EXTENDED CARE CLINICAL
DIRECTOR OF NURSING MEETING
NOVEMBER 11, 2015

AGENDA

Life Scan Lab	Ralph Scorpio
MAC RX Framework Prior Authorizations Medication Returns Survey Window Preparedness	Isabel Gomez

Report Task Meeting Tracking Tool
(Hand out for updates)

Maximizing Reimbursements

CNA Transfer Observation

Shower Sheets

Electronic Monitoring

Trach Policy Review

Coumadin Process

POC (Point of Care) Compliance (Behavior Tracking)

Medication Related Adverse Events (Acetaminophen)

Central Line Weekly Report

Dietary Snacks

Referral Bonus

5255 Golf Road
Skokie, IL 60077
1-800-270-0037
Office 847-663-8300
Fax 847-663-1977

October 19, 2015

Final Notice

To Administrators and Directors of Nursing:

LifeScan Laboratory would like to remind you that Medicare only reimburses for the glycated hemoglobin A1c test if it is done no more than once every 90 days. Please see below:

The Medicare National Coverage Determinations Manual, Chapter 1, Part 3, Section 190.21, states:

> It is not considered reasonable and necessary to perform glycated hemoglobin tests more often than every 3 months on a controlled diabetic patient to determine whether the patient's metabolic control has been on average within the target range.

Medicare does provide for situations where more frequent testing is allowed. For example:

> More frequent assessment, every 1-2 months, may be appropriate in the patient whose diabetes regimen has been altered to improve control or in whom evidence is present that intercurrent events may have altered a previously satisfactory level of control (for example, post-major surgery or a s a result of glucocorticoid therapy).

As a result of Medicare's policy and to be CMS compliant, effective November 1, 2015, Lifescan Laboratory will bill the facility directly with any standing order for A1C that is less than every 3 months. Additional orders for A1C falling within the 90 day period will be accepted if accompanied by a letter of medical necessity signed by the physician, or an acceptable ICD-10 code (s).

Please share this information with your Medical Director, attending physicians and nurses.

Thank you in advance for your cooperation.

Sincerely yours,

Sam Lipshitz, M.D.
Medical Director

Memo Received:

Facility: ____________________ Date: ____________________

Authorized Staff: ____________________ Cust. Serv. Rep: ____________________

Laboratory Order Procedures

Scheduling STAT and one time orders:

STAT and one time orders must be called/faxed into LifeScan Lab and accompanied with a completed requisition form. Please make sure a confirmation number is provided for you to make sure STAT/one time lab orders have been scheduled.

Call: (847) 663-8300

Fax: (847) 663-1930

STAT orders should be called into the laboratory on the SAME day of the requested service

Specimen Pickups:

Specimen pickups must be called in to LifeScan Lab when they have been collected and ready for pickup. Please call us 24 hours in advance and provide the LifeScan Representative with the following:

1. Name of patient
2. Exact location of the specimen.

Therapeutic drug peak and trough:

All therapeutic drug monitoring tests should be called 24 hours in advance and provide the LifeScan Representative with the following:

1. Provide when the medication is administered
2. Does the patient have a line
3. Will there be an RN on duty or if our Phlebotomist should draw peripherally on the other arm.
4. Provide supply request if needed for RN draw

Matrix Laboratory Orders

Problems

- As a laboratory we encounter multiple errors with entering laboratory orders for patients.
  - Wrong/multiple frequencies
  - Repeated draws
  - Terminology
  - Multiple orders

Causes

- **Multiple draws**
  - Patients are drawn more than what's ordered
- **Patient's wellness**
  - Inconvenienced
  - Distress
- **Additional costs**
  - Facility being billed for unnecessary draws

Solution

- Terminology

Terminology	[illegible]	Wrong
Date of the order	1M, 2TUE, 4FRI	Once a day on the 18th of the month
Start Date	1/01/2015 - Open Ended	1/20/2015-Open Ended

Examples of Errors

Order Information

Received Date:	09/24/2014	Received By:	[redacted]
Start Date:	09/25/2014	End Date:	Open Ended
DC Date:	08/25/2015 [illegible] (See [illegible] for details)		

Lab Test 1	CMP (Comp Met Prof) 1348 *
Lab Test 2	Hepatic Function Panel 1233
Lab Test 3	Lipid Panel 37 *
Lab Test 4	CBC with Differential 7995 *
Lab Test 5	TSH 2212 *
Lab Test 6	FBS 1130 *
Other Tests:	[illegible] D 25 Hydroxy *
Frequency:	Once A Day on the 18th, 23rd of Every 6th Month

Times / Shifts:
Shift

	Description	Start Time	End Time
1:	Shift 3	11:00 PM	07:00 AM

Display options:
☑ Display Description
☐ Display Times

Repeat:

Examples of Errors

ORDER INFORMATION

Order date: 10/28/2015 - Open Ended
Created date: 10/28/2015 11:55:39AM
LABS: Lipid Profile w/calculated LDL; Liver Panel;
Once A Day on the 1st of Every 6th Month; 08:00 AM

Received by: [redacted]
Received date: 10/28/2015
Ordered by: [redacted]
Order source: Written

This Order Not Signed

Examples of Errors

ORDER INFORMATION

Order date: 11/04/2015 - Open Ended **Created date:** 11/4/2015 12:59:23PM
LABS: Basic Metabolic Panel; CBC w/ Auto Differential; ALT (SGPT); AST (SGOT); TSH;
Other Tests: (labs every 6 months)
Once between the 1st - 31st of the Month
Received by: [redacted] **Received date:** 11/4/2015 1
Ordered by: [redacted] **Order source:** Verbal

This Order Not Signed

Examples of Errors

diabetes mellitus without complications, F31.9 Bipolar disorder, unspecified, F32.9 Major depressive disorder, single episode, unspecified, G60.8 Other hereditary and idiopathic neuropathies, I10 Essent...

3W 1-11

ORDER INFORMATION

Order date: 01/20/2016 - Open Ended **Created date:** 10/21/2015 11:29:16AM
LABS: Depakene (VPA) / S;
Once A Day on 2nd Mon of Every 3rd Month; Days
Received by: [redacted] **Received date:** 10/21/2015
Ordered by: [redacted] **Order source:** Telephone

This Order Not Signed

Examples of Errors

Lab	CBC with Differential L; CMP (Comprehensive Metabolic Panel) SG; Hemoglobin A1C L Once A Day on 2nd Wed of Every 3rd Month 07:00 AM - 03:00 PM	12/10/2014	Open Ended	Labs
Lab	Hemoglobin A1C L Once A Day on 2nd Mon of Every 3rd Month 07:00 AM - 03:00 PM	04/06/2015	Open Ended	Labs

Correct Entry Example

ORDER INFORMATION

Order date:	11/05/2015 - Open Ended	**Created date:**	11/3/2015 8:07:42AM
LABS:	FBS 1150, Once A Day on 1st Thu of Every 3rd Month; 06:30 AM		
Received by:	[illegible]	**Received date:**	11/3/2015 1
Ordered by:	[illegible]	**Order source:**	Telephone

