

# Thief River Care Center

## Communications

### Care Center Companions

We are looking for people who are interested in volunteering here at Thief River Care Center. Become a Friend: visit, read/write, go for walks, play games, hold a hand, be a listener, give out smiles. Assist with programming: sing-a-longs, current events, crafts, games, outings, cooking, etc. Helping hands: deliver mail, water plants, serve coffee, pass water, transport residents, chaperone residents to appointments, greet and direct the public at the door. If you or you know of anyone that would be interested in volunteering some time, we are having an organization/ orientation meeting **Thursday Jan. 26th at 2:00 in the Care Center Conference room.** Every-

### From the desk of: Michele Halvorson, Administrator

Happy New Year!!

We have now been in our new building for 2 months!! Since becoming a St. Francis Health Services Facility we have also received our 500<sup>th</sup> admission of residents.



Lynn Harnack, Dietary manager

Thanks for attending our Christmas Program and giving us such great suggestions for next year. Our program for Christmas 2012 will be on Saturday December 15, 2012.

As we are in our survey window this bring more excitement and opportunities for change in our care center. There will be more people doing audits and reviewing how we do our standards of care. Please let us know where we can improve.



We have hired a new dietary manager and her name is Lynn Harnack, she is coming to us from the Rochester area. She will start her full time employment with us on February 20<sup>th</sup>. Please help me welcome her when you see her. I will be glad to give her the responsibility for the department as I had helped lead them since the

### Special points of interest:

- > Volunteer orientation.
- > Meet the new Dietary Manager.
- > Meet the new dietician.
- > Meet the new Social Worker.
- > Good Luck Deb Ernst.
- > Update from environmental services.
- > Care transition project.
- > Memorials

### Inside the issue:

Care Center Companions	1
Administration update	1-2
Good Luck Deb	3
Environmental update	3
Rec. Therapy update	3
Memorials	3
Care Transition Project	4-5

**Gabe Mooney, Dietician**



**Administrator continued:**

end of December. We have made Sherry a lead to assist with ordering, scheduling, organizing the kitchen and training in new staff. I hope you also like our new menus and food choices. I know many of you have changes you wanted seen in this dietary department so I hope you are pleased with some of our changes. As always continue to submit your items of interest.

We have also contracted with a dietician named Gabe Mooney from the Baudette area to provide nutritional guidance to our residents and assist with the dietary department on menus, processes and procedures. Please help me welcome Gabe to our facility! His primary days of being in the building will be on Fridays and Saturdays.

**Jennifer Johnson,  
Social Service Director**



We have hired a new social services director and her name is Jennifer Johnson, she is coming from Oakland Park Communities right here in Thief River Falls and her full time employment with us will be on February 15<sup>th</sup>, 2012. I had assumed many of these responsibilities along with the assistance once a week from Desire, a LPN in our nursing department. I have enjoyed getting to know many of the residents and families in this role.

Our Director of Nursing June Johnson has submitted her resignation and her last day with us will be Friday February 17<sup>th</sup>, we have divided her roles and responsibilities and given them to other RN's to ensure the quality of care of our residents until the position is filled. We wish her the best in her new opportunities!!

St. Francis Health Services has ordered our new van for TRCC. It is being built now and we don't know when we will receive it. Until then we have had the luxury of using a Prairie Community Services (PCS) van for some of our transportation issues. Activities is doing a lot of transportation of residents which I am very pleased about, but there are some days that they are unable and we are looking into having volunteers ride with our residents in "The Bus" or with our staff. Thanks for your flexibility!

**Michele Halvorson,  
Administrator**



Many of you have also asked if I have moved into the Thief River Falls community and I wanted to let you know that yes, my husband Andrew, daughters, Siri, Annika and Kjersti are happy to be in our new home. Andrew has also received a position with Sanford Hospital as a Biomedical Equipment Repair Technician. Thanks for your warm support and we look forward to meeting all of you!! For those of you who are receiving this letter for the first time, I relocated from the Aitkin Area where I was an Administrator of Aitkin Health Services. It is also a St. Francis Health Services facility that owns Thief River Care Center and 10 other long term care facilities.

If you would like to receive this newsletter via email, please submit your email address to activities at: [lathompson@trcc.sfhs.org](mailto:lathompson@trcc.sfhs.org)

### Good Luck Deb Ernst!!

Deb Ernst has moved on after 35 yrs. working with residents of CNC and Thief River Care Center. She will be missed and again we thank her for all the assistance serving our community members and surrounding area.

### From the desk of Herb Hiltabrand, Environmental Services

A few reminders from the staff. Please remember that there are many rules we have to follow to keep all our residents safe. Please don't put any items on top of the wardrobes or place decorations on the residents room doors. Also tapestry or quilts hanging on the walls are not allowed. These issues violate fire codes that we have to follow. Also please no extension cords. A surge protector is allowed but not extension cords.

When bringing in clothing for a resident please drop off at nursing station to have marked before use, if it doesn't get marked first our laundry department doesn't know who to return it to.

If a picture or other item is brought in for a resident we will be happy to hang it for them. Ask for a work order at the nursing station, fill out, and maintenance will complete the order.

### From the desk of Lori Thompson, Dir. of Rec Therapy

\*Congratulations to the Quilt winners. Jolayne Simpson (Margaret Greenwald's daughter) won the quilt donated by the Goodridge Parish Women, and Jeanette Reieron (Clifford Reieron's wife) won the quilt donated by the Grace Lutheran Parish of Grygla. We raised \$68.00 which will go toward replacing the hymnals. Thank you all for your support.

