Compliance Guidelines
Change of Condition and Monitoring
C270 - OAR 411-054-0040 (1 & 2)

Purpose of the Compliance Guidelines
ORS 443.436 requires the department to develop, maintain and periodically update compliance guidelines for residential care facilities serving seniors and persons with disabilities.

Intent of This Rule
To ensure facilities identify and respond when a resident experience a change of condition to promote the overall health and safety of the resident.

Introduction to C270
To provide proper care and ensure a resident's safety and well-being, every facility must have an effective system for responding when something out of the ordinary occurs for a resident that represent a change of condition. OAR 411-054-0040 (1 & 2) provides requirements for monitoring a resident and, if necessary, implementing interventions to address a resident's change of condition.

Special Note to RNs, LPNs and administrators: It is important that every RN and LPN working in a CBC setting understands and adheres to the standards, and works within the scope of practice, for their profession, and that facility policies and procedures support the nurses in meeting these standards.

As you review this compliance guideline, please refer to "OSBN and DHS Joint Statement on the LPN who Practices in a Community Setting (3/20/18)" and OAR 851-045 Chapter 851 Oregon State Board of Nursing Division 45 - Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse. (Links at end of this document).

Compliance Guidelines for Change of Condition

Tag #	Oregon Administrative Rule	Compliance Guidelines
C270	**OAR 411-054-0040 (1) (a & d)** **Short-term Change of Condition:** Short term means a change in the resident's health or functioning that is expected to resolve or be reversed with minimal intervention or is an established, predictable, cyclical pattern associated with a previously-diagnosed condition.	Based on the definition of short-term change of condition, below are examples of short-term changes of condition which may include, but are not limited to: • Minor injuries such as skin tears, bruises, scratches, abrasions; • Urinary tract infection; • Cold, cough, flu; • Change in medication related to medical condition; • Rash; • Swelling • Falls;

	(d) If a resident experiences a short-term change of condition that is expected to resolve or reverse with minimal intervention, the facility must determine and document what action or intervention is needed for the resident. (A) The determined action or intervention must be communicated to staff on each shift. (B) The documentation of staff instructions or interventions must be resident specific and made part of the resident record with weekly progress noted until the condition resolves.	• Changes in resident behavior; • Loss or death of a person close to the resident or a pet. 1. Process for determining compliance for short-term change of condition: a. Identification and documenting change of condition: • There is documentation in the resident's record as to what resident-specific actions or interventions were needed to address the change of condition. The facility should also document what to monitor and how often staff are to document on the status of the condition. • Documentation of needed action or intervention can be made by an RN, LPN or trained and experienced staff[1]. Interventions can also be obtained from outside health professionals such as the resident's health care provider or an ER physician. Examples include physician orders, and ER or hospital discharge instructions for care. • The resident's condition will dictate the involvement of the RN. Per C 280: ○ 411-054-0045(1)(f)(C): The facility must specify the role of the LN in the facility's monitoring and reporting system and must be consistent with OSBN Standards and Scope of Practice; ○ 411-054-0045(1)(d): The facility's RN is notified of nursing needs; ○ 411-054-0045(1)(f)(A): RN assessment in accordance with facility policy and resident condition and consistent with OSBN Standards and Scope of Practice. • Interventions to be implemented may be documented in: ○ Resident service plan – must include a written description of who shall provide the services and what, when, how and how often the services shall be provided; ○ Temporary or interim service plan; ○ Medication Administration Record (MAR); ○ Treatment Administration Record (TAR); ○ Electronic health records; ○ Behavior logs; or ○ Other facility-specific documents as defined in facility policy. • The change of condition and the determined action or interventions must be communicated to staff on each shift.

		b. Monitoring a short-term change of condition:
		• Monitor each resident consistent with his/her evaluated needs and service plan.
		  ○ The resident's needs were evaluated, and the service plan updated as applicable.
		  ○ Monitor: "to observe and check the progress or quality of something over a period of time." The intent of monitoring is to monitor the resident's progress and to review the effectiveness of the interventions or make changes to the interventions.
		  ○ This means the facility needs to evaluate whether existing service planned interventions as well as new interventions developed to address the change of condition are being implemented, are effective or whether new or additional interventions need to be developed.
		• There is documentation that describes the status of the resident's condition. Weekly progress noted ("noted" means documented) until the condition resolves.
		  ○ "Weekly progress" represents a minimum standard for meeting the rule. "Weekly" means progress is noted within 7-day intervals from the date the change of condition was identified. Some conditions may require more frequent monitoring (and documentation of that monitoring).
		  ○ To be able to document on the progress of the condition change, there must be an initial adequate description of that change.
		  ○ Weekly progress may be documented in:
		  ▪ Progress notes;
		  ▪ MAR or TAR;
		  ▪ "Skin sheets";
		  ▪ Behavior tracking logs; or
		  ▪ Other tracking tools that become part of the resident record.
		• Monitoring may be discontinued when it has been determined and documented that the condition has either resolved or represents a new baseline or permanent change to the level of functioning for the resident.