This Order Not Signed

Stephanie Peterson

From: Dawn Lisante
Sent: Wednesday, October 28, 2015 11:50 AM
To: Assistadm Southsuburbannursing; Michael Stoudt; Daniel Elkaim; Celeste Jensen; Margie Thompson; Administrator Lemontcenter; Mark Steinberg; Laura Feliciano; Mary Rose Stucker; Assistadm Rainbowbeachnursing; Jackie Gully; Ron Nunziato; Nikki Dinsmore; Mike Hunter; Stephanie Mohr; Stephanie Peterson; Stephen Brumer; Sarah Simons; David Taylor; Assistadm Dyerrehab; Katie Robertson; Kenan Weekley; Kim Urban
Subject: FW: MACRx

From: Ron Nunziato
Sent: Wednesday, October 28, 2015 11:20 AM
Subject: MACRx

Folks,

When we were with Omnicare they had Omniview which was a database that can be used for Clinical information and pricing of medications when considering an Admission. MACRx has their version now and it is called Framework which is available on the MACRx website. MACRx's customer service staff will be coming to the facilities to train the Admissions staff on their site. DONs should not be burdened with pricing out potential admissions medications. Please respond to the email below for Isabel with the name(s) of the individual(s) and their email addresses of who you would like to have access/ trained to this site.

Isabel will coordinate their user name and password as well as ensuring these people are trained. The following Business Dev people at ECC will be trained as well:

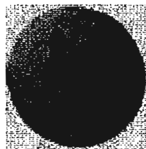
Helen Friedman hfriedman@extendedcarellc.com
Monika Peterson mpeterson@extendedcarellc.com
Danielle Chamberlin dchamberlin@extendedcarellc.com
Brian Magnabosco bmagnabosco@extendedcarellc.com

Thanks, Ron

Isabel.gomez@macrx.com

Ron Nunziato
Chief Executive Officer
Extended Care Clinical, LLC
Office: 847-905-3000
Direct: 847-905-3283
Efax: 866-570-5619

Service Means I Lead by Example



Extended Care Clinical, LLC
Providing Care with Dignity

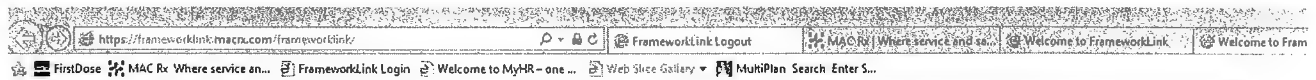
1. Log onto MAC RX.com
2. Click on MAC RX Link in the right hand corner

About Us What is MAC Services Careers Contact Us

MAC IS THE PRICE THAT THE STATE OF ILLINOIS PAYS PHARMACIES FOR GENERIC MEDICATION –
SHOULDN'T YOU PAY MAC TOO?

What is MAC Pricing? LTC Pharmacy Services What are my Savings?

3. Framework Link appears: Double Click Enter



Welcome to FrameworkLink

With FrameworkLink you can:

- Admit/Discharge Patients
- Maintain Patient Records
- Place New Drug Orders & Refills
- Print Medical Records

Enter

4. Enter User ID and Password & Click Login

(If User ID & Password needed, please contact rep)

Framework

Thursday, November 05, 2015
03:24

FrameworkLink User Login

User ID: 1052
Password: ••••••••

Login Cancel

If you are unable to see anything after following steps 1-4. You will need to work with your IT department to remove any security firewalls.

Once all firewalls removed. Please contact your Customer Service Rep to set up training at your facility.

IV PUMP/EQUIPMENT RETURN

Serial #: ______________________________

Patient Name: ______________________________

End of Therapy: ______________________________

Duration of Rental: ______________________________

Upon initial receipt of IV pump, the receiving facility is liable for the cost of the pump (including rental fees and damages) until this form is signed and returned to MAC RX. The IV pump is property of MAC RX and is to be returned to the pharmacy IMMEDIATELY following the discontinuance of use for the assigned patient.

HOW TO RETURN THE PUMP: Fax this COMPLETED document to MAC RX: (224) 220-2730 Place pump and power cord in red biohazard bag to signify the pump is ready for pickup.

Signed and Agreed:

(Responsible Facility Staff Member)

Signature: ______________________________

Printed: ______________________________

Date/Time: ______________________________

*** Failure to return this form within 48 hours of receipt will result in additional rental charges ***

Report/Task/Meeting Tracking Tool

Report/Task	Date Due	Person Responsible	Mark date received/done in box				
			Week 1	Week 2	Week 3	Week 4	Week 5
			Day 1-7	Day 8 - 14	Day 15-21	Day 22-28	Day 29 - 31
Monthly wts/vitals recorded	7th						
Monthly legal/risk stuff to Holly	5th						
Monthly Referral Reports	5th						
Monthly wt report	by the 10th						
Monthly Sig wt notified & summary note	by the 12th						
Monthly Lab Audit	by the 8th						
Key Indicator	9th						
Key Indicator input to corporate	10th						
Old MAR/TAR audited & to HIM	10th						
Printing Monthly MAR/TAR's, glucose, prn sheets	by the 1st						
Recruiting Openings Due	23rd		Every Day				
Change of Condition Audit	Daily		Every Day				
Reportable investigations	Daily		Every Day				
Audit New/Re-admissions	Daily		Every Day				
High/low checks for glucose machines	Daily		Every Day				
Vaccination Program	Daily		Every Day				
Temperature logs for friges	Daily		Every Day				
Admission inquiry reviews	Daily		Every Day				
Crash cart logs	Daily		Every Day				
Psychotrotic Program	Daily		Every Day				
Lab Results reported and uploaded	Daily		Every Day				
Falls uploaded to QA Reader	Daily		Every Day				
Point of Care ~~audits~~	Daily		Every Day				
Isolation Tracking Log updated	Daily		Every Day				
Assign nursing observations to nurses per MDS schedule/audit	Daily		Every Day				
MAR/TAR Ommisions audit for completion	Daily		Every Day				
AR Review	Weekly						
Weekly measurements recorded	Weekly						
Weekly pressure/skin report	Weekly						
Weekly wts recorded	Weekly						
Infection logged on website	Weekly						
Sig weekly wt notified	Weekly						

Oxygen tubing baged/dated	Weekly						
Dietary Rec's completed	Weekly						
Nursing Infection Rounds	Weekly						
Housekeeping/Laundry Infection Rounds	Weekly						
Dietary Infection Rounds	Weekly						
Roster Updated	Weekly - Friday		/	/	/	/	/
I/O audit	Mon / Wed		/	/	/	/	/
Shower Sheets/Skin checks audit	Monday/ Thursdays						
Staff Evaluations	Monthly						
Pharmacy Rec's Completed	Monthly						
PSA	Monthly						
Mamo/paps	Monthly						
slit eye exam audits	Monthly						
MEETINGS & MISC							
NAR/Wound	Weekly Wednesdays	Team					
QA	Monthly	Team					
Incidents/Accidents	Daily	Fall Team	Every Day				
Safety	Monthly	Team					
Medicare Meeting	Wednesday	Team					
Gaurdian Angel Rounds	Daily	all managers					
Ethics Committee	Monthly	SS/ NSG/ ACT/ DIET					

Interact

Central Line Report

Identified Offender

Cash box Report

Slips in cash box

Med E verification 1st/3rd each month. Need care address changed (we aren't getting paid, renewal date past, call bookkeeper for new date)

Mastering the new SNF regs to maximize reimbursement

October 7, 2015 by Pamela Tabar, Editor-in-Chief

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REPRINTS

2016 begins a brave new year for skilled nursing facilities (SNFs), a year when readmission rate scores will become a direct and deliberate determiner of Medicare reimbursement amounts. A reimbursement of two percent is on the table, and facilities whose readmission scores don't compare favorably to other SNFs across the country could lose most or all of it, explained policy experts at this week's American Health Care Association/National Center for Assisted Living (AHCA/NCAL) Annual Conference and Expo in San Antonio, Texas.

