patterns and trends. Trends revealed that poor lighting, no or poor footwear and nonuse of assist device for ambulation contributed to most falls in the Gretna PACE population. A 27% increase in falls was noted between quarter (Q)1 and Q2. Get a Grip on Falls- with LSD campaign was initiated July 2021. Flyers were created and posted in the center and homes (nursing home) of the participants. Team continued post fall huddles and added weekly Friday Fall huddles for multi-discipline input regarding fall prevention. Fall prevention week was conducted in September 2021. In October 2021 quality meeting, it was agreed to add Hy for hydration, to remind staff to encourage participants to drink more water

Results: Fall rate declined by 19% in Q3 over Q2, 2021. There was one fall with laceration. Program does not use restraints.

Conclusions: Identifying and addressing factors that increase the risk of falls in older adults are crucial to the development and implementation of fall reduction programs. Successful fall reduction programs require multiple intervention and an IDT approach. Encouraging older adults to ambulate in adequate light, to wear appropriate shoes (footwear), use their assistive device and stay hydrated can prevent falls with fractures.

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Implementation of Interprofessional, Multimodal Non-pharmacological Pain Management at the Community Living Center

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Background: Based on the CDC's 2019 National Health Interview Survey, veterans are more likely to experience chronic pain than the general population (31.5% compared to 20.1%). Chronic pain negatively affects residents' balance, mobility, sleep, mood, social functions, and health-related quality of life. Evidence supports a multidisciplinary approach including restorative therapies, interventional procedures, behavioral health approaches, and complementary and integrative health approaches to managing chronic pain and recommends non-opioid therapy as first-line treatment for chronic pain in most situations. However, there is substantial use of opioids for chronic pain in our Community Living Center (CLC), a post-acute and long-term care facility for veterans. For example, in February 2021, the CLC administered 506 doses of "as-needed" opioids to 21 veterans with chronic pain.

Objective/Aim: This quality improvement project aimed to create an interprofessional pain team to implement a non-pharmacological pain management program for veterans in the CLC. The project will identify facilitators and barriers to implementing this pain management intervention.

Quality Improvement Methods: The project follows the "Plan Do Study Act" framework. The project lead established an interprofessional team to meet weekly and develop the pain management program. We created a learning needs survey, a menu of non-pharmacological approaches (TENS application, mindfulness, Tai Chi, acupuncture, music therapy, aromatherapy, and heat/cold application), patient education materials, facility practice guidelines, and medical record documentation templates. Project champions were trained and credentialed to administer the non-pharmacological modalities. Based on learning needs, the team organized an interactive educational fair to address gaps in knowledge and attitudes related to chronic pain. A post-education focus group provided feedback on the program. A re-assessment of staff's knowledge and attitudes will occur at the end of the intervention.

Results: The interprofessional team consisted of current staff, including provider, pharmacy, nursing, physical therapy, restorative therapy, and recreation therapy disciplines. The learning needs assessment (n=52) revealed several areas for improvement. For example, 30% of respondents reported no recent pain management education, and half do not offer non-pharmacological interventions. Promisingly, 86% desire to learn about non-pharmacological interventions. 50 staff members attended the education fair.

Conclusions: The response rate for the learning needs assessment was 47%, yet staff optimism and engagement at the education fair is promising. Early findings support the feasibility of an interprofessional pain management team in the CLC and staff's willingness to incorporate non-pharmacological interventions for chronic pain. Successful implementation of this project required no redistribution or hiring of additional staff, demonstrating the feasibility of uptake in similar settings.

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Improving Osteoporosis Screening and Treatment in the Nursing Home

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Background: In the United States 4% of men and 19% of older women have sustained a hip fracture: the clinical manifestation of osteoporosis. The rate of hip fractures among nursing home residents is 2 times higher than community-dwelling older adults. Fewer than half are treated with fracture prevention medications. The cost of treatment for hip fractures is 665 million dollars per year, from nursing home residents alone. Hip fractures are a large financial burden on the healthcare system and have a substantially increased risk of major morbidity and mortality in adults, especially in nursing home residents who may already have multi-morbidity. Approximately 50% of patients are unable to regain their prior level of function after a hip fracture and there is a 1-year mortality of 24%. Appropriate treatment for osteoporosis can decrease the risk of hip fracture. Short treatment durations are beneficial; 3 years of appropriate pharmacologic therapy has been demonstrated to reduce risk of fracture by 50%, with benefits seen as early as 1 year after initiation of treatment. Unfortunately, this is often not done in nursing homes despite being a vulnerable population.