\*We are looking to name the pods as currently we are calling them EAST and WEST. If anyone has any great ideas please pass them on the Lori. If your idea is used you will get \$10.00 in Chamber bucks.

\*We will be crowning a King and Queen for Valentine's Day, and I will be sending out invitations for our annual couple dinner for Feb. 14th.

### Remembering our friends:

- |                   |                  |
|-------------------|------------------|
| Genevieve Johnson | Harlan Melo      |
| John Burian       | Gladys Sorter    |
| Erling Olson      | Joseph Shirbish  |
| Raymond Olson     | Doris Augustine  |
| Lenore Kraemer    | Gladys Stromberg |



Www.trcc.sfhs.org



#### Contacts:

Administration

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Social Services

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Director of Nursing

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Human Resources

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Director of Rec. therapy

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Environmental Services

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Dietary

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## Care Transitions Project

St. Francis Health Services is pleased to announce they have been awarded a government grant to create and implement a Care Transitions Project. This project is designed to improve systems and processes for transitional care between hospitals and our Skilled Nursing Facilities (SNF's), end of life care and an improved resident discharge process to assure successful transitions back home.

"Transitional Care" is defined as 'a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location'. In a recent audit of our eleven SNF's, St. Francis Health Services found, as most SNF's nationwide are finding, we are not identifying causes of resident rehospitalizations. Random audits of residents with frequent rehospitalizations revealed that some of these residents are being readmitted to the hospital for the same diagnoses that have been identified in national studies as being the leading diagnoses for hospital readmissions. Patients and families often feel unassisted as they navigate across different providers and care settings. By improving communication and accountability for patients among multiple providers we can reduce medical errors, waste and duplication. The opportunity therefore exists to make significant changes in the health care system that can enhance both quality and efficiency at the same time.

According to the National Quality Forum (NQF), about 40 percent of nursing home-to-hospital transfers are considered inappropriate, which means that they could have been handled by an outpatient work-up, the patient could have remained in the SNF, or the patient's condition did not warrant hospital inpatient care.

Research has shown that 28 percent of hospitalizations may be avoidable. Failure to identify issues such as health literacy, cultural barriers, and educational issues are factors that may lead to higher rates of rehospitalization, particularly in vulnerable populations.

Among Medicare patients, 20 percent are rehospitalized within 30 days, and more than one-third are rehospitalized within 90 days. Such rehospitalizations account for 25 percent of Medicare hospital costs, or \$15 billion per year. The Medicare Payment Advisory Committee (MedPAC) estimates that fully 76 percent of Medicare rehospitalizations are avoidable.

In its June 2007 Report to Congress MedPAC identified the following conditions that make up almost 30 percent of spending on hospital readmissions: heart failure, COPD (chronic obstructive pulmonary disease), pneumonia, AMI (acute myocardial infarction), CABG (coronary artery bypass graft), PTCA percutaneous transluminal coronary angioplasty). Of these seven conditions the MedPAC retransluminal coronary angioplasty). Of these seven conditions the MedPAC report cited there were 318,760 admissions with readmissions nationally. The average Medicare payment for each of those readmissions was \$7,593 for a national total of \$2.29 billion.

The Affordable Care Act also targets poor transitions of care, aiming to reduce unnecessary hospital readmissions by 20 percent. Beginning in 2012, hospitals will have their reimbursement cut for readmissions of Medicare beneficiaries with 30 days of discharge.

Since the 1991 Federal law, the Patient Determination Act, residents and family members have been given an opportunity to put wishes such as No CPR or Do Not Intubate into writing. However, processes for Advanced Care Planning and specifics of when end of life services are warranted have been lacking.

Also, research released by the American Association of Home and Services of the Aging (AAHSA), now known as Leading Age, indicates fewer than one in five SNF's provide end-of-life care services even though as many as 25% of all deaths occur in a SNF. Recent studies suggest that medical care for advanced illnesses result in inadequately treated physical distress, fragmented care systems, and poor communication between physicians, patients and families. As our residents progress in these illnesses, goals of care should necessarily change from curative care to palliative care. Unfortunately, more than a million people die each year without ever having access to palliative care. Many of them



will endure prolonged and needless suffering and costly ineffective treatments. Residents of long-term care facilities are at risk of serious medical illnesses and being unable to express choices when difficult treatment decisions must be made. Advance care planning (ACP) allows residents to consider, make, and communicate their preferences for how medical decisions should be made if they are later unable to participate in the decision-making process. There are three steps in ACP: 1) consideration of options and expression of values, 2) communication of decisions, and 3) documentation of the choices.

Our goals in this project, across our 11 Skilled Nursing Facilities, include processes and procedures that:

1. Prevent unnecessary hospital readmissions by coordinating prompt, comprehensive 'transitional care' after discharge from the hospital to our facility.
2. Promote successful transitions to home or community settings through improved discharge planning processes.
3. Promote supportive end of life care that focuses on reducing the severity of symptoms, which can result in better quality of life and reduced hospital readmission rates.

\*Any questions contact: Rachael LaPlante, QA Nurse 683-8128 or email [rlaplante@trcc.sfhs.org](mailto:rlaplante@trcc.sfhs.org)