"We've been saying for years that you can't separate quality from financial. Now it's absolutely happening," said Mary Ousley, RN, president of Ousley and Associates and a licensed nursing home administrator in Kentucky.

A SNF's score will be derived from its actual readmission rate divided by the national average, explained David Gifford, MD, MPH, senior vice present of quality and regulatory affairs, American Health Care Association. Then, the score will be compared to everyone else's. The reimbursement formula reserves the harshest penalties for facilities that score in the lowest 40 percent of the country.

"If you're in the top 60 percent in the country, you'll likely get most of the two percent withholding back," Gifford explained. But, he warned, "If your rehospitalization rates are above 20 percent, you are most likely going to be in the bottom 40 percent of the country."

What's next

The next phases of implementation will involve much more than readmissions, and organizations that don't prepare now will find themselves far behind the curve, said Ousley, who also serves as chief strategy officer for PruittHealth. While most SNFs are accustomed to documenting pressure ulcers, falls and functional status, the IMPACT Act is raising the bar significantly on documentation, both at intake and at discharge. Medication reconciliations, detailed plans for discharge to community, efficiency measures, spend per beneficiary measures and other documentation will all be required.

SNFs will have to show the plans for care but also the care that was actually delivered, Ousley said. "What care did we deliver for the Medicare dollars? We need the whole snapshot from when they come in to when they leave."

Care plan development and documentation are key parts of the new SNF documentation and delivery world. "We're being asked to move to a whole new level of care planning," Ousley said. Care must be customized according to the needs and values of the resident, including personality, nationality, ethnicity and beliefs and culture. This goes way beyond 'what time do you want to get up?' and 'what do you want for dinner?'"

In addition, the results of quality measures must be shared with families and will be compared across post-acute facilities, she added. Now is the time for SNFs to rethink the role of the MDS Coordinator, who needs to be a true champion of care coordination, not just a data-entry person, she said.

Improving internal processes takes honest and deep introspection, and SNFs can hurt their own efforts by assuming that some readmissions are simply a cost of doing business, Gifford insisted. "It's all about the attitude and viewpoint when you do root-cause analysis. You need to view all readmissions as preventable or you'll miss the things you need to see. That applies to pressure ulcers, falls, everything."

CNA TRANSFER OBSERVATION

Resident:			Date:
Please Check:	Hoyer	Sit-to-stand	1 person with gait belt
Did employee have the proper equipment?			
Did employee perform the transfer with the proper technique?			
PRINTED NAME of staff person being reviewed			
Signature of reviewer:			

Instructions: CNAs are responsible for having either a Nurse Manager, Physicial or Occupational Therapist observe **one** transfer per month and sign off. Residents and type of transfer must be rotated each month. This form must be handed to HR to be filed in the employees record, once it is signed off on.

REVISED 11/2015S

BATH AND SKIN REPORT SHEET

Month_______________ Year ____________

Resident Name ____

Instructions:

The Nurse is to perform skin checks during the resident's bath & shower days.

The Nurse should record observation on the chart below. Check 'Skin Intact' if no alterations noted.

Mark and label all skin conditions as to type on the body diagram below, such as bruise, blister, open area.

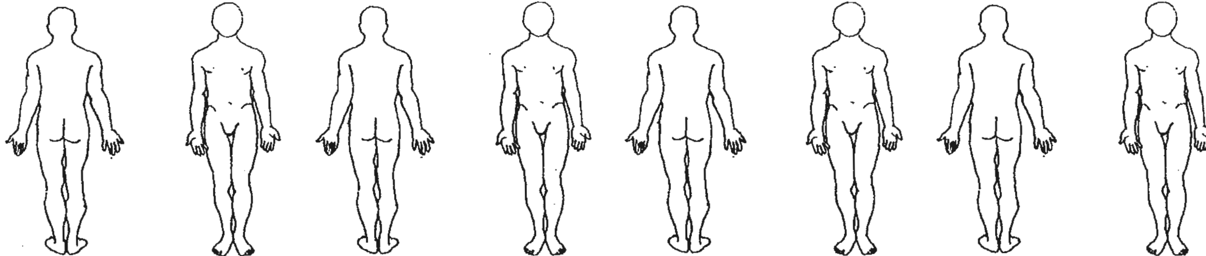
Documentation of refusals and interventions must be recorded on the reverse of this report and in the resident record.

To be completed by a Nurse:

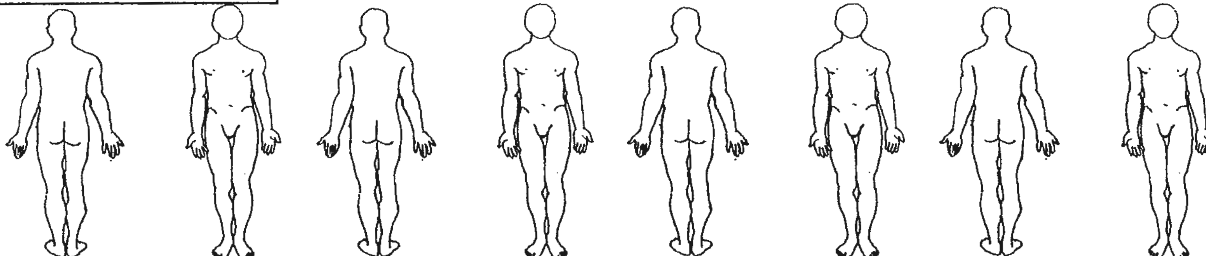
Date	Skin Intact	Bruise	Blister	Open Area	Redness & Rash	Excoriation	Other	List Action(s) Taken	Nurse Signature

To be completed by a CNA:

Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:



Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:	Date: Lotion Applied Y / N Resident Shaved Y / N Nails Trimmed Y / N CNA Signature:



Documentation of Shower/Bath Refusal Only

Month______________ Year ______________

Resident Name: ____ ***Room Number:*** ______________________

Indicate with a check mark intervention/approach utilize to guide/meet goal of hygiene care.

