

***The Food and Dining Side of the Culture Change Movement:
Identifying Barriers and Potential Solutions to furthering
Innovation in Nursing Homes***

Pre-symposium Paper: to the February 11, 2010 Symposium

***Creating Home in the Nursing Home II: A National Symposium on Culture
Change and the Food and Dining Requirements***

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This pre-symposium paper is intended to provide a context and a detailed background for the presentations and discussions at the February 11, 2010 symposium.

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Introduction

Robinson and Gallagher have stated that the future long term care “...customer, savvy and well educated, will re-formulate long term care by demanding fine dining, and concierge services, and healthy fast foods from a food court with ‘brand’ named franchises open 24 hours per day” (Robinson and Gallagher, 2008).

So let’s imagine the New Nursing Home. No one wakes you up. You sleep until you naturally rouse. You decide if you want a cup of coffee, tea or your drink of choice now or later. Maybe you have a coffee pot in your room. If you live in a neighborhood or household, coffee is brewing in the kitchenette or kitchen. You drink out of your own ceramic coffee cup. There is a coffee cart available, or better yet a coffee bar that is open early and open late. When you’re ready, someone asks you what you’re hungry for. Whether you eat breakfast early, late or not at all, but are hungry for lunch a little earlier than most, open dining times make it possible to eat when you are ready. You can order room service if you don’t feel like getting up or wander down to the continental breakfast to see what’s available today. Not only are you asked what you want every meal, you are also involved in deciding the menus, even making up the grocery list. You are welcome to cook what you’re famous for. Or you contribute by setting the table and washing dishes, no one’s offer is turned away. Some of the food comes from the garden in the backyard, presenting the opportunity to eat fresh healthy foods you yourself may have tended to and harvested.

In the New Nursing Home, there are home-living environments called Households with a full kitchen, living room, dining room, and, usually, all private rooms led by self-directed work teams and a Town Center where residents gather for large events, often a coffee shop and sometimes a general store. Nurses and other clinicians circulate among several co-located houses to provide needed care, where residents enjoy private rooms, a large dining room table where they can dine together and a hearth, often with a cozy fireplace.

Many homes focused on providing individualized and personalized dining services are trading in the traditional tray line meal service for a variety of dining styles such as buffet, restaurant, family-style and others with increased choice and direct resident access to refrigerators and the kitchen throughout the day. These alternative dining arrangements, although common in society at large, are new to the nursing home setting and have sometimes led to difficulties with nursing home surveyor interpretation of the federal requirements as applied to these innovations.

In April of 2008, the Pioneer Network and the Centers for Medicare and Medicaid Services (CMS) co-sponsored *Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment Requirements*. Almost 700 people attended, experts gave presentations, and everyone was invited to give public comment. This was followed by an invitational workshop of culture change experts and stakeholders who were formed into workgroups to study and further develop the options discussed. All options regarding the nursing home environment were collected and many were acted upon. All speakers’

papers and presentations, the transcript from the entire symposium, and the background paper written for it are available at: www.pioneernetwork.net.

Due to the many questions arising around food and dining, the Pioneer Network and CMS decided to co-sponsor a second symposium inviting another national dialogue to discuss them. The purpose of this paper is to provide background and context for the upcoming February 11, 2010 symposium: ***Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements.***

Welcome to the table. Bon appétit.

Note to readers:

In this paper, italics are used for CMS regulations and interpretive guidance.

Lighting, use of color, contrasting plate and table color, music, and other environmental factors affect the dining environment. However, because the physical environment was the focus of the 2008 symposium, many issues of the physical setting for the dining environment came to light then and will not be revisited in this paper. Instead, the symposium planning team has set an agenda that focuses on some of the clinical and quality of life issues regarding food and dining.

It should be stressed that, when referring to nursing home residents, we mean all residents including those with dementia. The content of this paper is applicable to all residents, and in particular each person's right to make their own choices and to receive superb individualized care. Persons with dementia "tell" us everyday their preferences, sometimes with words, sometimes not. We must only observe and, as Naomi Feil, the founder of Validation Therapy, says "exquisitely listen" (2003).

Chapter One

The Importance of Food and the Dining Experience in Creating Home

Food and the experience of dining happen every day, and are so important and unique to each of us. In fact, very often food and dining are spoken of, not separately, but together:

“We should look for someone to eat and drink with before looking for something to eat and drink...” Epicurus

“Good food ends with good talk.” Geoffrey Neighor

“One cannot think well, love well, sleep well, if one has not dined well.”
Virginia Woolf

“Food is the most primitive form of comfort.” Sheila Graham

“When I walk into my kitchen today; I am not alone. Whether we know it or not, none of us is. We bring fathers and mothers and kitchen tables, and every meal we have ever eaten. Food is never just food. It’s also a way of getting at something else; who we are, who we have been, and who we want to be.”
Molly Wizenburg, from *A Home Made Life*

“Food is the heart of the home and most often one of our life’s daily pleasures.”
LaVrene Norton, from *Nourish the Body and Soul*

Food. Dining. Eating. “What’s for dinner?” “Let’s eat.” “Let’s go out for dinner.” Favorite foods. Comfort foods. Potlucks. Cookie exchange. Out for coffee. Over for tea. “Come on over for a beer.” Grilled. Sauted. Steamed. Carmelized. Cookies baking. Soup simmering. Tea steeping. Coffee brewing. Bread baking. Dishes clinking. Setting the table. Washing the dishes. Fresh fruit. Just picked veggies. Shucking corn. Snapping peas. Appetizers. Soup and salad. Chips and dip. Bread sticks and dipping oils. The main entree. Dessert. “I’m full.” “That was sooo good.”

So what should food and dining look like, even in a nursing home?

“Like Mom’s chicken noodle soup, the focus on food seems to hold an answer for just about every ailment of institutionalized living.” Keith Schaeffer, from *Nourish the Body and Soul*

“Comfort foods – those familiar foods that evoke a caring, pleasant feeling even before (emphasis added) they are tasted.” Frampton, Gilpin and Charmel, from *Putting Patients First*

“Providing nourishment is more than just providing the right number of calories; it is taking care that the appearance, presentation, aromas, flavors, delivery and setting are optimal as well.” Ibid

“We know that uneaten food provides no nourishment.” *Ibid*

“The feeding of persons in health is of great importance, but when (one) succumbs to disease, then feeding becomes a question of extreme moment.” Fannie Farmer, from *Food and Cookery for the Sick and Convalescent*.

“Food for the sick should be carefully prepared and attractively served at regular intervals. The person who is ill is frequently more difficult to please than when he is well. Individual tastes of the patient must be considered, as well as the suitability of foods to be served.” Gorrell, McKay and Zuill, from *Food and Family Living*

“Let food be your medicine.” Hippocrates

There may be four different causes, any one of which will produce the same result, viz., the patient slowly starving to death, from want of nutrition:

1. Defect in cooking;
2. Defect in choice of diet;
3. Defect in choice of hours for taking diet;
4. Defect of appetite in patient.

“Yet all these are generally comprehended in the one sweeping assertion that the patient has 'no appetite.'” Florence Nightingale

“Our goals are always two: increase our residents’ intake and increase quality of life through celebrations around food.” Linda Bump, from *Nourish the Body and Soul*

Food is the Heart of Home

Linda Bump, a leader in the culture change movement, dietitian, and licensed nursing home administrator has written one of the only books on changing the culture of dining. It is called *Life Happens in the Kitchen...How to make the kitchen the heart of your home*. She says:

Food is the heart of our home...and most often one of our life’s daily pleasures. When we enhance the dining experience of our elders, we nourish their souls, as well as their bodies. As caregivers committed to maximizing the quality of life and quality of care for the elders residing in our long term care facilities, we are called to best serve our elders’ nutritional needs while best serving their psychological and psychosocial needs. When we honor our elders’ preferences in dining, we honor their past and best serve their future (Bump, 2004-2005).

Bump says so much here - home and daily pleasure, nutritional and psychological and psychosocial needs, quality of life and quality of care. All of that is precisely our focus for this paper, as well as *Creating Home II*. Moving away from institution and toward home. Using food to nourish both body and soul. Using food to honor past and serve future. Food is one of the main mediums to reflect and build upon our past, and as psychologist Dr.

Judah Ronch teaches: when our choices and preferences are not honored we have no “future self” (2009). Nothing to look forward to, nothing to decide, nothing to affect in our lives. And lastly the time has come to stop viewing quality of life and quality of care as separate.

