(c) The facility provides indoor and outdoor arrangements that allow residents freedom to ambulate in a controlled setting.

(d) Doors are marked with items familiar to the individual resident, which enhance the resident's ability to recognize his or her room, and bathrooms are specially marked and easily accessible.

8:39–46.4 Advisory activity programming

The Alzheimer's/dementia program provides a daily schedule of special activities, seven days a week and at least two evenings per week, designed to maintain residents' dignity and personal identity, enhance socialization and success, and to accommodate the various cognitive and functional abilities of each resident.

8:39–46.5 Advisory nutrition

(a) The Alzheimer's/dementia program provides nutritional intervention as needed, based upon assessment of the eating behaviors and abilities of each resident. Interventions may include, but are not limited to, the following:

1. Verbal and non-verbal eating cues;
2. Modified cups, spoons, or other assistive devices; and
3. Simplified choices of foods or utensils.

(b) The Alzheimer's/dementia program provides a small dining room, separate room, or designated dining area furnished to meet the needs of the residents, with staff members or trained volunteers to assist.

8:39–46.6 Advisory social services

(a) The facility provides individual and group counseling to residents if appropriate, utilizing techniques designed to reach the dementia resident and to maintain the resident's maximum level of functioning.

(b) Families are encouraged and provided with opportunities to participate in planning and providing resident care.

(c) The facility provides individual and group counseling, support and education groups for families, and information and referral on bioethical and legal issues related to dementia, including competence, guardianship, conservatorship and advance directives.

(d) Family members are referred to community Alzheimer's disease support groups or other family counseling agencies, as required.

(e) Discharge care plans, including preparation for discharge from the unit, are discussed with the legal next of kin, and, if possible, with the resident at the time of admission to the program.

SUBCHAPTER 47. SUBACUTE CARE UNIT IN AN ACUTE CARE GENERAL HOSPITAL

8:39–47.1 Scope

All hospital-based subacute care units shall comply with the rules in this subchapter, all other pertinent rules in this chapter, the provisions of State of New Jersey P.L. 1996, c.102, and Federal Medicare requirements at P.L. 89–97 (42 U.S.C. §§ 1395 et seq.).

8:39–47.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Hospital-based subacute care unit" means a distinct unit located within an acute care general hospital that utilizes licensed long-term care beds to provide subacute care.

"Subacute care" in an acute care general hospital means a comprehensive inpatient program for patients who have had an acute illness, injury, or exacerbation of a disease process, have a determined course of treatment prescribed, and do not require intensive diagnostic or intensive invasive procedures, but the patient's condition requires physician direction, intensive nursing care, frequent recurrent patient assessment and review of the clinical course and treatment plan for a period of time, significant use of ancillary medical services and an interdisciplinary approach using professional teams of physicians, nurses and other relevant professional disciplines to deliver complex clinical interventions.

8:39–47.3 Licensure of hospital-based subacute care units

A hospital-based subacute care unit shall obtain a license to operate from the Department prior to accepting any patients. The hospital shall contact the Long–Term Care Assessment and Survey Program of the Department in order to schedule an initial licensure survey. A license shall be issued by the Long–Term Care Licensing Program only upon a finding by the Department that the unit is in compliance with the licensure requirements specified at N.J.A.C. 8:39–47.4.

8:39–47.4 Licensure requirements

(a) Prior to receiving a license and prior to the initial licensure survey by representatives of the Department, the hospital-based subacute care unit shall develop written clinical admission criteria and utilization review protocols as described in this section.

1. A resident of a long-term care facility who is admitted to, and discharged from, an acute care hospital shall not, upon discharge from the hospital, be admitted to the hospital-based subacute care unit, unless the long-term care facility is unable to readmit the resident within 24 hours after written notification to the long-term care facility that the resident is to be discharged from the

hospital. In this case, the patient shall be discharged to the long-term care facility of origin as soon as such facility is able to readmit the individual. The hospital-based subacute care unit shall, on a daily basis, document in the patient's medical record the continuing inability of the long-term care facility of origin to readmit the patient.

2. The hospital shall identify clinical admission criteria for its hospital-based subacute care unit which shall include:

i. Prospective clinical admission criteria; and

ii. Clinical exclusion criteria.

3. The hospital shall specify within the clinical admission criteria that the hospital-based subacute care unit is intended for patients who will need post-acute care for eight days or fewer.