Date	Shift	Interventions Implemented/Reviewed	C.N.A Initials	Nurse Signature
		❑ Bed bath Given ❑ Full body check completed and documented ❑ Alternative shower day & time offered (Date:______________ Shift:_______) ❑ Resident preference for shower days & time discussed and documented ❑ Behavior Occurrence Form Completed ❑ Responsible party consulted ❑ Care Plan Updated/Revised ❑ Provided set up for shower/bath ❑ Scheduled meeting with IDT team members/resident/responsible party		
		❑ Bed bath Given ❑ Full body check completed and documented ❑ Alternative shower day & time offered (Date:______________ Shift:_______) ❑ Resident preference for shower days & time discussed and documented ❑ Behavior Occurrence Form Completed ❑ Responsible party consulted ❑ Care Plan Updated/Revised ❑ Provided set up for shower/bath ❑ Scheduled meeting with IDT team members/resident/responsible party		
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		❑ Bed bath Given ❑ Full body check completed and documented ❑ Alternative shower day & time offered (Date:______________ Shift:_______) ❑ Resident preference for shower days & time discussed and documented ❑ Behavior Occurrence Form Completed ❑ Responsible party consulted ❑ Care Plan Updated/Revised ❑ Provided set up for shower/bath ❑ Scheduled meeting with IDT team members/resident/responsible party		
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Electronic Monitoring In Long-Term Care Facilities Act

Illinois has now followed New Mexico, Oklahoma, Texas and Washington in passing the Authorized Electronic Monitoring in Long-Term Care Facilities Act (hereinafter the "Act"). In short, the Act allows residents or families of residents in long term care facilities to install cameras or other electronic monitoring devices.

Who Is Affected?

According to the definitions provided in the Act, the Act covers intermediate care facilities for the developmentally disabled licensed under the ID/DD Community Care Act that has 30 beds or more, a long-term care for under age 22 facility licensed under the ID/DD Community Care Act, or a facility licensed under the Nursing Home Care Act. Authorized Electronic Monitoring in Long-Term Care Facilities Act, No. 99-0430, § 5 (Aug. 21, 2015).

When Does The Act Take Effect?

January 1, 2016. § 99.

What Does The Act Require?

In short, the facility must now allow the resident or their families to electronically monitor their rooms. Section 10(a) states: "A resident shall be permitted to conduct authorized electronic monitoring of the resident's room through the use of electronic monitoring devices placed in the room pursuant to this Act." § 10(a).

The Act expressly does not allow for still photographs and non-consensual monitoring. § 10(b).

Who Can Request The Monitoring?

The resident or the legal guardian of the resident. § 15(a). Additionally, the monitoring can be requested by the "resident's representative" as defined by the Nursing Home Care Act as a person other than the owner not related to the resident, or an agent or employee of a facility not related to the resident, designated in writing by a resident to be his representative, or the resident's guardian (210 ILCS 45/1-123). People who may request monitoring would include the resident's representative, the resident's spouse, parent, and adult children as long as other adult siblings consent. § 15(a)(5).

Who Pays For The Monitoring?

The resident. § 25(a). However, the law envisions some (very limited) public funding for the monitoring. § 27.

If the monitoring device requires the internet, the resident must make arrangements for the internet access and pay any associated charges. § 25(b).

The Department intends on creating an "Assistance Program" which will be a scholarship program to provide financial grants to residents receiving medical assistance under Article V of the Illinois Public Aid Code. § 27(a). It is the intent of the law for the Department to develop an application for the assistance. § 27(c). The Act intends on the Department distributing $50,000 on an annual basis. § 27(b).

Can The Facility Charge For The Monitoring Or Allowing The Monitoring?

No. § 25(e).

Is The Resident Required to Notify the Facility? and What About Roommates?

The IDPH has 60 days from January 1, 206 to draft a consent form which is required to be completed by the resident. § 20(a). A resident shall notify the facility in writing of his or her intent to install a camera and must include, among other things, the date the resident was asked if he or she wants a camera (or requested a camera), the resident's roommate's signed consent, witnesses to the consent and/or request, and any conditions prescribed by the roommate. Conditions or restrictions that a resident or roommate may elect include, but are not limited to: prohibiting audio recordings, prohibiting broadcasting and blocking or turning off monitoring during exams, procedures, dressing, bathing, or consultations with ministers, attorneys, financial planners or other visitors. § 20(c).

Electronic monitoring will not prevent staff from performing duties as normal e.g. curtain pulls and any other measures used for privacy. The Federal Nursing Home Reform Act still gives residents the right to privacy, dignity, etc.

What Are The Duties Of The Facility?

Room Accommodation

If a resident residing in a shared room wants to install a camera and his or her roommate does not wish to have a camera, the facility shall make a reasonable attempt to accommodate the resident who wishes to install a camera. Per the Act, a facility has met the requirement (to make a reasonable attempt to accommodate a resident who wishes to install a camera in his or her room) if the facility offers to move either resident to another shared room that is available at the time of request. However, the new roommate obviously would need to consent to a camera. If a facility is unable to accommodate a resident due to lack of space, the facility must reevaluate the request every 2 weeks until the request until the request is fulfilled. § 15(e) If a resident transfers rooms, the resident or family needs to move the camera (or the facility can remove)

Installation Accommodation

Under the Act, the facility must make "a reasonable attempt" to accommodate the resident's installation needs, including, but not limited to, allowing access to the facility's telecommunications or equipment room. § 25(c) However, the facility is not required to provide internet services to the room. The resident has to procure internet service. It would not be a reasonable accommodation to allow cameras on the facility's wireless network.

The facility must allow the resident to install the camera in a conspicuous place. However, all electronic monitoring device installations and supporting services shall comply with the requirements of the

National Fire Protection Association' Life Safety Code. § 25(f). Presumably, the facility could also prevent installation which would violate OSHA or any other safety regulation.

This is an important point because a facility has the burden of proving that a requested accommodation is not reasonable. § 25(c).

Is There Reporting Requirements?

The facility must also provide information to the Department as to the number of "authorized electronic monitoring notification and consent forms received annually." § 55.

Additionally, the facility must document the request by the resident or guardian. § 20(c). The facility must use an approved form (to be developed by the department) to document the request and logistics of the request. § 20(b). The form will then be contained in the resident's clinical file. § 20(c). The facility will need to document reasonable accommodation decisions.

Notice To Others

Signs must be posted by the facility in the entrances to the buildings and the rooms being monitored advising of the electronic monitoring devices. § 30.

Penalties

The Act makes "knowingly hampering, obstructing, tampering with, or destroying an electronic monitoring device installed in a resident's room" a Class B misdemeanor. § 40(a), (c). A person or entity that violates this Section in the commission of or to conceal a misdemeanor offense is guilty of a Class A misdemeanor. § 40(c). A person or entity that violates this Section in the commission of or to conceal a felony offense is guilty of a Class 4 felony. § 40(c).

Additionally, the facility can be held liable for intentionally retaliating or discriminating against any resident for consenting to authorized electronic monitoring or to prevent the installation or use of an electronic monitoring device. § 70. A violation of this Section is a business offense punishable by a fine not to exceed $10,000. § 70.

Who Owns The Information From The Monitoring Device?

The resident. The facility has no right to the footage. § 45.

How Can The Information From The Monitoring Device Be Used?

The Act expressly provides that the information "may only be disseminated for the purpose of addressing concerns relating to the health, safety, or welfare of a resident or residents." § 45(b). This would expressly include litigation. § 45(c).