The Institute of Medicine study and precursor to OBRA '87 said the same thing in different words in 1986:

For the very sick and disabled, the quality of the care and the way it is provided are probably the most significant contributors to well-being.....Many aspects of nursing home life that affect a resident's perceptions of quality of life – and therefore, sense of well-being – are intimately intertwined with quality of care (Improving the Quality of Care in Nursing Homes, 1986).

Pioneer and culture change leader Linda Bump encourages “**excellence in individualization**” and says in order to do that we must provide:

Choice – the choice of what to eat, when to eat, where to eat, who to eat with, and how leisurely to eat. True choice, not token choice. Choice of beverages, breads, desserts. Choice of service style, whether waited, self-selected, buffet or family style.

Accessibility – foods of choice available when hungry, or when just longing for a specific food. Food available 24 hours a day/7 days a week, and someone available 24/7 to help prepare it. Refrigerator rights, perhaps even a refrigerator in their own room, and perhaps a microwave too!

Individualization – the elder's favorite foods, comfort foods, ethnic foods, foods prepared from their own favorite recipes, foods they choose to eat in their own home, foods that make them look forward to the day, foods that warm their heart and soul, as well as nourish their bodies.

Liberalized diets – The elder's right to choice in following a restrictive diet.

Food First – An expectation of OBRA since 1987, choosing food before supplements, and food before medication is a natural decision in culture change. With choice, accessibility and individualization, our residents eat foods of choice throughout the day, and even during the night if need be, eliminating the need for costly, and often refused, commercial supplements. Similarly, the need for laxatives is reduced and often eliminated with increased fluid intake and increased opportunities for fiber-rich, bowel-stimulating foods of choice. Even the need for medication for behavioral management can be reduced when foods of choice are available at times of choice and places of choice.

Quality Service - Relationships are the key to quality care giving, and relationships are the key to quality service in dining. Knowing the elder, their choices, their preferences, and their daily pleasures in dining, results in service that encourages optimal intake. Relationship-based service is caregiving from the heart. Knowing what an elder ate, knowing what they need to eat, knowing what to tempt them with, all can make the difference between joy in dining and failure to thrive.

Responsiveness - Relationship-based service, refrigerator rights, 24/7 accessibility...the common theme is responsiveness, and just the right amount of attention – not hovering, just quiet attention to every need (2004-2005).

Quiet attention. Responsiveness. Quality of care and quality of life together. Individualized care. “Excellence in individualization.” Good food. A warm and inviting dining experience. All contribute to a person’s well-being.

Progression of the Food and Dining Side of the Culture Change Movement

Moving from Traditional to Transformational

Transformation begins when there is an awareness of the need for change and resident-centered care, consistent staff, engaging direct care givers and residents in decisions and increasing choices at meal times. In the *Nourish the Body and Soul* DVD, Linda Bump advises us to “Think about the opportunities to have the coffee pot on all day, smell fresh cookies baking and enjoy a warm treat in the evenings. Even if we can’t cook the hot food there, we can start simple hosting, offering choice of beverage, choice of white or wheat bread, a simple salad bar cart with just a few choices or a dessert cart” (2008). It can all start with toast:

Transformational design can be as simple as - we brought our toasters to the table. We actually physically set the toasters in the middle of the dining room. When the core team met, they said, “We always cook it in the kitchen, stack it up, bring it out and by the time it gets to the dining room its cold and hard. And that’s just the way we’ve always done it. Now a resident asks for a piece of toast, we put the bread in, butter it and we give it to them right there. Now, it was just an experiment and the whole building was talking about it for days afterwards, over toast. It was probably the very best thing we did, to start with that because everybody got excited about all the other things we could do.” (*Nourish the Body and Soul* DVD, 2008)

Thus, it is within the transformational model where steam tables, open dining times, buffet style, waited table service and family style start to become possible.

Early Pioneers do Dining Differently

Sister Pauline Brecanier is considered a pioneer in the culture change movement, leading transformation at Teresian House in Albany, New York as administrator since 1970. Sister Pauline’s pioneering spirit began before then however. She tells of when she was at St. Joseph’s nursing home in Connecticut in the 1960’s and sent two men to Culinary Arts school - two brothers, who came back to serve residents as chefs. She explains that in order to provide good cooked food for the residents, Mother Bernadette, Teresian’s administrator from 1964 to 1970, always had a chef and “never apologized for the cost of food as food was the most important part of a resident’s day.” She advises you’re “going to pay a little bit more [for a chef] but you’re going to get better quality. Pre-prepared foods, anyone can put those together.” In her matter of fact way, she says, “we’ve always had a chef” (2009). At Teresian House there is a cocktail lounge that serves drinks and food with hours of operation and a menu. What is most striking about it, as Sister Pauline explained, is it gives residents the opportunity to “treat their guests,” something most nursing home residents no longer have.

Planetree is a patient-centered model of care begun in hospitals by Angelica Thieriot. Planetree affiliates focus on providing comfort foods, creating kitchens in patient care areas for families to prepare their relative's favorite foods, and never turning down a request for food any time day or night (Frampton et al, 2003). The first nursing home to adopt the Planetree model was Wesley Village in Shelton, Connecticut under the leadership of Heidi Gil. One of the Planetree Continuing Care Components is *Recognizing the Nutritional and Nurturing Aspects of Food* (Frampton and Charmel, 2009).

Restaurant Style Dining

As reported in the book *Person Centered Care: A Model for Nursing Homes*, Eric Haider, as administrator of a nursing home in Kansas in 1989, implemented a restaurant style dining service with waiters taking orders from a menu and longer/open dining times. He realized, looking at a restaurant one day, that a nursing home has everything a restaurant has – food, a kitchen and a dining room. In 1992 at Crestview nursing home in Missouri he added buffet style dining, and by 1995 food was available upon request 24 hours a day (2003).

Although nursing homes have food, kitchens, and dining rooms just like a restaurant, restaurants are able to offer a large menu, instead of only one or two choices typical of traditional nursing homes. Restaurants are able to serve each customer what that person wants from their menu, at the time the customer arrives. This has functioned “backwards” in the nursing home where traditionally the “customers” are made to be ready when the food is ready.

Buffet Style Dining

Although it began as a research study by Robin Remsburg and others, due to its success buffet-style meal service was adopted by Johns Hopkins Geriatric Center in Baltimore for all meals (2001). Dr. Remsburg reports that buffet style dining advantages include the opportunity to bring tantalizing smells into the dining room to increase resident's appetites, and staff doesn't get “overtaxed” when there are typically just two main items and several side dishes (Roloff, 2006). And who doesn't like getting to pick exactly what they want?

Neighborhood Dining

From the Norton/Grant Stage Model, Stage III is the Neighborhood. Here is where self-led interdepartmental teams start to make greater changes to dining practices. Dining becomes decentralized, residents eat in smaller dining rooms on their neighborhoods, are supported to sleep until they wake and eat when they want. Med pass, housekeeping and activity schedules all must change, therefore it must be done as Bump says, “in team.” The need for kitchenettes and even full kitchens with shared decentralized production kitchens placed between two neighborhoods begins to be realized (Bump, 2008).

In 1991 Teresian House remodeled into smaller neighborhoods of 40 residents from 60 (Ronch and Weiner, 2003). Each neighborhood has its own country kitchen and pantry.

Meals are made in the main kitchen and brought to the steam tables in the neighborhood, bringing the point of service closer to the residents. A new staff position of neighborhood coordinator was developed to administer these small settings within the larger nursing home. Neighborhood coordinators were chosen for their leadership skills, and applicants were not restricted to nurses.

Interestingly enough, Providence Mount St. Vincent also began its journey of neighborhoods with food served from steam tables in each neighborhood's kitchen in 1991, after hiring Charlene Boyd as administrator in 1990. Charlene brought experience from the Mary Conrad Center in Anchorage, Alaska where she had been administrator from 1986- 1990. At Mary Conrad Center, the "neighborhood concept" gave residents access to a kitchen and snacks at all times (Ronch and Weiner, 2003).

Family Style Dining

Another familiar dining style being implemented is family style, which affords one the opportunity to serve themselves what they want and as much as they want just like at the table at home. "From bowls and baskets on their table, residents are able to serve themselves as much as they want of the foods they enjoy and none of the foods they dislike" (Roloff, 2006). Apple Health Care, a small for-profit nursing home chain, implemented family style dining in 1997 beginning at Watrous Nursing Center in Madison, Connecticut under the leadership of dietitian Karen Morton. Sue Misiorski, former Apple nurse consultant shares that "family style dining was very successful. Food temperatures were great because the food came straight from the kitchen to the table and was served immediately. Plate waste decreased dramatically because residents took what they want. They also took lots of smaller first portions and then second helpings of things they particularly liked" (Misiorski, personal communication, 2009).