4. Except as provided in (a)5 below, patients shall be admitted to the hospital-based subacute care unit on the recommendation of the attending physician, if such admission is in accordance with the written clinical admission and exclusion criteria.

5. Except as set forth at (a)6 below, the hospital-based subacute care unit shall not admit a clinically stable patient with one of the diagnoses listed at (a)5i below and meeting all of the criteria for inpatient rehabilitation hospital care listed at (a)5ii below.

i. Nonadmissible diagnostic categories shall include patients with stroke; congenital anomaly; major multiple trauma; polyarthritis, including rheumatoid arthritis; neurological disorder, including multiple sclerosis, motor neuron disease, polyneuropathy, muscular dystrophy, and Parkinson's disease; traumatic or nontraumatic brain injury; spinal cord injury; amputation; joint replacement; fracture of the femur, including hip fracture; and burns.

ii. Criteria for inpatient rehabilitation hospital care shall include the following:

(1) The need for close medical supervision by a physician with specialized training or experience in rehabilitation;

(2) The need for 24–hour per day rehabilitation nursing;

(3) The need for a relatively intense level of rehabilitation services;

(4) The need for a multidisciplinary team approach to the delivery of the program;

(5) The need for a coordinated program of care;

(6) The expectation of significant practical improvement in a reasonable period of time; and

(7) The establishment of realistic goals of self-care or independence in activities of daily living.

6. In order to admit a patient described at (a)5 above, the hospital-based subacute care unit shall:

i. Forward information pertaining to the clinically stable patient to either a licensed comprehensive rehabilitation hospital or an acute care hospital which has licensed comprehensive rehabilitation beds;

ii. Receive a favorable recommendation from either the licensed comprehensive rehabilitation hospital or the acute care hospital which has licensed comprehensive rehabilitation beds;

iii. Receive a written concurring recommendation regarding the patient's admission from the case manager at the acute care hospital; and

iv. Receive a recommendation to admit from the patient's attending physician.

(b) Upon determination that admission of a patient to a hospital-based subacute care unit is appropriate, information concerning the patient's rights shall be provided to the patient. Such information shall include the rights enumerated at N.J.A.C. 8:39–4 and shall assure the patient of at least the following:

1. That, although the patient's stay is not expected to exceed eight days, the patient has the right to remain in the unit until a transfer or discharge is medically necessary to meet the patient's needs or until transfer or discharge is appropriate due to improvement in condition;

2. That the patient shall be notified as soon as practical prior to transfer or discharge; and

3. That, during the patient's stay, the hospital-based subacute care unit shall provide all care and services necessary to maximize the physical, mental, and psychosocial well-being of the patient.

(c) The hospital-based subacute care unit shall establish a procedure for a patient assessment, utilizing the Standardized Resident Assessment Instrument (see N.J.A.C. 8:39–11.2(e)) to have an assessment reference date of any day, one through eight, with days one through five being optimal, but days six through eight being acceptable.

(d) The hospital-based subacute care unit shall develop written utilization review protocols in accordance with the following:

1. Utilization review protocols shall be prospective, concurrent, and retrospective in nature. The protocols shall be designed to verify, in all cases, the stringent use of the clinical admission criteria, the provision of continual discharge planning, and appropriateness of stay;

2. Prospective utilization review shall occur before the patient is discharged from the acute care hospital or while the patient is completing the preadmission process for the hospital-based subacute care unit;

3. Utilization review staff shall visit each patient and review the patient's medical record prior to admission in order to ensure that for each patient:

i. An appropriate length of stay is expected;

ii. The level of care provided in the unit is commensurate with the patient's needs; and

iii. A discharge plan has been prepared prior to admission;

4. Utilization review staff shall assess each patient on the first day, the fourth day, and daily thereafter to ensure the continued appropriateness of the patient's stay in the unit; and

5. Utilization review staff shall retrospectively examine diagnostic and length of stay information concerning each admission. Such information shall be reported to the Department, and to an independent utilization review organization (IURO), quarterly on a form and in a manner prescribed by the Department. The $35.00 per admission health care quality fee prescribed by P.L. 1996, c.102 shall accompany submission of the form to the Department. Such form shall be submitted to the Department within 30 days after the conclusion of each quarter.

i. An IURO which has been approved by the Department shall review a representative sample of all admissions to the hospital-based subacute care unit in order to verify the accuracy of the quarterly reports regarding length of stay.

ii. The hospital shall be responsible for the cost of the services provided by the IURO.