The Act provides that the information obtained may be "admitted into evidence in a civil, criminal, or administrative proceeding." § 50. However, the information cannot have been "edited or artificially enhanced and the video recording includes the date and time the events occurred." § 50.

What To Do Going Forward?

Policies and procedures will need to be updated to comply with the Act. Specifically:

• Revisions to resident rules and regulations to allow for the electronic monitoring consistent with the logistical issues presented by the particular facility.

• Education of the other residents and the residents' families as to this new law.

• Education of the clinical and non-clinical staff regarding the new electronic monitoring.

• Logistical training for those working around the electronic monitoring devices to prevent damage and injury.

• Development of policies and procedure for addressing complaints centering on the electronic monitoring devices.

Dropcam Pro Wi-Fi Wireless Video Monitoring Security Camera

Stunning Video Quality: New optics and updated image sensor provide 2x sharper video

60 Second Setup: Connect to Wi-Fi via computer or iOS mobile device via Bluetooth Low Energy (BLE), live stream from your Dropcam security camera in under a minute

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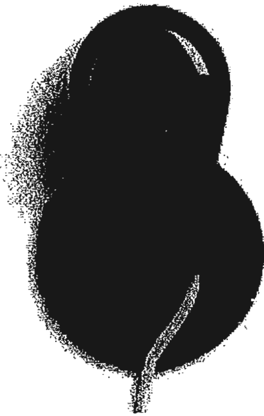

Tracheostomy Care

Purpose

The purpose of this procedure is to guide tracheostomy care and the cleaning and sterilization of reusable metal tracheostomy tubes.

Equipment and Supplies

1. Gloves;
2. Mask and eyewear (as indicated);
3. Tracheostomy care kit;
4. Hydrogen peroxide;
5. Sterile water or normal saline;
6. Suction catheter;
7. Suction machine;
8. Replacement tracheostomy tube (as necessary);
9. Gauze dressing; and
10. Twill ties.

Procedure Guidelines

Tracheostomy Care:

1. Wash hands.
2. Put exam gloves on both hands.
3. Remove old dressings and ties. Pull soiled glove over dressing and discard into appropriate receptacle.
4. Put on fresh gloves. (Note: Sterile gloves must be used for anything other than stoma care.)
5. Set up tracheostomy-care kit.
6. Clean tube and site with hydrogen peroxide and saline (or water).
7. Change disposable tracheostomy tubes in accordance with established policy.
8. Change dressings when soiled or wet.
9. Change ties when soiled or wet.
10. Remove gloves and discard into appropriate receptacle.
11. Wash hands.

Miscellaneous

1. Aseptic technique must be used:
   a. During all dressing changes until the tracheostomy wound has granulated (healed);
   b. During tracheostomy tube changes, either reusable or disposable;
   c. During endotracheal suctioning; and
   d. During cleaning and sterilization of reusable tracheostomy tubes.
2. Gloves must be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be used during aseptic procedures.
3. A mask and eyewear must be worn if splashes, spattering, or spraying of blood or body fluids is likely to occur when performing this procedure.
4. Tracheostomy tubes should be changed as indicated, and at least monthly.
5. Sterilize reusable metal tracheostomy tubes monthly.
6. Provide tracheostomy care as often as needed, at least once per shift and PRN.
7. A replacement tracheostomy tube must be available at the bedside at all times.
8. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times.

Continues on next page

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9. Ambu bag with mask must be available at bedside at all times.
10. Masks are indicated if the resident is coughing, there is aerosolization of secretions during suctioning, and/or exposure of mucous membranes of the staff person's mouth and nose are likely.

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Tracheostomy Equipment (required to be at bedside)

Federal and State standards

1. A replacement tracheostomy tube (must be same size tube or one size smaller)
2. Suction machine (must have a back-up battery or ability to hook up to emergency power)
3. Suction catheter (size must fit into trach)
4. Ambu bag
5. Mask

All About Tracheostomies

PEL/VIP LTC RESPIRATORY CONSULTING DIVISION

OBJECTIVES

- Definition/Rationale for a tracheostomy including basic anatomy of the trachea
- Definition/Rationale for a tracheostomy including basic anatomy of the trachea
- Correctly identify parts of a tracheostomy tube
- Discussion of the cuff, pilot balloon, and inner cannula
- Discussion of rationale/procedure for tracheostomy care including suctioning the airway
- Discussion of equipment needed at the bedside
-

DEFINITIONS

- Tracheotomy
  - The operation of opening the trachea with insertion of a tracheostomy tube (cannula) to provide a means of breathing (airway).
- Tracheostomy
  - The surgical stoma
- Tracheostomy (Trach) tube
  - The tube or cannula that fits into the stoma and supports the airway
- Fenestration- hole in trach tube
- Decannulation- permanent removal of trach tube
-

THE RESPIRATORY SYSTEM

- Nasal Cavity
- Nasopharynx
- Oropharynx
- Larynx (voicebox)
- Trachea (windpipe) - Bifurcates with R/L mainstem bronchus which lead to the R/L lung lobes and segments
- Lungs
  - Right lung- 3 lobes (upper, middle, lower) ; R mainstem bronchus divides many times into smaller segments
  - Left lung- 2 lobes (upper and lower); L mainstem bronchus divides many times into smaller segments
- Trachea is the largest airway
  - Adult trachea is between 4-6 inches long and about ½ to ¾ inches in diameter
- Carina is where the trachea bifurcates into the R/L main stem bronchi
- As the main stem bronchi divide into smaller and smaller segments the airways are called bronchioles
- Bronchioles finally end in small air sacs called alveoli where gas exchange takes place
-

INDICATIONS FOR A TRACHEOSTOMY

- Maintain the airway
  - Bypass upper airway obstruction
    - Foreign bodies, airway edema, tumors, burns
    - OSA-Obstructive Sleep Apnea
- Facilitate Removal of Secretions
  - Neuromuscular diseases
  - Debilitated (deconditioned)
  - Paralysis of chest muscles/diaphragm
- Long Term Positive Pressure Ventilation
  - Many reasons why someone is on a ventilator and may have trouble weaning off
  - Changing from endotracheal tube to trach may:
    - Decrease WOB
    - Patient comfort/increase mobility
    - Enable eating/speaking

PARTS OF A TRACH TUBE

- Cuff
- Flange
- Pilot Balloon
- Inner Cannula
- Obturator

WHAT IS THE PURPOSE OF A CUFF?

- To form a seal between the tracheostomy tube and tracheal wall to prevent aspiration and/or facilitate effective ventilation with a ventilation bag/mechanical ventilator.

WHAT IS A PILOT BALLOON?

- It is a small external balloon that shows if the cuff is inflated or deflated
  - Does not show how much air is in the cuff
  - Do not squeeze the pilot balloon, as that will increase the pressure on the patient's airway

WHAT IS THE PURPOSE OF AN INNER CANNULA?

- The inner cannula "lines" the trach tube and keeps it clean. Inner cannulas can be taken out and cleaned/replaced every shift.
- **Just think: Why do we place a garbage bag in a garbage can?**
  - Answer: to keep it lined and clean. The Inner cannula is used for the same purpose.

