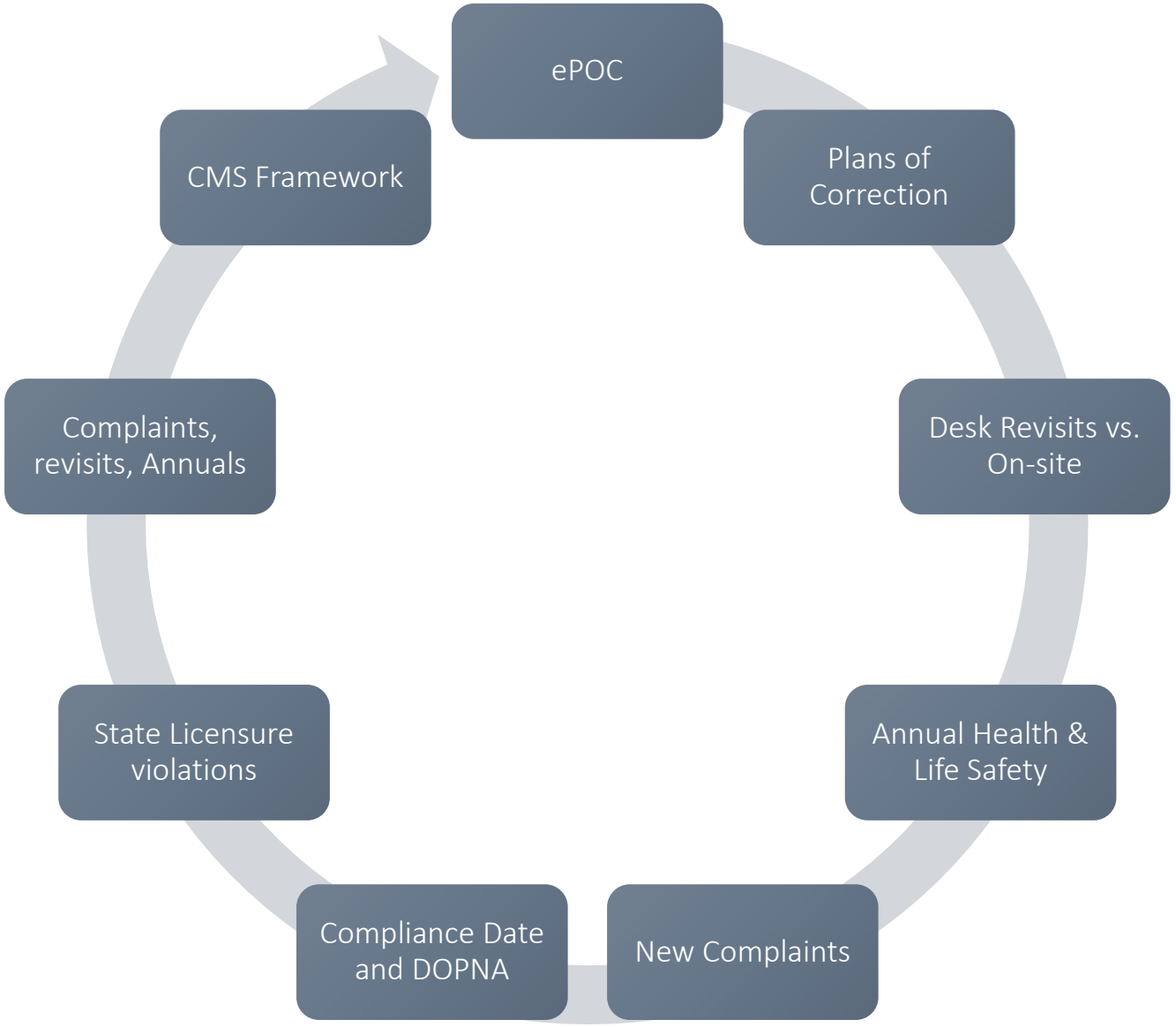
Termination in 6 months

Other remedies may be imposed, recommended or imposed

With "A," "B," or "C" must still submit POC or correct- but are considered in substantial compliance.