Petition for Rulemaking.
See: 34 N.J.R. 1975(b).
Petition for Rulemaking.
See: 35 N.J.R. 2532(a).

8:39–47.5 Licensure renewal

(a) Renewal of a license to operate a hospital-based subacute care unit shall be based upon the unit's compliance with the rules in this subchapter, all other pertinent rules in this chapter, the provisions of State of New Jersey P.L. 1996, c.102, and Federal Medicare requirements at P.L. 89–97 (42 U.S.C. §§ 1395 et seq.).

(b) The findings of the IURO which verified the accuracy of the hospital-based subacute care unit's quarterly utilization reports shall be submitted to the Department prior to, or as part of, the application for licensure renewal. The findings of the IURO shall include at least verification of individual length of stay for a representative patient sample, determination of aggregate length of stay for a representative patient sample, and specification of sample size for each quarter.

(c) The Department shall use the aggregate length of stay (total patient days/number of admissions) for the hospital-based subacute care unit as a monitoring benchmark, as an indicator of conformance with provisions of P.L. 1996, c.102, and as a condition of licensure renewal. For each annual renewal of the license, if the aggregate length of stay for patients admitted to the hospital-based subacute care unit during the four quarters immediately preceding the renewal application is determined to be greater than eight days, the Department shall not renew the subacute care license for the next annual licensure renewal cycle. A hospital shall not be permitted to reapply for a new certificate of need for a hospital-based subacute care unit for six months from the date of licensure nonrenewal or revocation.

1. In the case of licensure renewal applications submitted to the Department within one year after initial licensure, the aggregate length of stay shall be determined for the three quarters immediately preceding the licensure renewal application and used by the Department in accordance with (c) above.

2. For any patient who remains in the hospital-based subacute care unit in accordance with all provisions of N.J.A.C. 8:39–47.4(a)1, patient days accrued after the hospital has issued its written notice to discharge to the long-term care facility of origin shall not be included in the calculation of aggregate length of stay for the unit.

APPENDIX A

GUIDELINES AND CONSIDERATIONS FOR PET FACILITATED THERAPY IN NEW JERSEY INSTITUTIONS

I. All Pets
- A. Companion pets should not pose a threat or nuisance to the patients, staff, or visitors because of size, odor, sound, disposition, or behavioral characteristics. Aggressive or unprovoked threatening behavior should mandate the pet's immediate removal.
- B. Animals which may be approved include: dogs, cats, birds (except carnivorous), fish, hamsters, gerbils, guinea pigs, and domestic rabbits. Wild animals such as turtles and other reptiles, ferrets, and carnivorous birds should not be permitted in the program.
- C. In order to participate, dogs or cats should be either altered or determined not to be in estrus ("heat").
- D. Sanitary constraints:
  1. Pets should be prohibited from the following areas:
     - a. Food preparation, storage, and serving areas, with the exception of participating resident's bedroom;
     - b. Areas used for the cleaning or storage of human food utensils and dishes;
     - c. Vehicles used for the transportation of prepared food;
     - d. Nursing stations, drug preparation areas, sterile and clean supply rooms;
     - e. Linen storage areas; and
     - f. Areas where soiled or contaminated materials are stored.
  2. Food handlers should not be involved in the cleanup of animal waste.

3. The administrator is responsible for acceptable pet husbandry practices and may delegate specific duties to any other staff members except food handlers. The areas of responsibility include: feeding and watering, food cleanup/cage cleaning, exercising, and grooming.
4. Spilling or scattering of food and water should not lessen the standard of housekeeping or contribute to an increase in vermin or objectionable odor.
5. Dogs and cats must be effectively housebroken and provisions made for suitably disposing of their body wastes.
6. Animal waste should be disposed of in a manner which prevents the material from becoming a community health or nuisance problem and in accordance with applicable sanitation rules and ordinances. Accepted methods include disposal in sealed plastic bags (utilizing municipally approved trash removal systems) or via the sewage system for feces.
7. Proper and frequent handwashing shall be a consideration of all persons handling animals.

E. Animals found to be infested with external parasites (ticks, fleas, or lice) or which show signs of illness (for example, vomiting or diarrhea) should be immediately removed from the premises and taken to the facility's veterinarian.