DISPOSABLE INNER CANNULAS (DIC)

- Should be changed at least daily and PRN
- Cannot be cleaned or sterilized
- One time patient use
- Popular with many facilities
- Shiley- has "clips" or "wings" on the sides to fasten to the trach tube.
- Portex has a "pull ring" to remove inner cannula

STANDARD (NON-DISPOSABLE) INNER CANNULAS (SIC)

- Should be inspected/cleaned every time you do trach care and PRN
- Gets changed when whole tube is changed
- Shiley-has a turn-lock mechanism (two blue dots should "line up")

TYPES OF TRACH TUBES

- Metal Jackson
  - Used commonly many years ago
  - Cannot comingle sizes
  - Comes in sizes 5.0-10.0
  - Does not have 15mm connector for manual resuscitator
    - Adapt Portex ETT connector to this tube for manual resuscitator
    - Some of the newer Metal Jackson tubes **do** have an inner cannula with the ability to connect a manual resuscitator to it

- Shiley
  - Most commonly used
  - Composed of PVC
  - Comes in several styles
    - Cuffed/Uncuffed
    - Disposable/Standard inner cannulas
    - Varying lengths including XLT
    - Adult Sizes 4.0-10.0

- Portex
  - More flexible PVC
  - Disposable inner cannula has "ring"
  - Adult Sizes from 5.0 to 10.0
  - Comes in several styles
    - Blue line style is radiopaque (can see better in CXR)
    - Has color-coded style to better visualize size/inner cannula

- Bivona
  - Composed of Silicone
    - Outer cannula is very flexible
    - Decreased adherence of secretions
    - No inner cannula
  - Comes in several styles
  - Not an ideal choice for a patient with excess secretions

STANDARD TRACH CARE KITS

- Sterile gloves
- Trach stoma dressing (drain sponge)
- Cleaning brush
- Drape
- Gauze
- Cotton tip applicators
- Pipe cleaners

BASIC STEPS TO PERFORM TRACH CARE

- Assess for need to suction/suction if needed
- Don gloves/remove old trach dressings/assemble all needed supplies at bedside
- Open trach care kit/assemble sterile field
- Pour ¼ to ½ strength hydrogen peroxide/sterile water solution in one basin and sterile water solution in other basin
- Clean/change inner cannula
- Clean stoma area aseptically-inspect stoma as well
- Change trach ties- inspect neck area

CHANGING TRACH TIES

- Types of trach holders
  - Strings
    - Not used anymore due to strings cutting into skin
  - Velcro (ie: Dale)- most commonly used
  - Metal beaded
- Tips
  - Do not over tighten
  - If using velcro, ensure that it is securely fastened
  - Trach ties fit right if you can put two fingers between the ties and your neck.
  - You want trach holder to be snug, but not too loose or too tight.

SUCTIONING A TRACH

- How do you know when to Suction:
  - Auscultation
  - Observation

- Tips
  - Do not routinely instill saline prior to suctioning
  - Do not apply suction when inserting the catheter
  - Do not reuse catheters
  - Suction pass should not last longer than 15 seconds

LONG TERM TRACH COMPLICATIONS

- Infection-tracheal and stomal
- Tracheal Stenosis
- Tracheal-Esophageal Fistula
- Voice changes and vocal cord abnormalities

STANDARDS AND GUIDELINES FOR TRACHS

- Although there are not any evidence-based guidelines, there are standards that different facilities practice by.

- The standards for trachs and trach care are the following:
  - Trach care= AT LEAST Qday and PRN
  - Trach tube change= 30-90 days, or per manufacturer recommendation
  - Trach tube holder= Qday to Qweekly and PRN, most facilities change holders Qdaily and PRN
  - Inner Cannula= AT LEAST Qday and PRN
  - Aerosol tubing= Q72 hours and PRN to Qweekly and PRN

- Suctioning
  - Evidenced based recommendations are: only suction when secretions are present
  - Routine use of instillation of normal saline is not recommended
  - Duration of suctioning event should be less than 15 seconds

TRACHEAL DECANNULATION

- When to decannulate?
  - Reason for requiring trach has resolved
  - ENT evaluation has cleared airway for procedure
- How to decannulate?
  - MD/SLP/RT/Nursing involved
    - Requires Physician order to begin
  - Methods
    - Slowly downsize trach
    - Capping

TRACH ADMISSION EQUIPMENT AND SUPPLIES

- Continuous Aerosol Setup to Tracheostomy
  - Aerosol tubing
  - Aerosol drain bag
  - Air compressor
  - Tracheostomy mask
  - Oxygen bleed in tee
  - Oxygen tubing
  - Aerosol bottle (Refillable or Prefilled)
- Suction machine
- Oxygen Concentrator or Liquid Tank with Flowgauge

- Pulse oximeter
- Oxygen analyzer
- Oxygen Nipple Adapter
- Manual Resuscitator (single resident use)
- Tracheostomy Tubes (Spare and one size smaller)
- Tracheostomy Ties
- Suction catheters
- Trach care kits
- Suction canister
- Suction tubing (6 foot and 18 inch)
- Sterile water
- Transport E Cylinder with Venti/Mixing mask set for current oxygen percentage
- Orders require documentation of desired oxygen percentage to be delivered:___________________%

EQUIPMENT SET UP FOR A TRACH

- Aerosol bottle
  - Bottle should be tightly connected to cap
  - Bottle should never run dry
- Tubing and tubing connections
  - Ensure tubing and all adaptors are securely connected
  - Empty any water condensation in tubing
  - Should have drain bag in aerosol tubing
- Mist output
  - There should be visible aerosol mist in the trach collar
- Venturi system backup (if oxygen is used) should always be at bedside

TRACH ACCESSORIES-SPEECH

- Speaking valve
  - Passy Muir (PMV)
  - Shiley
- Requires MD order
- Pt must be assessed for use
  - Nursing/SLP/RCP
- Should only be used with trained caregivers in attendance
- Tips
  - Use PMV with O2 port if needed
  - Suction, if needed, prior to placement
  - Observe that valve is working properly after placement
- Cleaning
  - Swish the Valve and accessories in pure fragrance-free soap and warm water
  - Rinse thoroughly in warm water
  - Allow valve to air dry thoroughly before storing in closed container
  - DO NOT use hot water, peroxide, bleach, vinegar, alcohol, brushes, or cotton swabs

OTHER CONSIDERATIONS WITH SPEAKING VALVE

- To use the valve, the tracheostomy cuff **HAS TO BE** deflated
- To use the valve, patients should also be medically stable, be able to exhale around the tracheostomy tube and out through the nose and mouth.
- Stay with the patient during first wearing. (i.e.5-10mins)
- Increase wear-time as tolerated.
- Ensure patient has a sputum container or tissues and bag for orally expectorated secretions.
- Assess the patient's work of breathing.
- Observe secretions. Thick unmanageable secretions are a contraindication for wearing the valve.
- **DO NOT WEAR SPEAKING VALVE WHILE SLEEPING**
- **DO NOT THROW VALVE AWAY**

Anticoagulant Medication Process (Submit to your nurse consultant by 11/24/2015)

How does the facility ensure that documentation of clinical indication is in the medical record?