Enforcement Process (cont'd)





Enforcement Cycle Information

Future Policy/Regulatory Agenda

"... federal and state governments, nursing homes, health care and social care providers, payers, regulators, researchers, and others need to make clear a shared commitment to the care of nursing home residents. Fully realizing the committee's vision will depend upon the collaboration of multiple partners to honor this commitment to nursing home residents, their chosen families, and the staff who strive to provide the high-quality care every resident deserves."

National Academies of Sciences, Engineering, and Medicine 2022. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. Washington, DC: The National Academies Press. https://doi.org/10.17226/26526.

Illinois Policy/Regulatory Agenda 2022

- Quality Improvement
- IDPH/Industry collaboration
- State agency collaboration
- Civil Money Penalty distribution
- Infection control/COVID 19
- Staffing Rules
- Modernizing Website
- Strikeforce CDC Grant

National Policy/Regulatory Agenda

- Establish minimum staffing
- Increased regulatory oversight/enforcement
- Technical Assistance
- Transparency
- Improving staffing/workforce sustainability

References

CASPER Report of Enforcement Actions, 2019-2022

National Academies of Sciences, Engineering, and Medicine 2022. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. Washington, DC: The National Academies Press. https://doi.org/10.17226/26526.

Nursing Home Care Act, 210 ILCS 45. 210 ILCS 45

Fact sheet: Protecting seniors by improving safety and quality of care in the nation's nursing homes. The White House. February, 2022. Skilled Nursing & Intermediate Care Facilities Code 77 Ill.Adm.300

Sheltered Care Facilities Code 77 Ill.Adm.330

Intermediate Care for Developmentally Disabled Facilities Code 77 Ill.Adm.350

Community Living Facilities Code 77 Ill.Adm.380

Specialized Mental Health Rehabilitation Facilities Code 77 Ill.Adm.380


QUESTIONS


Thank
You

Dealing with Difficult Families

Benjamin Surmi, MSG, Social Gerontologist

The focus of Benjamin's work as a social gerontologist is to empower people to thrive, no matter the disability or cognitive disorder they may have. He is passionate about designing powerful user experiences for elders and the people who serve them. Benjamin joined Koelsch Senior Communities in 2016 as the Director of Programs and Training before moving into the Director of Education and Culture in 2018, where he shapes innovative engagement experiences for seniors, as well as specialized programming for people living with dementia. Benjamin also guides person-centered training for over 2,000 employees in 8 states, leads Koelsch Innovation Lab, and coaches 70+ wellness directors and 32+ Executive Directors who support over 1,500 seniors. His passion is imagining the impossible and building alliances that make it possible. Benjamin holds a Bachelor's degree in Communication and Sociology from Biola University and a Master's degree in Gerontology from California State University.

Dealing with Difficult Families

Benjamin Surmi
Koelsch Communities
Director of Education and Culture

50 YEARS+
Forum
EXTENDED CARE SERVICES

Learning objectives

1. Identify the common causes of stressful encounters with family members of patients and residents

2. Determine where gaps exist in their current practices with best practices for proactively preventing challenging family dynamics

3. Develop a toolbox of simple-to-implement actions they can quickly choose from when experiencing an unpleasant family interaction

Evaluation questions

A. Assuming care, food, and service are quality, why do many family members communicate with anger or frustration toward team members?

a. They have a rude or mean character

✓ b. They are experiencing an overwhelming amount of emotion and stress

c. It's the best approach to advocating for a loved one

d. Our culture teaches us this is acceptable

Evaluation questions

B. If we become present to the task a family member is trying to accomplish, which word could we use to help us re-frame the phrase “difficult family member?”

a. Best friend
b. Team member
✓ c. Advocate
d. Professional

Evaluation questions

C. What is the primary reason writing down concerns immediately in front of a family member is so helpful?

a. It helps you not forget
b. It keeps a record for quality assurance
✓ c. It shows the family member you are actually listening and taking them seriously
d. The practice trains team members in hospitality best practices

Evaluation questions

D. What is the one thing we should almost never do when responding to an unpleasant interaction with a family member?

✓ a. Defend
b. Educate
c. Persuade
d. Listen

Evaluation questions

E. Why is training family members how to advocate a powerful strategy?

✓ a. It removes their fear that things may be going wrong
b. It gives them the tools to succeed at advocacy
c. It creates a safe space for sharing concerns
d. It helps them see you care

Thank you!