Choice Menus, Full Service Restaurant and Room Service

The Providence Benedictine Nursing Center in Marion County, Oregon underwent major dining transformations in the autumn of 2009 because of low resident satisfaction scores, an overly clinical atmosphere, and an outdated dining environment. Choice Menus are offered within the long-term care units, with staff assisting residents in choosing what they want to order for the following day. Room Service with 19 meal options and 12 sides is offered on the skilled unit, where there are phones in each room. A grant and donations helped the facility to acquire the computerized menu system, which tracks preferences and allergies for each resident. Whereas most residents used to eat on their units making the main dining room underutilized, the full-service, updated restaurant is now filled to capacity, residents encourage and help each other get to the restaurant, and many are "dressing for dinner." Through all three options residents are now "self-directing their lives" (Havens, 2009).

Household Dining

From the Stage Model, Stage IV is the Household Model, and also includes the Green Houses®, small houses, and the Scandinavian Service Houses. Home has been established again, living in houses with self-contained fully functioning kitchens, cross-trained staff reporting into the house and not to departments. Elders run their lives, get up when they want, eat what and when they want, choose snacks, have friends over for dinner or coffee, and plan their lives (*Nourish the Body and Soul*, 2008). In some households there is a new staff role, homemaker, responsible for cooking meals and other homemaking duties. Many households designate a food budget for the household for true resident choice. On a weekly basis, residents make their grocery list. They decide what kind of ice cream they would like or cereal - Captain Crunch anyone?

LaVrene Norton, Executive Leader of Action Pact, often speaks of residents' "refrigerator rights." When one lives where there is a kitchen, they have the same "refrigerator rights" as any one of us has in our own home. That right to open up the fridge and ponder, "Hmm, what do I want to eat...." We might as well take it one step further and call them "kitchen rights." This is something the Household Model affords. It also affords limitless opportunities for hosting. Residents have hosted others in their homes all their lives, the household/house also makes this possible again. According to Linda Bump, "The systems that have held us back in the other stages are now transformed, and the entire household team can focus on resident preferences, their rhythm of the day and their choices" (2008).

Homes that have not progressed to the Household Model yet have, nonetheless, come up with various ways of honoring "refrigerator rights" such as pantries, snack and beverage bars, coffee bars, the "general store" where residents can choose food items without paying extra, ice cream parlors and loaded snack carts taken to resident living areas.

Eden Alternative® and Green House Project®

The Eden Alternative® was born in the mid 1990's with the idea that it is better to live in a garden than an institution. The theme of the garden describes the Eden Alternative® in many ways. Eden has helped remind us that residents should flourish and thrive in their home. In addition, staff members, or "care partners" as Eden refers to them, also deserve to grow as individuals. As Nancy Fox, first Executive Director of the Eden Alternative says, "we've been managing for the worst in people instead of for the best" (2007). Dr. Bill Thomas, founder with his wife Jude of the Eden Alternative®, was one of the first to talk about giving back to residents the opportunity to till the garden and enjoy the bounty of fresh foods from it.

After ten years of the Eden Alternative's existence, Dr. Thomas decided it was taking too long to transform nursing homes. He preaches that nursing homes shouldn't be changed, they should be abolished - calling himself a nursing home abolitionist (Baker, 2007). This led to the next level of creating home he called the Green House. Green House® communities have Culinary Arts, not dietary departments. In fact, the root word "diet" of Dietary has a negative connotation for most, and is treated by many as a four letter word.

All the more reason to move away from the medical model and offer dining and culinary services instead (McKorkell Worth, 2009). Ten to twelve elders live in a Green House® and lead their lives in a home where they can access the kitchen, dine together at the dining table, and enjoy “convivium.”

Convivium

Dr. Bill Thomas has resurrected the concept of “convivium,” an old Roman word that describes the pleasure that accompanies the sharing of good food with people we know well. Instead of fast food, instant food or, for instance, soup from large cans warmed up as in most institutional nursing homes, soup is made from scratch and cooked slowly. It simmers on the stovetop all day for all to experience, from the preparation if they so choose, to the aromas, to enjoying it for the evening meal. Dr. Thomas says this about food:

At its best food nourishes us – body and soul. A meal can embody powerful symbols of love and acceptance. The bond between comfort and food, which begins at the breast, is fortified throughout childhood and gains renewed strength in the late decades of life. Properly prepared, the meals we cook and serve to our elders should be drenched in memory, ritual and culture. ... Fresh, local ingredients prepared according to authentic regional recipes are served to people eager to share. They use smell, taste and texture as a springboard to good conversation and vital relationships (2008).

Staff Dining with Residents – Convivium and Building Relationships

Staff dining with residents is a culture change practice that has been implemented to build relationships between staff and residents. It opens up the opportunity for friendships to form and grow between those living in a nursing home and those caring for them. Of course, residents still need to receive any assistance they need, and good infection control needs to be practiced, and staff should interact with residents and not only with each other.

Dining Together Equalizes Everyone

“The extra socialization and encouragement, plus ready offers to get an alternate or to pour an extra cup of coffee makes all the difference between institutional food service and enhancing the residents dining experience” (Bump, 2004-2005). An example of “socialization in action” comes to mind. Beth Irtz, then the administrator of Clear Creek Care Center in Colorado and now Quality of Life Lead for Sava Senior Care Colorado region and President of the Colorado Culture Change Coalition, implemented a Wednesday Buffet where staff were invited to eat (free of charge) with residents. The buzz of conversation was almost deafening and thrilling to see and hear. When people dine together, they are just people, no longer separated as “residents and staff.” All people eat. Dining together serves as a well known experience that “equalizes everyone” a practice which serves to soften the “us-versus-them” atmosphere that may occur in institutional living (Krug and Bowman, 2009).

What Residents Really Hunger For

Richard Taylor, retired psychologist and outspoken person diagnosed with dementia, was interviewed as part of a “Leaders in Eldercare” series. He said these powerful words about dining based on an experience of his own in an institution:

The staff would come in, and they were cheery-deary and loveable and well-intended human beings who really loved what they did, and they’d come in and start everybody eating, and then they would leave, and everybody would just sit there silently, eating. Not saying anything, not talking to each other. Eating wasn’t an activity, it was barely an event. It was just something that they came and got me at five o’clock to do.

And so I started talking to people. Now, it took me five minutes to get about half the room talking. It’s not that I got everybody to talk or everybody wanted to talk or even could talk, but people who hadn’t talked in a long time started to talk because I took the time to sit and listen to them. And I don’t know if they were telling me the truth or not. They were telling me their version of it. And I found them to be very interesting and bright people (InsideElderCare.com, 2009).

The staff of one nursing home reported, after deciding to dine with residents, that residents didn’t eat. That sounds bad at first, but it turns out the residents just wanted to talk. Residents now “fight over” which staff members they want to eat with them. They’re showing they are hungry for companionship.

Culture change leader and administrator of Rowan Community in Denver, Colorado, Maxine Roby eats with her residents every day, moving from table to table. Maxine often jokingly says, “I know what’s going on in my building” - an added bonus perhaps.

Psychologist Dr. Susan Wehry on Part II of the CMS *From Institutionalized to Individualized Care* DVD series, relays the power of dining together in a story about a resident that staff were worried about. Staff identified signs of depression including not eating, although the resident, Helen, had always seemed to enjoy meals. Helen had Alzheimer’s disease and agnosia, meaning she didn’t know what to do with her meal. When Dr. Wehry put Helen’s fork in her hand, pointed to her potatoes and said, “This looks good- do you want to try some?” Helen would smile, nod her head yes, but take no action. “When I demonstrated what I wanted her to do, she mimed me very well. She wanted to eat. She had the physical capability to eat. My intervention was then to have lunch with her. I asked staff to bring me a tray. I would say, “That looks good,” take a bite, and she would do the same. She ate the whole meal independently by watching to see what I would do next. I suggested to the CNA that she do the same” (2007).

Probably every staff member in a nursing home has been asked by a resident somewhere along the way to “Sit and eat with me.” Yet staff members admit they have been programmed to reply with something like “Oh no, I can’t” even though they say they would love to. In a nursing home in Colorado after discussing this, the administrator said, “I’m

embarrassed to say this, but I was invited by residents to eat with them the other day, and I went and asked the dining supervisor if I could, and I still didn't eat with my residents." That is a bold and brave administrator to admit what to him was embarrassing. Culture change pioneer Eric Haider has said over the years that the culture change movement could be called the common sense movement. Dr. Thomas and his focus on convivium and experiences such as these are making the case that dining together makes good common sense.