Where is it kept in the record?

Who monitors that it is in place?

How does the facility ensure that lab results are routinely monitored?

What is the process?

Who is responsible?

How does the facility ensure that lab results (PT/INR's) are communicated to the physician?

What is the process?

Who is responsible?

Who is responsible for educating caregivers on both bleeding risks and dietary/food interactions?

What is your training process for your staff where is the training kept?

How does the facility ensure that the caregiver/resident is trained including discharge?

Who monitors that there is clinical documentation in the chart?

What is the process to alert prescribers and nursing staff of duplicate anticoagulation therapy?

Behavior Documentation

from 11/3/15 – 11/10/15

Facility	# of Behaviors Documented in POC
Beecher	44
Briar	24
Chateau	6
Dyer	24
Estates	14
Lakewood	31
Lemont	6
Lincolnshire	21
Munster Med-Inn	15
Park House	3
Prairie Manor	12
Sebos	24
South Suburban	9
St. James	4
Tri-State	28
Wheaton	10

Adverse Drug Event Trigger Tool

Adverse Drug Event (ADE)	**Risk Factors** - These increase the potential for ADEs. Multiple factors increase risk.	**Triggers: Signs and Symptoms (S/S)** - Any of these may indicate an ADE may have occurred.	**Triggers: Clinical Interventions** - These actions may indicate an ADE occurred.	**Surveyor Probes** - These questions are designed to assist in the investigation. A negative answer does not necessarily indicate noncompliance.
	order or protocol in place • Maximum daily dose of acetaminophen routinely nears or exceeds 4 gm • Uncontrolled pain • Residents with liver damage • Residents that consume three or more alcoholic drinks per day	• Confusion • Edema/ascites		• Is there evidence of a system to ensure changes in condition are identified, assessed, including an assessment of medications, and communicated to the physician promptly? • Is there evidence that the facility implements non-pharmacological pain management approaches? • Is there evidence of a system for ensuring that residents are routinely assessed for pain, including monitoring for effectiveness of pain relief and side effects of medication? • Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)?
Drug toxicity related to digoxin	• Advanced age • Hypokalemia • Hypomagnesaemia • Hypothyroidism • Decreased renal function • Drugs that impair renal function • Drugs that cause hypokalemia	• Elevated digoxin level • Abnormal electrolytes • Lethargy, drowsiness, fatigue • Neuralgia • Headache • Dizziness • Confusion • Hallucinations • Seizures • Visual disturbances (e.g., yellow-green distortion, snowy vision, photophobia) • Anorexia, weight loss • Nausea/vomiting • Abdominal pain • Diarrhea	• New order for and administration of IV fluids • Transfer to hospital • New order for and administration of activated charcoal • New order for and administration of digoxin-specific antibody (e.g., Digibind) • Abrupt stop order for medication	• Does the care plan reflect interdisciplinary monitoring for signs/symptoms of digoxin toxicity? • Is apical pulse prior to administration of digoxin with the drug held when pulse rate <60 bpm (unless other parameters are set by the physician)? • Is there evidence of a system to ensure changes in condition are identified and assessed promptly, including an assessment of medications? • Is there evidence of a system for routine monitoring of renal function and serum medication concentration level? • Is there a system to ensure lab results are appropriately communicated to the physician including when panic values are obtained?

Disclaimer: This tool is a draft and subject to revision. It is not mandated by the Centers for Medicare & Medicaid Services (CMS) for regulatory compliance nor does its use ensure regulatory compliance.

Adverse Drug Event Trigger Tool

Adverse Drug Event (ADE)	**Risk Factors** - These increase the potential for ADEs. Multiple factors increase risk.	**Triggers: Signs and Symptoms (S/S)** - Any of these may indicate an ADE may have occurred.	**Triggers: Clinical Interventions** - These actions may indicate an ADE occurred.	**Surveyor Probes** - These questions are designed to assist in the investigation. A negative answer does not necessarily indicate noncompliance.

Electrolyte imbalance (including dehydration and acute kidney injury) related to diuretic use	• Use of diuretics
	• Advanced age
	• Dependence in ADLs – especially eating
	• Diagnosis of dementia
	• Fluid restrictions
	• Recent diarrhea or vomiting
	• Hot weather or other trigger for increased fluid needs
	• Use of medical devices that increase fluid needs (e.g., air-fluidized mattresses)
		• Abnormal electrolytes
		• Dry skin and mucous membranes including cracked lips
		• Poor skin turgor
		• Thirst
		• Confusion
		• Concentrated urine and/or decreased output
		• Lethargy
		• Elevated temperature
		• Low BP with increase in pulse
		• Weight loss
			• Abrupt stop order for diuretic medication
			• New order for labs
			• New order for and administration of IV fluids
			• Transfer to hospital
				• For residents with risk factors for dehydration, does the care plan reflect interdisciplinary approaches for prevention including:
				  ◦ Monitoring for signs and symptoms of dehydration, and
				  ◦ Observation/documentation of consumption of liquids?
				• Is there evidence of a system for timely identification of residents with risk factors for dehydration?
				• Does the facility have protocols for:
				  ◦ Hydration?
				  ◦ Monitoring intake and output?
				  ◦ Dehydration risk assessment?
				  ◦ Fluid intake assessment?
				• Does every resident have access to fluids?
				• Are protocols in place to ensure hydration during extreme heat?
				• Are care plan approaches to ensure adequate hydration resident-specific and known to staff caring for the resident?
				• Are residents provided with the assistance they need to drink, including between meals?

Drug toxicity related to acetaminophen	• Concurrent routine and PRN orders for acetaminophen and medications containing acetaminophen • Failure to have a maximum daily dose of acetaminophen	• Elevated liver function tests • Fatigue or weakness • Abdominal pain • Loss of appetite • Jaundice, including yellowing of sclera • Itching • Bruising	• Abrupt stop of all acetaminophen products • Transfer to hospital • New order for liver function tests • New order for N-acetylcysteine	• Is there evidence of a system for ensuring residents with orders for routine or PRN acetaminophen do not receive more than 4 grams in a 24 hour period? • Is there evidence of a system to ensure that medications that contain acetaminophen are flagged to alert medication nurses that the resident has more than one medication containing acetaminophen ordered?

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DATE:______________

CENTRAL LINE REPORT

Facility______________________________

Name	Type of Central Line (CVC)	Date of Insertion	Length of external cathether	Projected Discontinue	Reason for CVC	Date of Weekly Dressing Change	Date Discontinued
Name	Type of Central Line (CVC)	Date of Insertion	Length of external cathether	Projected Discontinue	Reason for CVC	Date of Weekly Dressing Change	Date Discontinued
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Name	Type of Central Line (CVC)	Date of Insertion	Length of external cathether	Projected Discontinue	Reason for CVC	Date of Weekly Dressing Change	Date Discontinued
Name	Type of Central Line (CVC)	Date of Insertion	Length of external cathether	Projected Discontinue	Reason for CVC	Date of Weekly Dressing Change	Date Discontinued

SNACKS

Revised: August 2015

Policy To provide additional nourishment between meals. Snacks are available to residents according to the menu or resident food preferences.