Shampoos, Tattoos, and Bar-B-Ques: What's New in the World of Infectious Diseases?

Barb Bancroft RN, MSN, PNP

Barb is an industry professional with more than 40 years of experience in healthcare as a nurse, author, editor, educator, and speaker. She is a passionate and informative speaker on clinical topics such as pathophysiology, physical assessment, and pharmacology. Barb has taught more than 2,800 continuing education seminars on health-related topics and has served as the keynote speaker for professional associations and corporations, including the American Association of Practitioners for Infection Control, the American Academy of Nurse Practitioners, and the National Association of Orthopedic Nurses. Currently, Barb is the Executive Director and President of CPP Associates, Inc., a continuing education provider. Barb holds a Bachelor's degree in Nursing from East Carolina University and a Master's degree in Nursing from the University of Virginia.

Shampoos, Tattoos, and Bar-B-Ques: What's New in the World of Infectious Diseases

Barb Bancroft
CPP Associates, Inc
Executive Director and President

Forum 50 YEARS+ EXTENDED CARE SERVICES

Let's start by listing the top "trends" in infectious disease today…

1) Hand washing—seriously? Handwashing has been around for ~175 years but some people still don't get it…
2) Immunization/vaccination—hundreds of millions of lives have been saved with vaccination from when the Chinese first "sowed" the smallpox in the 15th century—we ***can't*** get enough of these **(AND some people still don't get it)**
3) Sexually transmitted infections (STIs)—yep, we're still having sex after all these millenniums—there are just more of them…in my college days? There were just 2 "VDs"
4) Global everything—global warming (yes, it's happening under the guise of climate change), global travel, global economics

So, what are the top "trends" in the world of infectious disease?

5) Zoonoses—diseases from animals to humans from bats to bobcats, cow brains to cow pods, tomcats to turtles, puppies to parrots, reptiles to ragdolls; **3/4th of all emerging diseases are zoonotic**—begin in animals and via a genetic mutation are capable of jumping the species barrier to humans
6) "Microbes on the Menu" (Food-borne illnesses) so to speak—and there are over 100 of them
7) Immunocompromised patients of all ages, shapes and sizes—from neonates to nonagenarians
8) Healthcare Associated Infections—If you're not sick when you get to the hospital? Not a problem…admitted for a C-section? Stay awhile with C. diff
9) Antibiotic stewardship—We're finally figuring out how to use antibiotics—the right drug, the right dose, and the right amount of time

The 1st TREND in the world of infectious disease—a brief blurb on hand washing

- 80% of all infections are transmitted via contact—and the number ONE contact is touch
- Would you shake hands with a man who has just exited the men's room at O'Hare International Airport?
- The even bigger question…
- Gender differences--74% vs. 88% in handwashing after using the public bathroom

I know you know this…but ”just in case”…

- Dry your hands thoroughly with paper towels –damp/moist hands transmit pathogens more readily than dry hands—paper towels cost more but are better than…
- Hand blow dryers (the DYSON hand dryer, the Mother of all hand dryers, shoots pathogens around the restroom with hurricane force 420 mph winds) + the “still damp” factor)

(Huesca-Espitia C. et al. Deposition of Bacteria and Bacterial Spores by Bathroom Hot-Air Hand Dryers. Applied and Environmental Microbiology. 2018 Feb 9; DOI: 10.1128/AEM.00044-18)

Hand washing with soap & water—how long?

-  Happy Birthday to you x 2…at a normal pace is 22.83 seconds
- ABC's (alphabet) song x 2 is 28 seconds 
- And if you're Catholic? Two Hail Mary's (average pace) is 22.05 seconds (Source: Catholic friend) 

What about alcohol-based hand sanitizers?

- To kill the majority of bacteria on the hands with alcohol-based hand gels, you need to rub for at least 10 to 30 seconds—30 seconds being ideal.
- After 45 seconds, you're wasting your time…get back to work.