F. The parent or guardian of a child bitten by a dog, cat, or other animal, when no physician attends such child, shall, within 12 hours after first having knowledge that the child was so bitten, report to the person designated by law or by the local board, under authority of law, to receive reports of reportable communicable diseases in the municipality in which the child so bitten may be the name, age, sex, color, and precise location of the child (N.J.S.A. 26:4–80).

If an adult is bitten by a dog, cat, or other animal and no physician attends him, the adult, or, if he is incapacitated, the person caring for him, shall report to the person designated by law or by the local board of health to receive reports of communicable diseases in the municipality in which the adult so bitten may be the name, age, sex, color, and the precise location of the adult. The report shall be made within 12 hours after the adult was so bitten, or if he is incapacitated, the report shall be made within 12 hours after the person caring for him shall first have knowledge that the adult was so bitten (N.J.S.A. 26:4–81).

G. The local health department must be promptly notified by telephone of any pet that dies on the premises.
   1. If the deceased is a bird, the body should be immediately taken to the facility's veterinarian. If the veterinarian is not available, the deceased bird should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available. Payment for a laboratory examination should be the responsibility of the institution, or the pet's owner.
   2. If the deceased is another type of animal, the body should not be disposed until it is determined by the local department of health that rabies testing is not necessary.

H. The rights of residents who do not wish to participate in the pet program must be considered first. Patients not wishing to be exposed to animals should have available a pet free area within the participating facility.

II. Visiting Pets
   A. Visiting pets are defined as any animal brought into the facility on a periodic basis for pet therapy purposes. The owner should accompany the animal and be responsible for its behavior and activities while it is visiting at the facility.
   B. Visiting dogs should:
      1. Be restricted to the areas designated by the facility administrator;
      2. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus, coronavirus, bordetella (kennel cough), and rabies. Proof of vaccination shall be included on a health certificate that is signed by a licensed veterinarian and kept on file at the facility;
      3. Be determined not to be in estrus ("heat") at the time of the visit;
      4. Be licensed and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number; and
      5. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the approval of the administrator.
   C. Visiting cats should:
      1. Maintain current vaccination against feline pneumonitis, panleukopenia, rhinothracheitis, calcivirus, chlamydia, and rabies. Proof of vaccination should be included on a health certificate that is signed by a licensed veterinarian and kept on file at the facility; and
      2. Determined not be in estrus ("heat") at the time of the visit.
   D. Visiting hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice, or rats:
      1. The owner should be liable and responsible for the animal's activities and behavior.
   E. No visiting birds should be allowed to participate in the program.

III. Residential Pets
   A. Residential pets are defined as any animal that resides at a facility in excess of four hours during any calendar day and is owned by a staff member, patient, the facility, or a facility approved party. The financial responsibility for the residential animal's maintenance is the animal owner's responsibility.
   B. All documentation of compliance will be maintained by the facility administrator in a file for review and inspection. The official health records should include the rabies vaccination certificate and a current health certificate.
   C. Residential animals should have a confinement area separate from the patients where they can be restricted when indicated. An area should be available for each participating unit and should be approved by the administrator.
   D. A licensed veterinarian should be designated as the facility's veterinarian and should be responsible for establishing and maintaining a disease control program for residential pets.
   E. Specific Species:

1. Residential dogs should:
   a. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus and rabies. In addition, the animal's file should include a currently valid Rabies Vaccination Certificate, NASPHV #51. A three-year type rabies vaccine should be utilized;
   b. Have an annual heartworm test commencing at one year of age and should be maintained on heartworm preventive medication;
   c. Have a fecal examination for internal parasites twice yearly. Test results should be negative before the dog's initial visit to the facility;
   d. Follow the recommended procedures of the facility's veterinarian for controlling external parasites;
   e. Be neutered;
   f. Be licensed with the municipality and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number;
   g. Have a health certificate completed by a licensed veterinarian within one week before the animal's initial visit to the facility. The certificate should be updated annually thereafter;
   h. Be immediately removed from the premises and taken to the facility's veterinarian if infested with internal or external parasites, vomit, or have diarrhea, or show signs of a behavioral change or infectious disease. Medical records of the veterinarian's diagnosis and treatment should be maintained in the animal's file. The animal should not have patient contact until authorized by the facility's veterinarian;
   i. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the requirements of the administrator;
   j. Be fed in accordance with the interval and quantity recommended by the facility's veterinarian. Feeding and watering bowls should be washed daily and stored separately from dishes and utensils used for human consumption;
   k. Be provided fresh water daily and have 24–hour access to the water dish;
   l. Be provided a suitable bedding area. Bedding should be cleaned or changed as needed. Dirty bedding should be processed or disposed of as necessary;
   m. Be permitted outside the facility only if under the supervision of a staff member, a responsible person or within a fenced area; and
   n. Be regularly groomed and receive a bath whenever indicated.
2. Residential birds:
   a. Should be treated by a licensed veterinarian with an approved chlortetracycline treatment regimen prior to being housed at the institution to ensure the absence of psittacosis. The period of treatment varies between 30 to 45 days and is species-dependent. A signed statement from the veterinarian indicating such treatment should be kept in the bird's file; and
   b. That die, or are suspected of having psittacosis, should be immediately taken to the facility's veterinarian. In the event the bird dies and the veterinarian is not available, the bird's body should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available.
3. Residential hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice or rats should be examined yearly by a licensed veterinarian for health status. A health certificate should be completed for each animal or group of animals. Any animal that becomes sick or dies should be promptly taken to the facility's veterinarian.

APPENDIX B

GUIDELINE FOR THE MANAGEMENT OF INAPPROPRIATE BEHAVIOR AND RESIDENT TO RESIDENT ABUSE

I. The initial resident assessment should include a psychosocial behavior component with interventions, if appropriate, in the care plan. Reassessment should be done at least quarterly, or at any time when a resident's pattern of behavior changes. Resident response to interventions should be recorded in the medical record.

II. Inappropriate behavior and/or actions should trigger an immediate reassessment with adjusted interventions; notification of the physician and/or the designated resident representative. Resident response should be recorded in the medical record. The facility's actions/interventions in response to behavior changes should also be part of the plan of care and should be appropriately recorded. Prompt reassessment of behavioral changes will in most cases avert the continued progression of inappropriate behavior.

III. Inappropriate behavior and/or actions involving other residents should be identified in the records of all involved residents including assessments, interventions and responses. Notifications of physician and/or designated resident representatives should also be recorded in medical records of all involved residents.

IV. Incidents of inappropriate behavior or actions of abuse between residents should result in the following actions, as applicable:
   A. Immediate assessments of involved residents;
   B. Notification of attending physicians or advanced practice nurses;
   C. Interventions and responses of residents;
   D. Notification of residents' designated representatives;
   E. Protection of involved residents' civil and constitutional rights;
   F. Determination by administrator of facility's ability to assure safety and security of all patients;
   G. Implementation of emergency or short-term precautions to assure safety while working toward resolution; and
   H. Notification of police if necessary.

V. In the event that it is determined that a resident must be removed from the facility, the transfer should be initiated in accordance with the provisions of this chapter.

VI. Transfer from the facility should be based on the appropriate evaluation and transfer order of the attending physician, advanced practice nurse, facility medical director and/or consultant psychiatrist.

VII. In the event of an immediate emergency situation only:

1. Have patient removed to emergency room of local hospital for medical and/or psychiatric evaluation and consultation by a physician or advanced practice nurse. Return of patient to the long-term care facility should be based on the physician's or advanced practice nurse's written notation of the appropriateness of returning the resident to the long-term care setting. The administrator is responsible for the decision to accept or deny the return of the resident according to N.J.A.C. 8:39;
2. A police complaint should be filed against the abuser and have the individual removed. The complaint can be filed by the facility or the abused party; and
3. Notify all agencies (that is, Medicaid if applicable, Ombudsman for the Institutionalized Elderly, if applicable (over 60) and the Department of Health and Senior Services.)

VIII. In the event all guidelines have been followed and resolution has not taken place, assistance should be requested from the Department.

IX. Facility policies and procedures to address inappropriate resident behavior, including resident to resident abuse, should include all of the above outlined actions.

X. To determine resident's emotional adjustment to the nursing facility, including his/her general attitude, adaptation to surroundings, and change in relationship patterns, the following areas should be evaluated:

1. Sense of Initiative/Involvement

Intent: To assess degree to which the resident is involved in the life of the nursing home and takes initiative in activities.