C270	**Significant Change of Condition:** OAR 411-054-0040 (1) (b & c)	Based on the definition of significant change of condition, examples of significant change of condition may include but are not limited to the following:

	(b)Significant change of condition means a major deviation from the most recent evaluation that may affect multiple areas of functioning or health that is not expected to be short-term and imposes significant risk to the resident. (c) If a resident experience a significant change of condition that is a major deviation in the resident's health or functional abilities, the facility must evaluate the resident, refer to the facility nurse, document the change, and update the service plan as needed	• Broken bones; • Stroke, heart attack, or other acute illness or condition onset; • Unmanaged high or low blood sugar levels; • Uncontrolled pain; • Significant unplanned weight change; • Pressure injuries (stage 2 or greater); • Change in level of consciousness; • Fast decline in multiple ADLs; • Admission to hospice services; • Surgical or complex wounds; and • New colostomy, suprapubic catheter, dialysis port, amputee. 2. Process for determining compliance with significant change of condition: a. Identification and documenting change of condition: • Change of condition was identified and documented by facility staff. • There is evidence that a resident evaluation was completed by trained and experienced staff[1] (per C 252, Resident Evaluation [411-054-0034(2)(c)]). • There is evidence that the change of condition has been referred to facility nurse. This can be interpreted to mean the referral is to the facility RN because, under C 280, a significant change of condition must be assessed by the facility RN. 411-054-0045(1)(f)(A) • C 280 states the RN assessment must be "timely." Because C 280 also specifies that the licensed nurse must "participate on the service-planning team or review the service plan with date and signature within 48 hours", it is interpreted that the assessment must have been initiated within 48 hours and with enough information gathered to ensure that essential care needs are identified, the service plan is updated and interventions implemented in response to the significant change of condition. • 411-054-0045(1)(f)(A): The assessment may be a full or problem focused assessment as determined by the RN. A chart review or phone consultation may be performed as part of this assessment. The RN must document findings, resident status, and interventions made as a result of this assessment. • The service plan was updated as to what resident-specific actions or interventions were needed to address the significant change of condition. Nurses should refer to

		OSBN Standards and Scope of Practice. The facility should also document what to monitor and how often staff are to document on the status of the condition.
		• Interventions may be documented in:
		  ○ Resident service plan – must include a written description of who shall provide the services and what, when, how and how often the services shall be provided;
		  ○ Temporary or interim service plan;
		  ○ Medication Administration Record (MAR);
		  ○ Treatment Administration Record (TAR);
		  ○ Electronic Health records;
		  ○ Behavior logs; or
		  ○ Other facility-specific documents as defined in facility policy.
		• Changes to service plan are communicated and accessible to staff.
		
		b. Monitoring significant change of condition:
		• Monitor each resident consistent with their evaluated needs and service plan.
		  ○ The resident's needs were evaluated, and the service plan updated as applicable.
		  ○ Monitor: "to observe and check the progress or quality of something over a period of time." The intent of monitoring is to monitor the resident's progress and to review the effectiveness of the interventions or make changes to the interventions.
		  ○ This means the facility needs to evaluate whether existing service planned interventions as well as new interventions developed to address the change of condition are being implemented, are effective or whether new or additional interventions need to be developed.
		  ○ Monitoring of interventions implemented to address changes of condition may necessitate data collection, including measurements. For example: for a weight loss, monitoring might include documenting percentage of meals eaten, weight measurements, whether the resident consumed the high calorie drinks when given, etc. Refer to CBC Survey Protocol for Unplanned weight change.
		  ○ and other applicable protocols.

		○ Progress may be documented in: ▪ Progress notes; ▪ "Skin sheets"; ▪ MAR or TAR; ▪ Behavior tracking logs; or ▪ Other tracking tools that become part of the resident record. ○ An example of how a facility could document a summary of its monitoring following a significant weight loss: "Resident is on weekly weight, meal monitoring and Ensure between meals due to a significant weight loss of 10 pounds noted two weeks ago. Resident is being accompanied to meals by care staff and has been eating most of his meal. Resident is drinking approximately 75% of each Ensure provided. Resident has gained two pounds in the last week. Will continue to monitor weekly weights and meal attendance." ○ Monitoring may be discontinued when it has been determined and documented that the condition has either resolved or represents a new baseline or permanent change to the level of functioning for the resident. ▪ Examples of permanent change may include a new amputee, a stroke from which the resident does not return to baseline, conditions related to end of life (weight loss, bedbound).
C270	**OAR 411-054-0040 (2) MONITORING**. The facility must have written policies to ensure a resident monitoring and reporting system is implemented 24-hours a day. The policies must specify staff responsibilities and identify criteria for notifying the administrator, registered nurse, or healthcare provider. The facility must: (a) Monitor each resident consistent with his or her evaluated needs and service plan;	**<u>Policies and Procedures for Changes of Condition and Monitoring</u>:** 1. The facility must have written policies to ensure a resident monitoring and reporting system is implemented 24 hours a day. • The policy must specify staff responsibilities. • The policy must specify criteria for notifying the administrator, RN or health care provider. 2. Train staff to identify changes in the resident's physical, emotional and mental functioning and document and report on the resident's changes of condition. • This refers to general training requirements under C370 (Staff Training) and would apply to staff being able to identify and respond to a change of condition. • This also refers to staff being trained to adequately monitor each individual resident and the individualized interventions related to their specific change of condition.