Shouldn’t we just go back to plain ol’ soap and water? In some instances, yes.

- Use plain ol’ soap and water for certain bugs Norovirus, and *C. difficile,* and *MRSA* (Methicillin Resistant Staphylococcus Aureus)
- It’s not that alcohol doesn’t work, it’s just that soap and water work *better*)

Lots of reasons to wash your hands frequently…pathogens live on inanimate objects for long periods of time

- Flu virus lives on a doorknob? 24 hours
- Cold virus on the telephone in a hotel room? 24 hours
- MRSA lives on a computer keyboard? 24 hours, but up to 168 hours (7 days) in the seat pocket of an airline
- Coronavirus' such as SARS-CoV-1, SARS-CoV-2 (COVID-19) and MERS—3-9 days on metal, glass, plastic; Door handles, trashcan handles, elevator buttons for 48-72 hours

The 2nd most important fundamental aspect of preventing infectious diseases:

- Vaccinations/immunizations
- Vaccinations/Immunizations
- Vaccinations/Immunizations

- I don't care what you call 'em…just give 'em!

- **And it's NOT just kids--adults need vaccinations too!**

Thanks to vaccine miracles (and there are many), meningitis in kids is a “thing of the past”…

- No more meningitis in kids!! Over 90% was due to *H. flu* and *S. pneumoniae*
- There was so much meningitis in kids prior to the vaccines…every other bed was meningitis…It seemed like all we did in Pediatrics was lumbar punctures—to diagnose, during treatment, after treatment.
- Kids hated them…

As mentioned…it's not JUST kids—we, as adults, also need old + new vaccines and boosters

- Don't forget the Td vaccine (tetanus toxoid, reduced diphtheria toxoid) – every 10 years
- Highest risk of tetanus in the geriatric patient. Why? mainly because many of our older patients are not up-to-date with their vaccines.
- Geriatric activities that predispose? Geriatric activities that predispose? Gardening and fishing (old hooks in the fish bait and tackle box)
- Also, check vaccine status with Td prior to invasive procedures including dental procedures

Tdap BOOSTER includes acellular pertussis

- Tdap booster (Td + and acellular pertussis)-- Adacel (ages 11 to 64)— one time booster **(and over 65 if taking care of infants that have not yet been vaccinated)**
- Grandparents—listen up!! If you're going to be taking care of an infant, make sure you get your Tdap booster!! BEFORE delivery!
- Vaccinate all caregivers including Dad, grandparents, aunties, uncles, anyone coming in contact with the infant in the first 6 months.

Back to pneumococcal vaccines—kids and adults—see guidelines for administration

- Pneumococcal pneumonia kills about 1 out of 20 people who get it.
- Pneumococcal bacteremia kills about 1 out of 5 people who get it.
- Pneumococcal meningitis kills about 3 out of 10 people who get it.
- Ouch. Pneumococcus is a killer.
- We have 3 vaccines to prevent it!
- PCV-13 (pneumococcal conjugate vaccine) **(Pneu-C-13)(Prevnar 13)(2010)** protects against 13 of the approximately 90 types of pneumococcal bacteria that can cause pneumococcal disease, including the above three conditions.
- PPSV-23 (pneumococcal polysaccharide vaccine) protects against 23 types of pneumococcal bacteria. This vaccine helps prevent invasive infections like meningitis and bacteremia, but only offers low levels of protection against pneumonia.
- Pneumococcal-20-valent Conjugate Vaccine (Prevnar 20)* for the prevention of invasive disease and pneumonia caused by 20 Streptococcus pneumoniae (pneumococcus) serotypes in the vaccine in adults aged 18 years and older.