Process: Selected responses should be confirmed by the resident's behavior (either verbal or nonverbal) over the past seven days. The primary source of information is the resident. Secondarily, staff members who have regular contact with the resident should be consulted (for example, nursing assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Also, consider how resident's cultural standards affect the level of initiative or involvement.

Definition: At ease interacting with others—Consider how resident behaves during time you are together, as well as reports of how resident behaves with other residents, staff, and visitors. Does resident try to shield himself/herself from being with others? Does he/she spend most time alone? How does he/she behave when visited?

At ease doing planned or structured activities—Consider how resident responds to such activities. Does he/she feel comfortable with the structure or restricted by it?

At ease with self-initiated activities—These include leisure activities (for example, reading, watching TV, talking with friends), and work activities (for example, folding personal laundry, organizing belongings). Does resident spend most of his/her time alone, or does resident always look for someone to find something for him/her to do?

Establishes his/her own goals—Consider statements resident makes like, "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. Some things may not be stated

Involvement in life of the facility—Consider whether resident partakes of facility events, socializes with peers, discusses activities.

Resident accepts invitations into most group activities—Is resident willing to try group activities even if later, deciding the activity is not suitable and leaving? Does resident regularly refuse to attend group programs?

2. Unsettled Relationships

Intent: To indicate the quality and nature of the resident's interpersonal contacts (that is, how resident interacts with staff members, family, and other residents).

Process: During routine nursing care activities, observe how the resident interacts with staff members and with other residents. Do you see signs of conflict? Talk with direct-care staff (for example, nursing assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that the staff members describing these relationships may be biased.

Definition: Covert/open conflict with and/or repeated criticism of staff—Resident chronically complains about some staff members to other staff members; resident verbally criticizes staff members in therapeutic group situations, causing disruption within the group; or resident constantly disagrees with routines of daily living. (Note: Checking this item does not require any assumption about why the problem exists or how it could be remedied.)

Unhappiness with roommate—Includes frequent requests for roommate changes, grumbling about roommate spending too long in the bathroom, or complaints about roommate rummaging in another's belongings.

Unhappiness with residents other than roommate—Includes chronic complaints about the behaviors of others, poor quality of interaction with other residents, lack of peers for socialization. This refers to conflict or disagreement outside of the range of normal criticisms or requests (that is, beyond a reasonable level).

Openly expresses conflict/anger with family or close friends—Includes expressions of feelings of abandonment, ungratefulness, lack of understanding, or hostility regarding relationships with family/friends.

Absence of personal contact with family/friends—Absence of visitors or telephone calls from significant others in the last seven days.

Recent loss of close family member/friend—Includes relocation of family member/friend to a more distant location, even temporarily (for example, for the winter months); incapacitation or death of a significant other; a significant relationship that recently ceased.

3. Past Roles

Intent: To indicate recognition or acceptance of feelings regarding role or status now that the person is in the nursing home.

Definition: Strong identification with past roles and life status—This may be indicated, for example, when resident enjoys telling stories about own past; or takes pride in past accomplishments or family life; or prefers to be connected with prior lifestyle (for example, celebrating family events, carrying on life-long traditions).

Expresses sadness/anger/empty feelings over lost roles/status—Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use; I'm not capable of doing the things I always liked to do." Resident cries when reminiscing about past accomplishments. Be careful not to take the reaction out of context.

Process: Discuss past life with resident. Use environmental cues to prompt discussions (for example, family photos, grandchildren's letters or artwork). This information may emerge from discussions around other MDS topics (for example, Customary Routine, Activity Pursuits, ADLs). Direct-care staff may also have useful insights relevant to these items.

XI. To determine resident's mood and behavior patterns, the following elements should be considered:

1. Sad or Anxious Mood

Intent: To identify the presence of behaviors that may be interpreted as physical or verbal expressions of sadness or anxiety.

Definition: A distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful). This may be a disorder of mood which is usually, but not always, accompanied by a painful mood of such magnitude that it calls for relief because it is severely, or unnecessarily, distressing or threatening to physical health and life, or interferes with functional performance and adaptation. These symptoms may be preceded by anger or withdrawal.

Process: Determine if resident expressed signs of a sad or anxious mood over the past 30 days. Draw on your own interactions with the resident. Pay particular attention to statements of direct-care staff, social workers, and licensed personnel who may have evaluated the resident in this area. Does the resident cry or look dejected (unhappy) when no one is talking with him/her? When you talk with the resident, does he/she sound hopeless, fearful, sad, anxious? Does the resident report feelings of worthlessness, guilt? Does the resident appear withdrawn, apathetic, without emotion?