	(b) Train staff to identify changes in the resident's physical, emotional and mental functioning and document and report on the resident's changes of condition; (c) Have a reporting protocol with access to a designated staff person, 24-hours a day, seven days a week, who can determine if a change in the resident's condition requires further action; and (c) Provide written communication of a resident's change of condition, and any required interventions, for direct care staff on each shift. (d)	○ Actions/interventions determined should also include specific instructions for staff as to what they should be monitoring. • Examples: Diagnosis/reason for which new medications or antibiotics were prescribed and side effects, abnormal vital signs, food and fluid intake, symptoms of wound infection, increased pain. 3. Per C 280, the facility must specify the role of the LN (RN and LPN) in the monitoring system. [411-054-0045(1)(f)(C)]. 4. The facility's policies and procedures must support all RN's and LPN's adherence to OSBN Division 45 – Standards and Scope of Practice.

Examples of short-term and significant changes of condition and monitoring

1. <u>Example of Short-term Change of Condition</u>:

   Resident has a history of falls and the evaluation identifies the fall risk. Service plan includes several fall interventions, however resident falls again and sustains a skin tear.
   How to meet the rule:
   - Did staff identify the fall as a change of condition that requires intervention and monitoring by the facility and take timely steps to respond? Under C 370: Have staff been trained on identification of changes in the resident's functioning, reporting on the change and conditions that require assessment, treatment, observation and reporting?
   - Did the facility determine and document what needed to be done for the resident? The facility may employ root cause analysis or evaluation of causal factors which could be used to determine what actions or interventions are needed for the resident. In this example there are two changes of condition that need to be addressed, the fall and the skin tear.
   - Does documentation indicate that interventions are resident specific?
   - Is there evidence that interventions were communicated to staff and instructed as to what they should monitor?
   - Was the information made part of the resident record?

- Did the facility review previous fall interventions that were in the service plan to determine?
  - Were fall interventions being followed by staff?
  - Were they effective and/or new interventions were considered and developed?
- Is there weekly progress noted demonstrating the facility monitored the status of the resident in relation to the fall and the skin tear until the need for monitoring is resolved. The skin tear may require longer monitoring until the wound is considered resolved.
- Is there documentation that the facility monitored that interventions have been implemented and their effectiveness evaluated?
- Examples of documentation of monitoring:
  - "Skin tear appears closed with no redness observed. Resident has not complained of pain." Here, the facility has noted observation of the wound.
  - "Resident has been wearing call pendant today and has been walking with their walker. Has been calling for assistance before getting up when in room. When walking, resident has not shown any unusual gait or loss of balance." Assume the new resident-specific interventions implemented were to ensure resident wears a call pendant and is being reminded to call for assistance before getting up. The documentation confirms the interventions are being implemented and are effective. The documentation also includes observations as to irregularities in movement that represent a fall risk.

2. <u>Significant Change of Condition and Monitoring:</u>

   Resident returned from hospital with diagnosis of a shoulder fracture that has affected multiple areas of functioning.

   How to meet the rule:
   - Did someone document the change of condition?
   - Did someone evaluate the resident to identify immediate care needs?
   - Is there documentation the facility RN was notified of the change of condition?
   - Did someone update the resident's service plan with interventions to ensure new care needs are met?
   - Were staff informed of the new care needs and interventions?
   - Is there progress noted of the resident's status and response to interventions?
   - Is there documented evidence the facility is monitoring that any new interventions/supports are being implemented and are satisfactory?
   - Did the facility document that the condition either resolved or represented a new baseline/permanent change to the level of the functioning for the resident?
   - Additionally, survey will review the requirements under C280: 411-054-0045. Specifically, survey will confirm the facility RN completed an assessment of the significant change of condition.