The “Shingles” vaccine for adults over 50 — SHINGRIX

- With the aging population, the absolute # of herpes zoster cases is increasing dramatically due to the age-related decline in immunity…
- A single-protein recombinant subunit vaccine has been shown to be ~**90-97%** effective
- 2 IM injections – 2-6 months apart
- The vaccine contains varicella zoster virus **(non-live)** with a subunit antigen system to boost immunity
- Shingrix CAN also be given to immunocompromised patients 19 and over for the following:
  - Hematopoietic stem cell transplant (HSCT) recipients; Hematologic malignancies; Renal or other solid organ transplants; Solid tumor malignancies; HIV; Primary immunodeficiencies, autoimmune conditions, and use of immunosuppressive medications/therapies (Advisory Committee on Immunization Practices, November 2021)

What is your risk? Based on age?

- 10—0.5%
- 20—1.3%
- 30—2.7%
- 40—4.8%
- 50—7.5%
- 60—11.9%
- 70—19.7%
- 80—31.8%
- 90—46.1%

Donahue JG, et al. *Archives of Internal Medicine,* 1995.

Not convinced to get the Shingrix vaccine?

- Varicella Zoster Ophthalmicus (VZO)—especially dangerous High risk of postherpetic neuralgia (PHN); an increased risk of ischemic stroke (4.5%) and, a risk of dementia (3x greater w/ shingles in ophthalmic root (10.2 cases/1000 vs. 3.6 cases per 1,000 without ophthalmic shingles) (PLOS ONE 2017)

The seasonal FLU

- A seasonal virus that mutates every year…hence, a new 'tweaked' vaccine every year
- *"Barb, I don't know if I have the flu or not…"*
- Flu symptoms hit you like a Mac truck—there are no prodromal symptoms as observed in a cold, or bronchitis, or COVID-19
- Flu vaccine can be given to children starting at age 6 months

Vaccinate the kids first!!!

- Immunizing **20%** of children in a community is ***more*** effective at protecting the over-65 population than immunizing 90% of the elderly.
- Immunizing **70%** percent of school children may protect an entire community from the flu.
- Children are referred to as "super-flu-spreaders"—in other words, they "shed" more of the flu virus for longer periods of time than adults do.
- Hence, keep kids away from grandma and grandpa if they haven't had their flu vaccine yet.

(Ryan KA. Target the Super-Spreaders, *Scientific American* October 2012)

COVID-19 vaccines

- 3 approved in the U.S. with a new “caveat” about the Johnson & Johnson vaccine
- Pfizer, Moderna, are the mRNA vaccines; adenovirus vectors (Janssen Pharmaceuticals—the vaccine arm of J & J)
- Vaccines reduce the risk of severe illness, hospitalization, and death from COVID—they don’t negate your risk of acquiring the disease
- Effectiveness varies depending on the variant of the virus, the vaccine, and the patient’s immune system…
- One omicron variant has shown less response to the Pfizer vaccine and the Omicron variant (B.1.1.529) (NEJM, April 21, 2022).
- But a booster with Pfizer or Moderna mRNA vaccine substantially increases immunity

"These vaccines are so new, I don't trust 'em… they haven't been tested enough."

- YES, they have. The vaccine technique for the Pfizer and Moderna vaccines has been researched and tested for close to two decades…and in approximately 76,000 patients
- **Not a bad sample size for a clinical trial.**

On the other hand, sildenafil (Viagra)…

- Was only tested on 3,000 men before its release…
- You don’t see 23,000,000 men screaming that it hasn’t been tested enough for them to take it!!

Trend #4—Sexually transmitted and blood-borne infections (STBBIs)

- Nothing new about sex or sexual promiscuity
- In the 17th century, 1 out of every 5 adults in France had syphilis
- The treatment? Mercury— caused hair loss, uncontrollable drooling, and dementia

Back to the Pfizer riser…sildenafil and friends

- We can thank the ED drugs for the rise in STI's in the geriatric population…and higher rates of divorce and "on-line" dating…

(Sexually Transmitted Diseases in Older Adults. Benjamin Rose Institute on Aging, June 2019)

Back to the Pfizer riser…sildenafil and friends

- We can thank the ED drugs for the rise in STI's in the geriatric population…and higher rates of divorce and "on-line" dating…
- According to statistics released by the Centers for Disease Control and Prevention (CDC) on October 8, 2019, the number of cases of **gonorrhea rose 164 percent among Americans aged 55 and older between 2014 and 2018**, while cases of syphilis rose 120 percent in this population, and chlamydia rose 86 percent.
- 17% of new HIV cases are in patients over 50…