Staff Members Get to Know Residents' Preferences

On Part II of the CMS *From Institutional to Individualized Care* series, staff from featured home Salmon Family Services of Westborough and Northbridge, Massachusetts reported that residents eat better when staff look residents in the eye to connect and get a response directly from them. "One of the big things in my opinion is the Dietary staff. The people who were always on the serving line, always making up trays, now get into the dining room and actually meet people. Some of them don't speak English very well. It's amazing that they can communicate. They figure out exactly what the residents want, and they have come to know the resident" said Mike Salmon, Food Service Director (2007).

Many homes have experimented with all sorts of ways to serve residents with great results. At Littleton Manor in Littleton, Colorado, department managers have taken turns serving residents at mealtimes since 2003. The former director of nursing always remarked that when it came time for quarterly re-assessment, she knew firsthand what each resident ate or didn't eat. Brookside Inn in Castle Rock, Colorado, had all department managers become trained dining assistants. They rotate serving as the dining room host or hostess, and are available to assist residents to eat if needed. Many homes have brought the kitchen staff out of the kitchen, with many stories of relationships forming and staff members realizing things like, "Why would we serve that to Mary? She doesn't like it; never has."

Other Welcomed Dining Practices

As part of a dignified dining experience, forward-thinking pioneers questioned, and then simply stopped using bibs, serving food on trays, and got rid of what used to be called "feeder tables" - tables designed in a horseshoe shape in order to feed four residents at a time. What is also becoming a former long term care practice is referring to those needing assistance or to be fed as "feeders." Harm was not meant by these ideas, but they have contributed to putting the task, and the goal of efficiency before the person. Many have replaced the language "feed," "fed," and "feeder" with "dining," "dine," "assist with dining," and even more personal, some encourage the normal practice of using the person's name instead of any sort of label.

Lastly, some homes have had fun shopping with residents for real glassware and real coffee cups, no longer serving coffee in plastic mugs. Plate, glass and silverware that came from places like Pier 1 Imports and other dinnerware stores fits what Rose Marie Fagan, founding executive director of the Pioneer Network, teaches wherever she goes that the goal of the culture change movement is "rampant normalcy."

Chapter Three

Food and Dining Research and Outcomes Realized by Pioneering Homes

According to a 2005 American Dietetic Association *Report of the Task Force on Aging*, as many as 65% of long term care residents experience unintended weight loss and under-nutrition, and there is concern that the incidence of malnutrition is underreported. Many causes of weight loss may be amenable to intervention. Formal research studies and anecdotal evidence coming from homes focusing on individualizing food and dining services show some promising results.

In a Scandinavian study, food was served family style, and residents helped themselves. Residents experienced a 25% increase in protein and energy intake (Elmstahl et al, 1987). In a study of thirty Veteran's Administration homes where choice was increased, dining environment improved and restricted diets liberalized, 50% of the residents gained weight (Abassi and Rudman, 1994).

One family-style dining study that also focused on staff giving encouragement and praise to persons with dementia resulted in higher participation in eating and even improvement in appropriate communication (Altus et al, 2002). A family style dining study including persons without cognitive impairment resulted in improvements in quality of life measures, fine motor functioning and body weight (Nijs et al, 2006).

A study done in Canada found that "bulk" or steam table/buffet food service and a homelike dining environment optimized energy intake in individuals at high risk for malnutrition, particularly those with low body mass index and cognitive impairment (Desai et al, 2007).

Rolling Fields of Conneautville, Pennsylvania, an Eden registered home and winner of the OPTIMA Long Term Living 2009 Award, offers 24 hour dining. Residents can choose food they want to eat around the clock. As a result, pressure ulcers have healed, many residents at risk for weight loss have gained weight, supplements have decreased and even pain and behavioral issues have improved. Staff attributes this to being able to serve actual meals [rather than minimal snacks] for those who are awake and hungry, especially at night. Additionally, resident satisfaction has improved, care plan meetings and Resident Council meetings no longer revolve around food issues but instead are filled with compliments. During the last State surveys, not only were there no resident complaints about food, there were instead "many glowing reviews about the food service not only from our Elders but also from the state surveyors, who ordered lunch each day of the survey" (Ltlmagazine.com, 2009).

After being reminded personally of the feelings that foods like soup and bread evoke for him, Franco Diamond, administrator of Idylwood Care Center in Sunnyvale, California, embarked on a journey focusing on foods and their aromas. A Soup of the Day contest led his whole community into forty-plus food activities and events. Schaeffer writes, "Anyone could participate in that experience by merely inhaling, and letting memories arise with the aroma. For people with advanced dementia, food may be the last thing they lose interest in" (2008). One resident, Mrs. C, was not "so easily enticed," still complained about the

“lousy” food, and her eating habits declined. Staff decided to use food as an ice-breaker when they discovered her love for cooking Italian food with fava beans. Caregivers planted some, but because they “didn’t know beans” about fava beans, they got her to show them how to pick, shell and cook the gourmet bean which ultimately led to Mrs. C leading a cooking class. Not only did she flourish socially, but nutritionally as well. “Mrs. C’s magical transformation confirmed for Diamond that residents would become involved if offered familiar and meaningful activities. It also fed staff’s gastronomical approach to culture change: If Mrs. C could change so dramatically, maybe they should put more stock into how meals were presented and the ingredients in them” (Schaeffer, 2009). Perhaps Ildylwood’s experience makes the case for care planning “familiar and meaningful food and aromas” for each resident.

Dietitian Sharon Leppert makes a great case for creating “a social atmosphere and culture for resident dining” that is participatory with choice and independence as well as socially rich “as a treatment modality” (2007). Although the term “treatment modality” sounds a bit medical, Leppert is onto something. She invites us to consider how the dining atmosphere contributes or takes away from an individual’s health by asking:

When residents are given the opportunity to express preferences on food selection and portion size at the time of service, are they not also provided with an opportunity to contribute to their sense of self-esteem by exercising control over their environment in a small yet positive way? Adequate energy intake to prevent weight loss is an important factor in managing the health risk in populations with advancing age, but the value of food may impact more than nutrition when mealtime contributes to social interaction, self-esteem, and enjoyment for the aging individual (2007).

After Initial Increases, Budget Neutrality and Cost Savings

Linda Bump explains that initial food costs may increase with new enhancements, but as staff learn resident preferences and plan for them, those costs “reestablish within budget” (2004-2005). Eric Haider similarly says that staff learn what residents prefer and how much of each item to prepare, minimizing waste. He attributed a savings of \$20,000 per year to this process (Rantz and Flesner, 2004). This is also the experience of the facility identified in Linda Handy’s book *Surveyor M.O. for Nutritional Care (F325)* that there are “budget increases at first until you figure out who is going where,” “less prep,” residents “usually eat what they take which means we are not feeding the garbage can as much as we used to” and budget is now “actually more efficient and more effective” (2009). Also by avoiding the pre-plating of food, unused food may be used as leftovers following guidelines at Tag 371 or even as “planned overs,” both of which reduce costs according to Linda Bump (2004-2005).

There may be initial costs for a steam table and other equipment as it is added, but there can be a coinciding decrease in main kitchen equipment replacement and repair according to Bump. She also teaches that labor costs can be held budget-neutral following the initial

confusion of transitioning to new serving styles. She encourages teams to be creative, to tap underutilized staff minutes and to “take the plunge many homes have without increasing staff” (2004-2005).

Real Food instead of Commercial Supplements

Margie Haider, director of nursing at Crestview in 2001, espoused that by giving people foods they like to eat, you can minimize the use of supplements. Margie and Eric shared that Crestview saved \$1,164.00 per month by serving real foods residents wanted to eat. In *Person Centered Care* it is recorded that supplements went from 72 in 1998 to only 14 by July 2000 (2004). Bump explains that having foods of choice available 24/7 virtually eliminates the need for supplements. She adds, “There are not many residents who will choose a canned commercial supplement over real food or personal preference.” Bump points out that snack and “hydration” carts can also be eliminated with the addition of pantries and snack bars (2004-2005). Eliminating carts is also what many homes have done to lessen the institutional feel and to create home.

In his article on malnutrition in the older individual, Webster states that “Oral supplements are also not very beneficial and often go wasted or conflict with medications” (2008). Oral liquid nutrition supplements have been shown to be only moderately successful in increasing energy intake, which has also been shown to be related to the limited time staff can devote to getting the supplements delivered and giving verbal encouragement to consume them (Schlettwein-Gsell, 1992). Webster says that, “Improving taste is one of the best and simplest ways of improving nutrition” (2008). The “elderly have the same taste preferences as they have had all of their life, and thus low sodium, low fat meals are not always as appetizing as the normal version of a food with naturally high fat and sodium content” (Calverley, 2007).