Overall survey process for determining compliance with this rule

1. Review of available records that may provide information if a change of condition has occurred. Records reviewed may include, but are not limited to:
    - Resident service plan;
    - Temporary (or interim) service plan(s);
    - Medication Administration record (MAR);
    - Treatment Administration Record (TAR);
    - Alert charting log;
    - Shift reports or "24 - hour book;"
    - Incident investigations;
    - Evaluations and assessments;
    - Electronic health record;
    - Outside provider documentation;
    - Behavior logs; and
    - Other facility-specific documents as defined in facility policy.
2. Review of current evaluation and service plan to determine the condition(s) that have been evaluated and the existing information, support and interventions the facility is or should be providing. Previous evaluations and service plans may also be reviewed to compare the resident's past and current status and care needs.
3. Review of each individual change of condition to determine if the facility employed a process that meets OAR 411-054-0040. Review of the actions taken after the change of condition was identified.
4. Direct observations to determine that service-planned interventions are being implemented. These may include observations of resident(s) and staff; interviews with resident(s), direct care workers (DCW), medication technicians (MT), resident care coordinator (RCC), licensed nurse (LN) or other staff to gather information about the change of condition.
5. For some changes of condition (such as falls, development of skin issue(s), challenging behaviors, or exacerbation of a known or recurrent condition) there may already be supports and interventions service-planned. In these cases, survey will review documented evidence to ensure the facility evaluated/reviewed the change of condition to determine care was provided per the service plan. Survey will also review if the facility evaluated whether interventions and supports were still effective and/or new interventions were developed and added to the service plan.
6. If documentation is lacking or surveyor observations or interviews indicate that needed care or interventions are not being provided, survey will meet with appropriate staff (RN, LPN, RCC, Administrator) to review findings and afford the facility the opportunity to explain or provide documentation that the change of condition was responded to as required by rule.
7. If the facility provides documentation regarding the change of condition, the surveyor will review, document and consider the new information and determine whether the facility is in compliance. Findings of non-compliance are communicated to the facility during the Exit Meeting

Related OARs/tags that may be cited:
Chapter 411, Division 54 – Residential Care and Assisted Living Facilities:

a. OAR 411-054-0045(1) (C 280) – Resident Health Services – Must provide health services and systems in place to respond to 24 hour needs of residents.
b. OAR 411-054-0025 (C 154) Facility must develop and implement written policies and procedures that promote high quality services, health and safety of residents, and incorporate the community-based principles of individuality, independence, dignity, privacy, choice and a homelike environment.
c. OAR 411-054-0034 (c) (C 252) Resident Evaluation – Performed when resident has significant change of condition.
d. OAR 411-054-0036 (2) (C 260) – Service Plan updated when resident experiences a significant change in condition.
e. OAR 411-054-0045 (2) (C 290) – Coordination of on-site health services with outside providers.
f. OAR 411-054-0055 (C 303) Medication orders (failure to follow, document or have orders in record)
g. OAR 411-054-0055 (3) (C 315) Treatment orders (failure to document on the TAR)
h. OAR 411-054-0070 (5) (C 370) Training of direct care workers to identify changes in the resident's physical, emotional, and mental health functioning and documentation and reporting.
i. OAR 411-054-0028 (2) (C 231) Abuse is prohibited (failure to respond to a change of condition, monitor whether the service plan was being followed or monitor whether interventions were effective could be neglect and would be considered abuse)
j. OAR 411-054-0027 (f) (C 200) Resident Rights and Protections (to be free from neglect or abuse)

Chapter 411, Division 57 – Memory Care Community Rules (MCC):

a. OAR 411-057-0140 (1) (Z 140)– Licensee responsible for operation of MCC and provision of person directed care that promotes resident's dignity, independence and comfort. Includes supervision, training and overall conduct of staff.
b. OAR 411-057-0150 (2) (Z154) – Table 1 How to evaluate behavior and what behaviors mean by observing, collecting information, and reporting behaviors that require observation and on-going monitoring and assessment.
c. OAR 411-057-0160 (2) (b) (Z 160) – Health services provided in accordance with the licensing rules of the facility.

Note: The purpose of this document is to provide guidance on how to comply with Oregon administrative rules. It is not intended to replace, override, modify or otherwise amend regulatory text. Each survey is unique, and the survey process may vary.

Footnote:

1- “Trained and experienced staff” is referenced in 411-054-0034 Resident Move-In and Evaluation (2)(c) but is not defined. Staff may determine what actions or interventions are needed for a resident based on training in Basic First Aid, training in implementing a resident-specific protocol that is specified in the resident’s service plan for a predictable, cyclical, previously-evaluated condition or training in initiating a basic pre-determined protocol for a common change of condition until further evaluation or assessment can be completed as needed.

Resources:

Oregon State Board of Nursing – Chapter 851, Division 6
Oregon State Board of Nursing - Chapter 851, Division 45
OSBN and DHS Statement on LPNs Practicing in the Community Setting - Click on “General Policies and Information”
Online Training addressing change of condition (link coming soon)
PROTOCOL Unplanned weight change
PROTOCOL Pressure ulcer