TREND #5 – Global everything…warming

- Mosquitoes carry at least 35 diseases—West Nile virus, dengue fever, malaria, yellow fever, ZIKA virus, chikungunya
- DEET, DEET, DEET or Picaridin sprays…NO BOUNCE or Citronella
- With global warming they are moving further away from the equator
- If a patient has traveled to an endemic area for malaria and they present with a fever of unknown origin, anemia and a big spleen—consider malaria for up to one year after their trip
- Always ask about travel these days…"where ya' been lately? Did you use the antimalaria pills we gave you? The mosquito netting at night?" Uh…no

Trend #6 – Zoonoses – animals to humans…

Infectious diseases have "flourished" over the past 50 years…get used to it

- HIV…1980 (chimpanzees)
- BSE – 2003 MAD COW disease
- SARS CoV-1 – 2002-2003 (bats)
- AVIAN FLU – 2003 (birds)
- MERS CoV – 2012 (camels)
- EBOLA – 2013 (bats)
- COVID-19 – 2019 (bats, pangolins, minks, ferrets????)
- There's not doubt that there will be another pandemic—hopefully, we will have learned something from this current one!

TREND #6 – Microbes on the menu

- We all want our peaches, raspberries, mangoes, and lettuce year-round
- 40% of North American produce comes from other countries…Mexico, Chile, Guatemala, Costa Rica, Honduras…and most of the countries don't have food safety as their first concern (exception: Costa Rica)
- And there's no tag on the fresh fruit that says…
- But…let's not blame all of our food borne illnesses on produce imported from other countries…we have plenty of home-grown food-borne illnesses
- And everyone is on a PPI that reduces ACID in the stomach! Increased risk of food-borne illness

Top 5 acquired food borne pathogens accounting for 91% of the cases

• Norovirus	58%
• *Salmonella* (nontyphoidal)	11%
• *Clostridium perfringens*	10%
• *Campylobacter spp*	9%
• *Staphylococcus aureus*	3%
TOTAL	91%

#1 leading cause of food-borne illness: The “vacation of a lifetime”--Norovirus

- Cruise ships--the ship is a floating petri dish, poor hand hygiene, closed quarters
- buffets/food handlers), LTC facilities, (food handlers), restaurants (food handlers)
- In theory, one batch of vomit contains enough viruses to infect 3 million people. WHHAAAT?
- Huggin’ the porcelain bowl…you actually need two porcelain bowls...

Noroviruses—clinical signs and symptoms

- For the simultaneous diarrhea + vomiting ("shuking")- median duration of S & S = 23 hours; start shedding virus before symptoms occur and shed virus for 4 days after symptoms subside (hence, the rapid spread of infection); can shed virus up to 4 to 8 weeks after illness
- Stay home for 3-4 days symptoms subside, especially if you handle food or work in healthcare. You are still shedding billions of virus particles in those three to four days and you can infect co-workers and contaminate food. (Jones D. The Mark of Noro. *New Scientist* 2013 March;42-45. *Journal of Medical Virology*, vol. 80, p. 1468)

TREND #7 Increased population of immunocompromised patients…

- Diabetics (uncontrolled hyperglycemia)
- HIV+
- Cancer patients—especially hematologic malignancies—leukemias, lymphomas
- Transplant patients on immunosuppressive drugs
- Patients on corticosteroids
- Patients with autoimmune disease on certain monoclonal antibodies
- Obesity (5x greater risk of ICU admission w/ COVID-19; 2x greater risk of respiratory failure
- The elderly—over 65

TREND #8 – Hospital-acquired infections (HAI)

- Hospitals have become particularly notorious for spreading lethal infections. According to the US Centers for Disease Control and Prevention, hospital-acquired infections now affect one in 25 patients

- These superbugs are *"the biggest threat to patient safety in the hospital that we have. Unfortunately, it doesn't seem like anything is slowing their spread."* Dr. C. Sifri, infectious-disease MD and hospital epidemiologist at the University of Virginia Health System (2021)

Healthcare Associated Infections—what's happening?