Objective/Aim: By June 30 2022, we will increase osteoporosis treatment rates for older adults residing at our community Nursing Home.

Quality Improvement Methods: A report of nursing home residents at a community nursing facility was generated manually using the facility EMR. An initial review was conducted to capture demographics, weight, height, creatinine, history of osteoporosis, fragility fracture, osteopenia, rheumatoid arthritis, and current long-term steroid use. A standardized flowsheet was used to make treatment recommendations, which were given to the patient's physician to use at their own discretion. Diagnosis and treatment rates prior to and after the intervention were compared.

Results: Of the 27 patients reviewed, 40% met criteria for osteoporosis treatment. Only 8% of these eligible patients were on pharmacotherapy. 58% of untreated patients qualify for bisphosphonate therapy, while 33% would require denosumab due to contraindications to first line therapy. 86% of patients without a diagnosis of osteoporosis were found to have an elevated fracture risk and screening with DEXA was recommended to their primary provider.

Conclusions: We anticipate this intervention will increase screening and detection of osteoporosis as well as treatment rates in this vulnerable population. Many patients will not be initiated on therapy due to a variety of reasons including life expectancy, level of function, and contraindications to therapy including difficulty initiating pharmacotherapy due to insurance coverage and cost. We hope this will increase screening and treatment rates, subsequently decreasing osteoporotic fractures.

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Monitoring Laboratory Parameters for Drug Toxicity in Assisted Living Facilities

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Background: Evidence supports periodic labs for patients on certain medications. Nonadherence to these rules may have health consequences that could harm patients, especially frail older adults that reside in an Assisted Living Facility (ALF). Most residents at ALFs see doctors in the communities and use different pharmacies which makes it very difficult to universally track their medical records. This was especially difficult in the time of the COVID-19 pandemic restrictions at the facilities with an inability to organize safe and on time blood draws, on site or in the community. This resulted in many gaps of care for the health of frail older adults.
Objective/Aim: All patients in an ALF who are receiving certain medications should have recommended labs monitored as per FDA medication labeling. This is done to detect and react to drug toxicity to avoid any unwanted medication side effects that may have life threatening outcomes if left unaddressed.
Quality Improvement Methods: Medication lists and laboratory results were reviewed from patients' medical records and administrative data at a 58-bed assisted living facility. For each patient receiving ACEI/ARBs, diuretics, SSRIs, warfarin therapy, digoxin therapy or thyroid supplementation labs were reviewed to see if drug monitoring recommendations were satisfied. If lacking, effort was done to check if patient's physician visit or labs were planned or upcoming for that patient. To all recognized providers, a general letter containing the recommendations for Labs Monitoring for Common Medications (Pharmacist's Letter, Document 260704) was sent. A plan to send more concrete pharmacy recommendations to delinquent providers was in place as an additional step.
Results: Initially, before implementing this Quality Improvement Project, almost 60% of reviewed records had gaps in monitoring of recommended labs for unwanted side effects of different medication's classes. This period did overlap the time of restrictions with the COVID-19 pandemic. Since starting this ongoing QIP and start of close collaboration of all providers, almost 90% of the residents had physician's office or on-site visits and blood work orders to satisfy these recommendations. On initial review, labs were lacking in 26% of charts receiving ACE/ARBs medications and SSRIs. TSH results were lacking in 15% of patients on thyroid supplementation, to reach 100% after intervention. PT/INR were always done with full compliance (100%) and monitored through the analyzed period.
Conclusions: To provide on time, quality care for older adults at the ALF, there is a clear need for all involved health care providers to collaborate closely despite the divergence and non-universal teams involving parties from many different systems (different physician providers, pharmacies and laboratories). Individual education on all levels of professional care including but is not limited to RNs, MDs, PharmDs, facilitated by the Administrators and Medical Directors is mandatory for success.
Disclosures: All authors have stated there are no financial disclosures to be made that are pertinent to this abstract.