Real Foods, Less Meds and Cost Savings

When nutrients are offered in the form of yummy foods, medication usage will decline especially for laxatives, appetite stimulants and even multivitamins. Neighborhood and household kitchens virtually eliminate laxatives, using food instead to support normal bowel function (Bump, 2004-2005). Charlene Boyd of Providence Mount St. Vincent reports that “the number of special diets is reduced to a few, as homes learn it is more important for elders to eat appetizing food than to have meals medicalized into inedible ordeals,” leading to less food waste and reduced use of dietary supplements, all while residents gain weight (Baker, 2007).

Common Sense Ideas and Results

Debi Majo the director of nursing at the Northwood Health Care Center in Marble Falls, Texas shared some common sense ideas that more homes are trying in Part III of the CMS *From Institutional to Individualized Care* series:

We work diligently on reducing sugar in all of our menus because in reality, no one needs a lot of sugar in their diet. We sweeten our cakes with applesauce and sometimes add carrot juice or even prune puree to chocolate cupcake batter instead of sugar. So our reduced concentrated sweet diet is actually closer to sugar free. For all diets we do not add salt to any item that we cook. Some of the 'pre-made' breads contain salt so we call our reduced sodium diet 'no added salt' and I can tell you that corn bread tastes a little flat without salt, but you get used to it. And mechanically altered diets, these are just regular food that has been blended in the blender or hand chopped (2007).

Chapter Four

CMS – A Partner in the Culture Change Movement

The brochure for the upcoming *Creating Home in the Nursing Home II* Symposium, co-sponsored by CMS and the Pioneer Network states: “CMS has become a partner in the culture change movement, and wishes to encourage meaningful changes in food and dining service that provide greater quality of life for residents”.

CMS has a history of support for culture change. In 2002, CMS developed a satellite webcast for state survey agencies called “Innovations in Quality of Life: The Pioneer Network”. Surveyors were exposed to background information on culture change, its positive outcomes, and how facilities can make culture changes and remain compliant with nursing home regulations.

Culture change became the basis for a pilot project that included twenty-one states during the 8th Scope of Work for the CMS Quality Improvement Organizations (QIOs) between August 2004 and October 2005.

CMS also took part in the St. Louis Accord in 2005. This was a gathering of long term care stakeholders interested in culture change. The more than 400 participants included ombudsmen, advocate groups, regulators, providers, state and national trade associations, culture change experts, and QIO representatives. All 50 States were represented and State teams created action plans to promote transformation of institutional culture in their respective States (www.qualitypartnersriqio.org/cfmodules/objmgr.cfm accessed 1-11-10).

In April 2006, CMS let a contract for development of the “Artifacts of Culture Change” measurement tool. The tool is designed to capture tangible evidence of changes that come from a changed culture and includes several dining items under the domain of Care Practices. In 2009 the Pioneer Network developed a data base that automates the completion of the tool. The site, which is in the test stage at this writing, will enable a nursing home to fill out the Artifacts tool and receive a report comparing them to others in the data base.

In December of 2006, CMS issued a Survey and Certification letter with answers to culture change questions from the culture change community which is available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCletter07-07.pdf>. For convenience, the letter is also included in Appendix B.

In April of 2008 CMS and the Pioneer Network co-sponsored *Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment*. Subsequent to the symposium, the Hulda B. and Maurice L. Rothschild Foundation funded the Pioneer Network to convene the National Long Term Care Life Safety Task Force. The Task Force was composed of volunteer architectural and Life Safety Code experts. They submitted five proposals to the National Fire Protection Association regarding the Life Safety Code® in August of 2009 for the 2012 Edition. CMS issued new interpretive guidance effective

July 12, 2009 for ten regulations regarding the environment and quality of life, directly stemming from the symposium discussions.

CMS funded the writing of the background paper for the first symposium, as well as this background paper in preparation for the second symposium. In addition, the 2009 version of the CMS “Guide to Choosing a Nursing Home,” contains a section describing culture change and person-directed practices for the first time.

The Pioneer Network has asked AHFSA – the Association of Health Facility Survey Agencies – and AHFSA in turn has invited each State survey agency, to name a culture change contact person within their survey agency. In addition, the leadership of AHFSA has created an Individualized Care Committee, essentially its own culture change committee.

Chapter Five

Food and Dining Issues and the CMS Food and Dining Regulations

CMS has identified many culture change practices regarding food and dining in newer interpretive guidance. However, the issues surrounding new and innovative ways of serving food in the nursing home are not always completely addressed.

483.35(i) F325 Nutrition

Based on a resident's comprehensive assessment, the facility must ensure that a resident – 483.35(i)(1) Maintains acceptable parameters of nutritional status such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible: and

483.35(i)(2) Receives a therapeutic diet when there is a nutritional problem.

Receives a Therapeutic Diet

Therapeutic diet refers to two kinds of diets: restricted diets (such as no concentrated sweets and low or no salt) and altered texture diets (such as mechanical soft or pureed). As might be expected, residents would often prefer not to follow a restricted diet. Residents on a modified texture diet would also sometimes prefer a regular diet, which might put them at risk for choking.

The Intent statement in the interpretive guidance for this requirement currently states that care and services be *consistent with the resident's comprehensive assessment* and that *the therapeutic diet takes into account the resident's clinical condition and preferences*. The resident's personal wishes are acknowledged with the following: *Goals and prognosis refer to a resident's projected personal and clinical outcomes. These are influenced by the resident's preferences (e.g., willingness to participate in weight management interventions or desire for nutritional support at end-of-life)...*

Tag F325 Nutrition guidance identifies that a person has *dislikes, preferences and preferred portion sizes*.

Resident Goals

CMS Interpretive Guidance also identifies that *resident goals and resident specific interventions should be care planned*. The culture change community has begun "I-format" care planning which redirects staff to the person. I-format care planning is the resident's care plan in their own voice such as "I have diabetes and my goal is for my blood sugars to be stable." Approaches are also in the voice of the person stating to care givers what works best for them. Providers who have committed to I-format care planning state that it is "powerful" and helps staff see the resident as a person.

Resident Choice

The Interpretive Guidance includes a section on *Resident Choice* at F325 Nutrition. It states the following:

The resident or resident representative has the right to make informed choices about accepting or declining care and treatment. The facility can help the resident exercise those rights effectively by discussion with the resident (or the resident's representative) the resident's condition, treatment options (including related risks and benefits, and expected outcomes), personal preferences, and any potential consequences of accepting or refusing treatment. If the resident declines specific interventions, the facility must address the resident's concerns and offer relevant alternatives.

This section evidences real recognition of *the right to informed choice*, about the fact that one *may decline care and treatment*, and that the facility can even *help* the resident *exercise those rights*.

The *Resident Choice* section of Tag F325 follows:

The facility's care reflects a resident's choices, either as offered by the resident directly or via a valid advance directive, or based on a decision based on a resident's surrogate or representative in accordance with state law. The presence of care instructions, such as an advance directive declining some interventions does not necessarily imply that other support and care was declined or is not pertinent. When preferences are not specified beforehand, decisions related to the possible provision of supplemental or artificial nutrition should be made in conjunction with the resident or resident's representative in accordance with State law, taking into account relevant considerations such as condition, prognosis, and a resident's known values and choices.

Diet Liberalization

The CMS Interpretive Guidance contains a section at F325 Nutrition on *Diet Liberalization*:

Research suggests that a liberalized diet can enhance the quality of life and nutritional status of older adults in long-term care facilities. Thus, it is often beneficial to minimize restrictions, consistent with a resident's condition, prognosis and choices before using supplementation. It may also be helpful to provide the residents their food preferences, before using supplementation. This pertains to newly developed meal plans as well as to the review of existing diets. Dietary restrictions, therapeutic (e.g., low fat or sodium restricted) diets, and mechanically altered diets may help in select situations. At other times, they may impair adequate nutrition and lead to further decline in nutritional status, especially in already undernourished or at-risk individuals. When a resident is not eating well or is losing weight, the interdisciplinary team may temporarily abate dietary restrictions and liberalize the diet to improve the resident's food intake to try to stabilize their weight. Sometimes, a resident or

resident's representative decides to decline medically relevant dietary restrictions. In such circumstances, the resident, facility and practitioner collaborate to identify pertinent alternatives.