- We, as HCPs, start breaking down the patient's protective defenses the minute they are admitted into the hospital…
- Arterial lines, peripheral venous lines, urinary catheters, Hickman catheters, central catheters, PICC lines, ports, J -tubes, G-tubes, chest tubes, JP drainage tubes, and more tubes…
- We have a tube for every hole you have… and, if we have an extra tube and you don't have a hole, we'll make you a NEW HOLE…

Where are we now?
Common HAIs and examples:

- Methicillin-Resistant *Staphylococcus Aureus* (MRSA)(1960 and 1962)
- Vancomycin-Resistant Enterococci (VRE)—took 30 years
- Carbapenemase-producing *Klebsiella pneumoniae* strains (Cp-Kpn)
- Catheter-associated urinary tract infections (CAUTI)-- MDR-*pseudomonas aeruginosa* (Among UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter)
- *Candida auris*—the newest threat in hospitals and resistant to all anti-fungal drugs we have
- Antibiotic-associated diarrhea -- *Clostridioides difficile ("C. diff")*

TREND #9 Antibiotic stewardship— *"The first rule of antibiotics is try not to use them, and the second rule is try not to use too many of them."*

Antibiotic stewardship consists of:

1) Avoid antibiotics when appropriate
2) If indicated, use strategies to optimize which AB to use, how much to give, how long to give, and the route (PO, IV, IM, topical)—example: oral vancomycin works better than IV vancomycin to treat patients with *C. diff*
3) GOAL? Maximize clinical cure rates, but reduce the unintended consequences of antibiotic use, including adverse side effects and the emergence of resistant bacteria

OUT with the old…IN with a shorter duration of antibiotic therapy when necessary

- Old recommendation—10 days for uncomplicated cystitis in women—today 3 days of TMP/SMX—be careful with K+ levels due to the TMP and concomitant ACE inhibitor, ARB, ARNI and/or spironolactone
- Consider the type and severity of the infection, antibiotic choice and obviously the patient…resist the urge to treat longer— "just in case"
- There are NO "We'll treat longer, JUST IN CASE" scenarios!!

OUT with the old…IN with a shorter duration of antibiotic therapy when necessary

- 5 days of antibiotics for uncomplicated cellulitis or pyelonephritis…instead of 10-14
- Antibiotics are usually NOT needed for bronchitis, sinusitis, pink eye, etc. Usually viral. (If needed, a 5-day course for acute sinusitis. Rarely needed)

PLVoices and Antibiotic Therapy: When are shorter courses better? (Prescriber's Letter November 2016); PMID: 21089554 [PubMed - indexed for MEDLINE] Duc Volluz S1, Abbet P, Troillet N. Rev Med Suisse. 2010 Oct 13;6(266):1901-5.

BOTTOM LINE:

- **RIGHT** DIAGNOSIS
- **RIGHT** DRUG
- **RIGHT** DOSE
- **RIGHT** AMOUNT OF TIME
- Because of the time required for antibiotics to start working, the antibiotic should not be changed within the first 72 hours, ***unless*** marked clinical deterioration occurs or the causative bacteria is identified with via culture and sensitivity

Minimize the need for antibiotics by:

- Hand washing—DUH (all the way back to slide #1)
- Contact precautions—YES, MRSA especially
- Vaccinations—OF COURSE
- Controlling blood sugar –NO BRAINER! Blood glucose greater than 180 mg/dL inhibits neutrophil migration = bacterial infections and yeast infections; know that the SGLT-2 inhibitors (the "flozins" – empagliflozin/Jardiance, dapagliflozin/Farxiga) increase urine output with glucosuria and increase the risk of UTIs and genital yeast infections…super scrub the perineal area!! ☺
- Prevention of skin abrasions and decubitus ulcers—REALLY?
- Re-evaluating certain prescribing patterns – as mentioned, shorter durations…but not for everything…example: Acute prostatitis—still recommend up to 6 weeks of antibiotic therapy w/levofloxacin, ciprofloxacin or TMP-SMX! (Up-to-Date, April 2021)

And, we're finished!

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