Nursing Administrative Support Role Proves Reduction in Nursing Overtime and Staff Turnover

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Background: In the wake of the COVID-19 pandemic skilled nursing facilities (SNFs) and long-term care (LTC) facilities have been faced with a critical shortage of nursing staff while caring for an increasingly complex patient population. Due to these shortages the demand on staff has soared causing increased overtime and turnover. For years literature has cited the need for higher staffing ratios within the SNF and LTC setting. There is less literature, however, on how to best utilize our nursing staff to work at their highest level of training, while avoiding the stressors of overtime hours and potential burnout.
Objective/Aim: The aim was to assist registered nurses (RN) in utilizing their licensure to its highest capacity by providing staffing support through the implementation of unit clerks. The goal was to reduce nursing overtime per shift and cost within the first quarter of implementation.
Quality Improvement Methods: Columbine West Health and Rehab Facility is a for profit, 100-bed nursing home (NH) affiliated with Columbine Health Systems. Member NH teams receive training through Telligen, the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) delegated per CMS for the state of Colorado. Root cause analysis was utilized to evaluate overtime in the nursing department, revealing that administrative burden for facility admissions was playing a key role. Baseline data included staffing hours, admissions volume, acuity, arrival times, and nursing responsibilities within an admission. Staffing reports from Quarter 2, 2021 revealed an average of 8.3 hours of nursing overtime per day. The financial cost of these hours is estimated around $39,000 per quarter. In July 2021, unit clerks were implemented, and the impact was monitored by tracking staffing reports, overtime hours, and admission data.
Results: Average overtime hours in Quarter 2, 2021 (April, May, June) was 8.3 hours per day compared to 5.6 hours in Quarter 3, 2021 (July, August, and September). The average cost of nursing overtime wages prior to the implementation of unit clerks averaged $39,217.00 versus an average of $29,106 in Quarter 3. The average wage for unit clerks is $17.00/hour versus $38.50 for a registered nurse. Additional benefits showed nursing turnover rate reduction from 29.9 persons Quarter 1, to 17.2 in Quarter 2.
Conclusions: The COVID-19 pandemic has accelerated the nursing shortages in the post-acute and long-term care setting. Our findings suggest providing administrative support on the floor to nursing staff resulted in a reduction of nursing overtime hours and costs, with reduced turnover.
Disclosures: All authors have stated there are no financial disclosures to be made that are pertinent to this abstract.

Red Napkin Program (RNP) : A Nutrition Intervention for High-Risk Residents in Skilled Nursing Facility

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Background: Unintentional weight loss, which can lead to increased morbidity and mortality, is a prevalent problem among residents of long-term care facilities. Since the start of the COVID-19 pandemic, unintentional weight loss has been a persistent problem in long term care increasing up to 10% statewide in Georgia.
Objective/Aim: The aim of the study is to reduce unintended weight loss among residents by utilizing red napkins to identify residents with significant ongoing weight loss and offering those residents with assistance in feeding and supplements.
Quality Improvement Methods: In a single 150 bed skilled nursing facility, the facility dietician identified residents with weight loss over a 30-day period and the multidisciplinary team including medical director, director of nursing, dietician, MDS coordinators and speech therapists conducted weekly meetings to discuss weight loss prevention management. In this cross-sectional study, subjects' weight was recorded for 6-month periods each for preintervention by following the usual standard of care and post intervention with RNP program. Weight was monitored for minimum of 30 days during the intervention period. In order to implement the RNP, dietitians identified the subjects in the study and these residents were identified with red napkins on their meal trays. The staff was instructed to offer more robust assistance with feeding and or offer nutritional supplements to these identified subjects. To examine whether RNP was a significant predictor for weight change or weight change percent, a multivariate linear regression model was used to model weight change and weight change percent with RNP while controlling for other covariates, respectively.
Results: The study cohort included 40 subjects in pre and 37 subjects in post intervention group. Mean age was 85.8. More than 70% of the subjects were diagnosed with moderate to severe dementia. There were 10.8% individuals on appetite stimulants in RNP as compared to 17.5% in pre-intervention group. Fatality rate in RNP was 13.5% as compared to 20% in pre-intervention group. There is a significant decrease in weight loss with the RNP intervention with p-value of 0.003 with 95% CI (1.77, 8.44).
Conclusions: The outcome of the study demonstrated that the RNP was effective in reducing weight loss among the residents. An interdisciplinary approach including physicians, dietitian, director of nursing and therapists