Diet Liberalization – A New Standard of Practice

The American Dietetic Association (ADA) in 2002 released a position paper on diet liberalization called “Liberalized Diets for Older Adults in Long-term Care.” In it, the ADA stated, “It is the position of the ADA that the quality of life and the nutritional status of older residents in long-term care facilities may be enhanced by a liberalized diet.” The paper further states that nutrition in long term care settings must meet two goals: maintenance of health through medical care and maintenance of quality of life.

The ADA has gone beyond just looking at quality of care to consider quality of life as well: “To meet the needs of every resident, dietetic professionals must consider each person holistically, including personal goals, overall prognoses, benefits and risks of treatment, and perhaps most important, quality of life” (2002).

CMS Supports Culture Change

The following is excerpted from the *Environmental Factors* section of the F325 guidelines:

Appetite is often enhanced by the appealing aroma, flavor, form and appearance of food. Resident-specific facility practices that may help improve intake include providing a pleasant dining experience (e.g., flexible dining environments, styles and schedules), providing meals that are palatable, attractive and nutritious (e.g., prepare food with seasonings, serve food at proper temperatures, etc.), and making sure that the environment where residents eat (e.g., dining room and/or resident's room) is conducive to dining.

Flexible dining environments, styles and schedules help to improve dietary intake. Research shows that socializing with others improves appetite (Simmons et al 2001, Simmons and Schnelle, 2004). It is accepted that certain aromas such as chocolate improve appetite. Music, lighting, ambiance, basically a pleasant dining experience improves everything.

Real Food over Supplements

CMS guidance states that most people prefer real food to supplements: *With any nutrition program, improving intake via wholesome foods is generally preferable to adding nutritional supplements.*

Avoidable and Unavoidable

A definition of “unavoidable” in regards to nutrition is provided at F325:

“Unavoidable” means that the resident did not maintain acceptable parameters of nutritional status even though the facility had evaluated the resident’s clinical condition and nutritional risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

Thus, weight loss is not automatically considered a deficiency. Surveyors will investigate whether it was avoidable in light of poor care practice or unavoidable in light of good care practices. Only the avoidable weight loss will become a deficiency. When investigating whether any sort of nutritional decline was unavoidable, the guidance advises that the *resident’s needs and goals* be taken into account, as well as considering *recognized standards of practice*. That is part of providing good care, and is now a part of the guidance for Tag F242 Self-determination and Participation.

Investigative Protocol

Review of Facility Practices, If the interventions defined, or the care provided, appear to be inconsistent with recognized standards of practice, interview one or more health care practitioners as necessary (e.g., physician, hospice nurse, dietitian, charge nurse, director of nursing or medical director).

The CMS guidance supports person-centered, self-directed living ideas by stating under Observations in the Investigative Protocol for Tag F325 Nutrition:

During observations, surveyors may see non-traditional or alternate approaches to dining services such as buffet, restaurant style of or family style dining. These alternate dining approaches may include more choices in meal options, preparations, dining areas and meal times. Such alternate dining approaches are acceptable and encouraged.

Heavy Hitters

CMS has made a strong statement regarding the importance of resident choice and preferences at F325 Deficiency Categorization:

The first instance is an example of Severity Level 4 - Immediate Jeopardy:

Substantial and ongoing decline in food intake resulting in significant unplanned weight loss due to dietary restrictions or downgraded diet textures (e.g., mechanic soft, pureed) provided by the facility against the resident’s expressed preferences.

The following are examples given at Severity Level 3 - Actual Harm:

Unplanned weight change and declining food and/or fluid intake due to the facility’s failure to assess the relative benefits and risks of restricting or downgrading diet and

food consistency or to obtain or accommodate resident preferences in accepting related risks;

Decline in function related to poor food/fluid intake due to the facility's failure to accommodate documented resident food dislikes and provide appropriate substitutes.

And under the section Potential Tags for Additional Investigation, the very first tag mentioned is Tag 150 Resident Rights and stated is, "Determine if the resident's preferences related to nutrition and food intake were considered."

F360 483.35 Dietary Services

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

F361 483.35(a) Staffing, Qualified Dietician

CMS at Tag F325 Nutrition identifies that *qualified dieticians help identify nutritional risk factors and recommend nutritional interventions, based on each resident's medical condition, needs, desires and goals.*

Linda Roberts, RD and consultant in long term care, shares some insight into the role of the dietitian. She says the dietitian "has been trained to treat certain diseases with food" citing the extensive education an RD receives in chemistry, biochemistry, microbiology and anatomy. The dietitian understands the body's workings at the cellular level and how the components of food (carbohydrates, fats, proteins, vitamins, minerals, phytochemicals) affect the health and wellness of the individual. And dietitians want to help people. However, the other part of the equation, Roberts advises, is the patient's lifelong habits. She cites the example of 80 year olds. There will be some that are very interested in prolonging their life and others will say: "who cares if I live another 2 months or not - I'm 80 years old."

The goal should always be to individualize according to what each person wants, needs, will put up with, will concede to. To truly individualize means to figure out what works best for a person, remembering that we're all different.

Staffing to Complement the Dietitian

In order to focus on resident *needs, desires and goals*, some nursing homes are hiring chefs and restaurant managers to complement the role of the required qualified dietitian. Because chefs, restaurant managers and wait staff are used to serving people what they want when they want it, they have a real commitment to service.

Solid training in the facility's practice of encouraging and reminding residents of any food related recommendations is needed by all staff.

“Healthcare: Chefs Needed”

Ryan Krebs is Executive Chef/Director of Dietary Services at Victoria Special Care Center in El Cajon, California. A former executive chef from the restaurant world, Krebs is passionate about inviting executive chefs into the meaningful business of long term care. According to Krebs, a culinary education focus is service plus a passion and enthusiasm for food. What many suppose is that chefs cost more. Krebs says this is true initially but to “keep in mind that many chefs are also held to the highest of standards, especially from larger corporations and privately owned restaurants. They manage money, large staffs, and control costs and are held accountable to numbers in so many ways. And, their management experience could immediately impact overhead labor and purchasing costs, possibly allowing their salary requirements to be met. Having an executive chef is also a great marketing tool for organizations, stating that your business has made an investment in bringing in the best the industry has to offer....” (2009).

Johnson & Wales University, Krebs’ alma mater in Providence, Rhode Island, offers a degree in Culinary Nutrition, the first of its kind, blending the healthcare focus of nutrition with the culinary arts. Krebs says that as our economy suffers and restaurants and hotels are closing or making cut-backs, there are eager chefs awaiting the chance to enter the field of healthcare (2009).

F362 483.35(b) Sufficient Staff

This guidance points out that an assessment of whether residents are receiving sufficient assistance for meals should be included in an assessment of the adequacy of staffing.

F363 483.35(c) Menus and Nutritional Adequacy

Menus must: Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

483.35 (c) (2) *Be prepared in advance*

483.35 (c) (3) *Be followed.*

The Intent section of the guidance for this regulation states: *This regulation also assures that there is a prepared menu by which nutritionally adequate meals have been planned for the resident and followed.*

In 2008 the Colorado Department of Healthcare Policy and Finance developed the Colorado Nursing Facilities Pay for Performance (P4P) Medicaid reimbursement program which also includes resident participation in menu planning. One of the minimum requirements is:

Menus that include numerous options, menus developed **with resident input**. Menu options must be more than the entree and alternate selection. These options should **include input from a resident/family advisory group** such as resident

council or a dining advisory committee. **The residents have input** into the appearance of the dining atmosphere.

483.35 (c) (3) *Be followed*

The Procedures section of the interpretive guidelines for tag, F363 states:

*For sampled residents...observe if meals served are consistent with the planned menu and care plan in the amounts, types and consistency of foods served.
If the survey team observes deviation from the planned menu, review appropriate documentation from diet card, record review, and interviews with food service manager or dietician to support reason(s) for deviation from the written menu.*

The guidance does not state that deviation from the menu is automatically assumed to be a deficient practice, but rather that surveyors should investigate the reasons for the deviation. CMS guides the surveyor to conduct a *record review*. If the facility has explained the reasons in assessments and the plan of care, it should be taken into account.

483.35 (d) F364 Food

Each resident receives and the facility provides:

- (1) Food prepared by methods that conserve nutritive value, flavor and appearance;*
- (2) Food that is palatable, attractive and at the proper temperature;*

483.35 (d) (3) F365 *Food prepared in a form and designed to meet individual needs.*

483.35 (d) (4) F366 *Substitutes offered of similar nutritive value to residents who refuse food served.*

F367 483.35(e) Therapeutic diets

Therapeutic diets must be prescribed by the attending physician.