Policy Specifications:

1. Dietary will send snacks to the nursing station at the appropriate times.
2. The Dietary Department will maintain a list of residents receiving special snacks. Specific snacks will be labelled
3. Bedtime snacks will be sent to the nurse's station (s) in bulk. The bulk snacks for residents will not be labelled. Bedtime snacks must be offered to each resident.
4. Daily census will be sent with the bulk snacks. Census (Sourcetech) will include name of resident, room # and diet order.
5. Nursing will be responsible for noting if resident takes or refuses snacks.
6. When a resident requests a snacks and if not contraindicated by the diet, an individualized snack will be prepared, labelled and delivered.

REFERRAL BONUS PROGRAM

Purpose

In order to recruit and retain R.N.s, L.P.N.s and C.N.A.s, we have instituted a Referral Bonus Program. This program will compensate current employees for referring full-time and part-time R.N.s and L.P.N.s, as well as full-time C.N.A.s.

Who is Eligible to Receive the Bonus?

All active employees at the facility level are eligible to receive the referral bonus, with the exception of the following positions: Administrator, Asst. Administrator, Director of Nursing, Asst. Director of Nursing and Human Resources. In addition, all non-management ECC Consultants are eligible to receive the referral bonus. *This bonus does not apply to transfers from one ECC consulted facility to another OR rehires that have been gone less than one year from any ECC consulted facility*.

What does the Referring Employee Receive?

- Referral bonuses for R.N.s and L.P.N.s will be paid out on a quarterly basis in four quarters. After the new employee completes 90 days, the referring employee will receive the first installment. After the new employee completes 180 days, the referring employee will receive the second installment. This process continues at day 270 and day 360 for the new employee.

  - *Full-time RN = $3000.00 ($750 per quarter)*
  - *Part-time RN = $1500.00 ($375 per quarter)*
  - *Full-time LPN = $2000.00 ($500 per quarter)*
  - *Part-time LPN = $1000.00 ($250 per quarter)*

- Referral bonuses for C.N.A.s will be paid out in two quarters (six months). After the new employee completes 90 days, the referring employee will receive the first installment. After the new employee completes 180 days, the referring employee will receive the final installment.

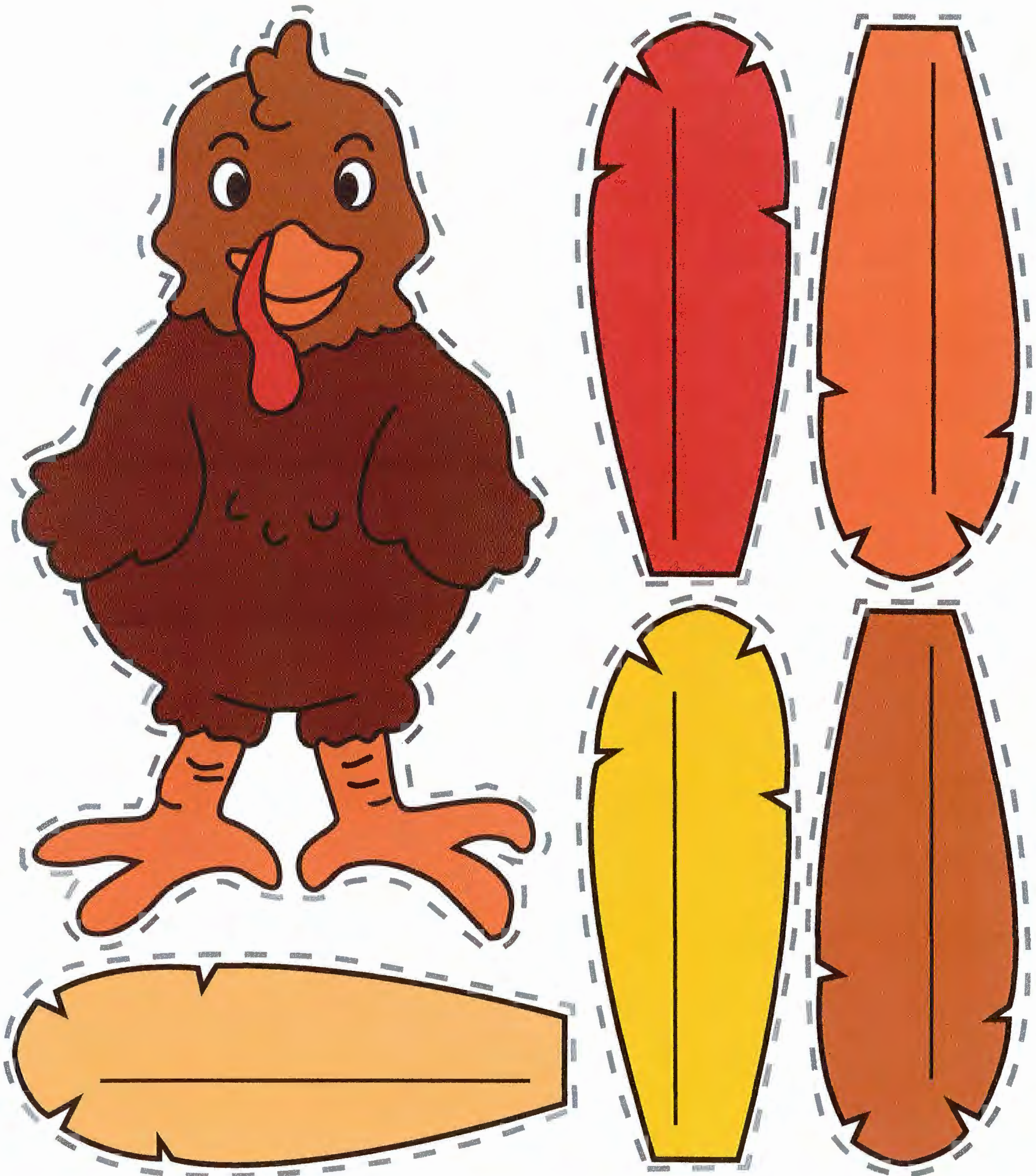
  - Full-time C.N.A. = $500.00 ($250 per quarter)

Procedures to follow for the Referral Bonus Program

- The applicant must indicate on the application and/or during the interview the name of the referring employee(s). If there is more than one referring employee, the referral bonus will be shared equally.
- Once the new employee has gone through general orientation, the HR Director at the facility level will complete the Bonus Acknowledgement Form with the referring employee(s). This signed form should go in the employee file.
- When the bonus is ready to be paid, the HR Director should put the employee name, file number, bonus description and dollar amount on the payroll bonus sheet.
- The HR Director should keep a spreadsheet of all bonuses to be paid out with the corresponding pay periods.
- The referring employee only receives the bonus if the person they referred is actively employed.
- If someone refers a new employee to a facility different than the one they work at, please contact the HR Director for payment instructions.

The Thankful Turkey

Write things you are thankful for on each feather.
Carefully cut out the turkey and feathers on the dotted lines.
Glue or tape the feathers to the turkey.



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