If you are unsure, seek confirming information from others who regularly come in contact with the resident (for example, activities professionals, social workers, or family members).

2. Mood Persistence

Intent: To identify a persistent sad/anxious mood that has existed on each day over the last seven days and was not easily altered by attempts to "cheer up" the resident.

Process: Normally, these moods apply to one or more of the indicators mentioned above of sad/anxious mood.

3. Problem Behavior

Intent: To identify the presence of problem behaviors in the last seven days that cause disruption to facility residents or staff members, including those that are potentially harmful to the resident or disruptive in the environment, even though staff and residents appear to have adjusted to them (for example, "Mrs. R's calling out isn't much different than others on the unit; there are many noisy residents.")

Definition: Wandering—Movement with no identified rational purpose; resident appears oblivious to needs or safety. This behavior must be differentiated from purposeful movement—for example, a hungry person moving about the unit in search of food; pacing.

Report on the most disruptive resident behavior across all three shifts. Code "1" if the described behavior occurred less than daily and "2" if the behavior occurred daily or more frequently.

4. Resident Resists Care

Intent: Identify problem behaviors related to delivering care/ treatment to the resident. These behaviors are not necessarily positive or negative; they provide observational data. They may prompt further investigation of causes in the care-planning process (for example, fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness to participate in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Consult medical record and primary staff caregiver. How does the resident respond to staff members' attempts to deliver care to him/her? Signs of resistance may be verbal and/or physical (for example, verbally refusing care, pushing caregiver away, scratching).

5. Behavior Management Program

Intent: Determine if a behavior-management program is in place wherein staff members identified causal factors and developed a plan of action based on that understanding. There must be evidence of structure and continuity of care in the program (for example, written documentation). This category does NOT include behavioral management by physical restraints or psychoactive drugs, if these are the only interventions used.

Process: Consult medical record (including current care plan); consult primary caregiver.

Examples

Mrs. S has been observed on numerous occasions to hit, shove, and curse the woman seated next to her at each meal. After observing the pattern of Mrs. S's behavior for several days, staff noticed that her tablemate was in the habit of moving toward Mrs. S to take food from her tray. As a result of their observations, the primary nurse made a change in seating arrangements. (Note: Although staff might have increased the amount of food provided at meals, the real issue was the taking of food; Mrs. S would not want to share with others, no matter how much food she was given.) Mrs. S does not tend to ask staff for help when she is annoyed; she takes direct and aggressive action on her own. Now that staff understand this behavior, they are aware of the need to be vigilant. Code "1" for Yes.

Provisions were made for safety monitored wandering for Mr. V (including use of "secure bands" that activate an alarm if he wanders away from a designated area). Mr. V does not really disturb others (he does not go into others' rooms). Without this "band," however, staff lost track of him and he was in danger of harming himself if he got off the unit (a busy street is very near his unit). Code "1" for Yes.

6. Change in Mood

Intent: Determine whether the resident's mood changed in the past 90 days, that is, onset of recent mood problem or changes in a longstanding problem. Changes may have been expressed verbally or demonstrated physically; they include increased/decreased number of signs/symptoms, or increase/decrease in the frequency, intensity, or persistence of sad or anxious mood.

Examples

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was disruptive. After the medication was discontinued, these feelings and behaviors improved. She is better than she was, but still has feelings of sadness. Code "1" for "Improved." Mrs. D is now better than her worst status in the 90–day period, but she has not fully recovered. (Note: If the mood problem was no longer present due to the continued efficacy of the treatment program, the correct code would also be "1" (Improved).)

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital. For the last 30 days (following readmission), Mrs. Y has improved and her appetite is restored. Code "1" for Improved.

7. Change in Problem Behavior

Intent: Determine if problem behaviors or resistance to care increased/decreased in number, frequency, or intensity in the past 90 days—that is, onset of recent behavior problems or changes in a more longstanding problem.

Changes can occur in many different areas, including (but not limited to) wandering, verbal or physical abuse, socially inappropriate behavior, or resistance to care.

Changes can be exhibited as increases/decreases in the number of signs/symptoms and/or change in the frequency or intensity of the behavior(s).

Process: Review nursing notes, medical records, and consult with primary staff caregiver.