In the California Dining Project, CMS Region IX encourages thinking about “partnership:”

Nursing facilities need to establish a partnership among the health care practitioners including consistently assigned direct care staff, the long term and short stay residents and his/her families (when appropriate) to ensure that food and fluid decisions respect all these residents’ wants, needs and preferences and that the capable residents, care givers and involved families are satisfied with their care, as well as their clinical outcomes. Coordination and integration of the nutrition and hydration services should involve and include clinical, ancillary, and support services staff. Capable residents should be encouraged to give on-going input about the program (2008).

F368 483.35(f) Frequency of Meals – “The 14 Hour Rule”

- 1) *Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.*
- 2) *There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.*
- 3) *The facility must offer snacks at bedtime daily.*
- 4) *When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.*

CMS has given guidance in the S&C-07-07 letter (Appendix B) answering questions including “the 14 hour rule” and the resident right to choice:

Question 1: Tag F368 (Frequency of Meals): You request a clarification that the regulation language at this Tag that “each resident receives and the facility provides at least three meals daily” does not require the resident to actually eat the food for the facility to be in compliance. You also ask for clarification about the regulatory language specifying that there must be no more than 14 hours between supper and breakfast (or 16 hours if a resident group agrees and a nourishing snack is provided). You state that some believe this language means all of the residents must actually eat promptly by the 14th hour, which makes it difficult for the facility to honor a specific resident’s request to refuse a night snack and then sleep late.

Response 1: The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at Tag F242, Self-determination and participation. You are correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complain about the food items provided. If a resident is sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident to eat when they awaken (such as continental breakfast items) if they desire any food before lunch time begins.

F369 483.35(g) Assistive devices

Assistive devices are very helpful to certain individuals needing them, contributing greatly to independence. This tag plays an important role in helping residents reach their highest practicable level of well-being.

F371 483.35(i) Sanitary conditions

The facility must: 1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2) Store, prepare, distribute and serve food under sanitary conditions.

The revised guidance for this Tag F371 was issued on June 20, 2008 with an effective date of September 1, 2008. The guidance recognizes new approaches:

Approaches to create a homelike environment or to provide accessible nourishments may include a variety of unconventional and non-institutional food services. Meals or snacks may be served at times other than scheduled meal times and convenience foods, ready-to-eat foods, and pre-packaged foods may be stored and microwave heated on the nursing units. Whatever the approach, it is important that staff follow safe food handling practices.

Unsafe Food Sources

Unsafe food sources are not approved or considered satisfactory by Federal, State or local authorities. Nursing homes are not permitted to use home-prepared or home preserved (e.g., canned, pickled) foods for service to residents.

This guidance was clarified with the following addition on May, 29 2009:

NOTE: The food procurement requirements for facilities are not intended to restrict resident choice. All residents have the right to accept food brought to the facility by any visitor(s) for any resident.

In a June 12, 2009 CMS Survey and Certification letter (SC 09-39 included in Appendix A) CMS also indicated to facilities:

The facility does have a responsibility under the food and safety regulatory language at F371 to help visitors understand safe food handling practices (such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees F) and to ensure that if they are assisting visitors with reheating or other preparation activities, that facility staff use safe food handling practices and encourage visitors and residents who are contributing to food preparation in the facility to use these safe practices as well.

So, food can be brought in, but the facility has responsibilities to keep it safe once it's there and to try to have it come in as safe a condition as possible. A facility can decide on their own policies and practices to uphold resident rights as well as keep food safe.

CMS gave guidance on this issue in the Survey and Certification S&C -07-07 December 21, 2006 answering culture change questions (Appendix B):

Question 2: (370) Approved Food Sources: You ask if the regulatory language at this Tag that the facility must procure food from approved food sources prohibits residents from any of the following: 1) growing their own garden produce and eating it; 2) eating fish they have caught on a fishing trip; or 3) eating food brought to them by their own family or friends.

Response 2: The regulatory language at this Tag is in place to prohibit a facility from procuring their food supply from questionable food sources, in order to keep residents safe. It would be problematic if the facility is serving food to all residents from the sources you list, since the facility would not be able to verify that the food they are providing is safe. The regulation is not intended to diminish the rights of specific residents to eat food in any of the circumstances you mention. In those cases, the facility is not procuring food. The residents are making their own choices to eat what they desire to eat. This would also be the case if a resident ordered a pizza, attended a ball game and bought a hot dog, or any similar circumstance. The right to make these choices is also part of the regulatory language at F242, that the resident has the right to, "make choices about aspects of his or her life that are important to the resident." This is a key right that we believe is also an important contributing factor to a resident's quality of life.

CMS articulates in this memo the difference between the facility procuring food from approved sources and the right of residents to make choice, an important distinction.

Gardens

In 2006, in the S&C -07-07 letter (Appendix B), CMS honored the resident's right to choose to eat foods they grew in a garden under the umbrella of involvement in activities, not food procured by the facility for all residents. Since that time CMS has received many questions as to whether food from gardens planted by the facility to serve the whole population is acceptable. CMS is working with the FDA on this issue, and Glenda Lewis from the FDA will address it at the Creating Home II symposium.

No bare hand contact

In the Employee Health section of this guidance it is stated: *Bare hand contact with foods is prohibited.* This requirement stems from the Food and Drug Administration's (FDA) Food Code. The Food Code's Intent at 1-102.10 is stated as, "The purpose of this Code is to safeguard public health and provide to consumers food that is safe, unadulterated, and honestly presented."

Chapter 3 of the Food Code at 3-301.11 states: (B) "...Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, tongs, single use gloves or dispensing equipment."

(D) “Food employees not serving a highly susceptible population may contact exposed, ready-to-eat food with their bare hands if...” (many points follow).

At 3-801.11 (D) Special requirements for Highly Susceptible Populations it is stated, “Food employees may not contact ready-to-eat food” and “Food employee’ means an individual working with unpackaged food, food equipment or utensils, or food-contact surfaces” according to Chapter 1 – Purpose and Definitions.

“Highly susceptible population” means persons who are more likely than other people in the general population to experience foodborne disease because they are:
(1) Immunocompromised; preschool aged children, or older adults; and
(2) Obtaining food at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney dialysis center, hospital or nursing home, or nutritional or socialization services such as a senior center.

The FDA Food Code can be accessed at <http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/ucm186464.htm> (as of Dec. 2009).

Gloves

CMS has given tighter guidance regarding gloves at F371:

Gloved hands are considered a food contact surface that can get contaminated or soiled. Failure to change gloves between tasks can contribute to cross-contamination..... NOTE: The use of disposable gloves is not a substitute for proper hand washing with soap and water.

Resident Refrigerators

The Environment task in the QIS survey directs surveyors to look at “snack/nourishment refrigerators on the units.” Nursing home residents sometimes have their own refrigerators, although there is some lack of clarity as to whether the resident or the facility has the responsibility of maintaining them.

Take-out and Delivered Foods

Based on the new CMS clarification, take-out and home delivery foods are the right of residents. And per the 5/29/09 Survey and Certification letter (Appendix B), the facility has the responsibility to keep foods safe.

Alcohol-based Hand Rubs

In the section Hand Washing, Gloves and Antimicrobial Gel, CMS has stated: *Antimicrobial gel cannot be used in place of proper hand washing techniques in a food service setting.*

Eggs

Guidance calls for any unpasteurized eggs to be cooked to a 145 degrees Fahrenheit internal temperature, and under the section called Pooled Eggs, CMS has made the statement: *Waivers to allow undercooked unpasteurized eggs for resident preference are not acceptable. Pasteurized shell eggs are available and allow for safe consumption of undercooked eggs.*

Hairnets

CMS only requires hair restraints of dietary staff at F371: *Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent their hair from contacting exposed food.*

The guidance is written with the assumption of the roles and duties of staff by department. In innovative homes with households or little houses, there is no departmental division of labor, and there is no large, main preparation kitchen that is off limits to residents. Instead, roles become blended. A person who is a certified nursing assistant may be cooking, a person who is a social worker may be dishing out food from large bowls at a table, the administrator or family member or resident may be taking cookies out of the oven, washing dishes, etc. There is a need for clarity on what duties and situations, not what positions or departments, need hair restraints.

Buffets and Steam Tables

There are standards of good infection control practice that are obviously required with buffets such as sneeze guards, serving utensils, tongs, tissues and ensuring proper food temperatures.

Food Holding Times

“Danger Zone” refers to temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause foodborne illness outbreak if consumed. CMS specifically mentions the time frame food can be on a steam table following this 4 hour rule: The maximum length of time that foods can be held on a steam table is a total of 4 hours.

Family Style Dining

Good infection control practice becomes especially important when foods are served in serving bowls, as they would be in our homes. Proper food temperature is also especially important in this instance.

Staff Dining with Residents

CMS addressed this issue in 2006 in the S&C-07-07 letter (Appendix B):

Question 11 (Dining Together): Is it permissible for staff and residents to dine together?

Answer 11: There is no federal requirement that prohibits this. We applaud efforts of facilities to make the dining experience less institutional and more like home. Our concern would be for the facility to make sure that residents who need assistance receive it in a timely fashion (not making residents wait to be assisted until staff finish their meals).

So dining together is welcome as long as residents always receive assistance needed.

Does a Nurse have to be in the Dining Room for Meals?

At Tag F373, regarding paid feeding/dining assistants CMS has stated:

Adequate supervision by a supervising nurse does not necessarily mean constant visual contact or being physically present during the meal/snack time, especially if a feeding assistant is assisting a resident to eat in his or her room. However, whatever the location, the feeding assistant must be aware of and know how to access the supervisory nurse immediately in the event that an emergency should occur. Should an emergency arise, a paid feeding assistant must immediately call a supervisory nurse for help on the resident call system.

F373 483.35(h) Paid Feeding Assistants – Dining Assistants

CMS published a Federal Register rule in September of 2003 creating the regulatory language that was then placed at Tag F373, making it possible for long-term care facilities to use Paid Feeding Assistants to help residents eat *who have no complicated eating problems*.

Paid Feeding Assistant/Dining Assistant Research

Now that dining assistants (DA) have been in existence for six years, several studies, co-sponsored by CMS and the Agency for Healthcare Research and Quality (AHRQ), have been completed to investigate the impact of DA programs. The primary researchers for these studies, Drs. Sandra Simmons of Vanderbilt University and Rosanna Bertrand of Abt Associates will share their findings as featured speakers at the upcoming Creating Home II symposium.

A Manual for Dining Assistant Programs in Nursing Homes: Guidelines for Implementation has been developed by Abt Associates and Vanderbilt University with funding and input from both CMS and AHRQ. It is available at www.VanderbiltCQA.org.

Dining Assistants play a large part in the 24-hour dining that is offered by Rolling Fields of Conneautville, Pennsylvania. Rolling Fields explains that in order to “pull off” 24 hour dining, staff roles had to be changed, every staff member stepped out of their traditional role and became a caregiver including, “all Staff in our home are certified feeding assistants; therefore, anyone can sit down and assist an Elder with his/her meal” (ltlmagazine.com 9/11/09).

Dining Assistants Enhance Quality of Care and Quality of Life

Rolling Fields says that because of their increased selection of food available and because there is more time for one-on-one interaction with dining, partly due to the DAs, they only have seven residents remaining on a pureed diet from the 20 to 30 they used to have. They also state, “quality of life for our Elders has been improved greatly because they now may choose exactly what and when they want to eat” (2009).

F240 483.15 Quality of Life

It is fitting for our discussion about food, dining, and self-directed living to think about the requirements of this Tag that states: *A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.*

Quality of life is personal to each person, as are food preferences. Facilities are required by CMS to maintain quality of life, or even better, enhance it for each resident. The facilities’ requirement to promote quality of life begins at this Tag which leads the regulatory section of Quality of Life and continues throughout the entire section, 483.15 (a) – (h).

Depression and Weight Loss

The results of the study conducted by Simmons et al: “Prevention of Unintentional Weight Loss in Nursing Home Residents: A Controlled Trial of Feeding Assistance” found that residents with a diagnosis of depression lost more weight than those without the depression diagnosis. In fact, studies by Morley and Kraenzle, Morley and Silver and Simmons, Cadogen and Carbonnera have shown that depression is a major cause of unintentional weight loss..

In 2006 CMS released the Psychosocial Outcome Severity Guide, which guides surveyors on how to select the level of severity for any deficiency with a psychosocial outcome or potential outcome to residents (State Operations Manual, Appendix P). This has helped bring attention to the severity of psychosocial outcomes that could occur as a result of any deficient practice.

F241 483.15(a) Dignity

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

CMS issued new guidance to ten tags in July of 2009, Dignity being one of them. These identified many institutional practices including several dining practices, and asked facilities to now avoid them. Food served on trays has been identified as institutional, a remnant of the old hospital-type institution. Staff standing while assisting residents to eat has been earmarked as undignified as well. Surveyors are now guided to watch for staff conversing with residents rather than only with each other and to provide any needed bathroom assistance during meals. And bibs have been identified as undignified: *Promoting dignity in dining by eliminating such practices as: bibs (also known as clothing protectors) and instead offering cloth napkins.* Bibs were addressed by CMS in the early 1990's in the guidance to this Tag F241 Dignity. The new guidance again places emphasis on bibs being undignified.

F242 483.15(b) Self-determination and participation

The resident has the right to:

- 1) **Choose** activities, schedules, and health care consistent with his/her interests, assessments and plans of care;
- 2) *Interact with members of the community both inside and outside the facility; and*
- 3) **Make choices** about aspects of his or her life that are significant to the resident.

Facilities must be *actively seeking preferences, choice over schedules important to the resident, i.e., waking, eating, bathing, and retiring* per CMS' new guidance.

Even if a person can't tell us their preferences, caregivers can still *actively seek* them. Pertaining to preference, CMS has stated: *If resident is unaware of the right to make such choices determine if the home has actively sought resident preference info and if shared with caregivers.* CMS' requirement is that the facility go deeper in finding out resident preferences even if a resident did not tell staff, even if a resident does not realize they have this right to choice and their preferences should be honored.

Informed Consent

A facility cannot just let people eat what they want and when they want with no oversight or care about it. Tag F325 addresses the right to make informed choice: *Sometimes, a resident or resident's representative decides to decline medically relevant dietary restrictions. In such circumstances, the resident, facility and practitioner collaborate to identify pertinent alternatives.* And stated is that the resident or representative *has the right to make informed choices about accepting or declining care and treatment.*

F279 483.20(d) Comprehensive Care Plans including Highest Practicable Well-being

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, physical, mental and psychosocial needs that are identified in the comprehensive assessment.

CMS calls for care plans to be *comprehensive*. This would include details of food preferences and choice, food passions and pet peeves, what someone loves to eat and hates to eat.

Highest Practicable Well-being

F279 continued - The care plan must describe the following:

The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

Highest practicable means innate capability, based solely on the individual's abilities, limitations, and potential, independent of external limitations (CMS Individualized Care series, 2006). If someone is capable of feeding him or herself, a facility is to do all it can to assist the person in maintaining this highest practicable level of well-being.

F280 483.10(d)(3) Participate in Planning Care and Treatment

The resident has the right to -- unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

F441 483.65 Infection Control

CMS released new guidance for this requirement, effective July 17, 2009. Many infection control guidelines having to do with food and dining are included in Tags F325, F371, and F441:

Note: It is important that all infection prevention and control practices reflect current Centers for Disease Control and Prevention (CDC) guidelines.

Residents can be exposed to potentially pathogenic organisms in different ways, including but not limited to the following:

- *Improper hand hygiene*
- *Improper glove use (e.g. utilizing a single pair of gloves for multiple tasks or multiple residents) and*
- *Improper food handling.*

Under *Hand Hygiene* the following are examples relating most to food and dining:

Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:

- *Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);*
- *Before and after eating or handling food (hand washing with soap and water);*
- *Before and after assisting a resident with meals (hand washing with soap and water);*
- *After removing gloves or aprons.*

483.15(h) Environment: Safe, Clean, Comfortable and Homelike – The Short Stay Experience and Food and Dining

In a facility in which most residents come for a short-term stay, the “good practices” listed in this section are just as important as in a facility with a majority of long-term care residents.

CMS also states in a Note, under Procedures:

Many residents who are residing in the facility for a short-term stay may not wish to personalize their rooms nor bring in many belongings

Persons needing a short rehab stay in a nursing home often do not want to be called residents, they are not moving in and they do expect a medical treatment atmosphere. However, the “good practices”/institutional features to eliminate listed in the new guidance are still important. Additionally, all people appreciate choice and the clientele for a short stays are quite accustomed to exerting choice. Choice in foods and meal times, choice in whether to go to a dining area or stay and eat in the room, all are choices most people want to make and are used to making every day.

The Role of the Consultant Pharmacist

Much could be said about medications: how they can alter taste, cause dry mouth, lethargy, nausea, confusion, etc. which can all affect a person’s eating patterns. Pharmacists enter into a resident’s food and dining experience in several ways besides their typical role of reviewing medications and identifying side effects. Pharmacists can affect appetite stimulation with medications and timing of medications, as well as identify contraindications of foods with medications. They are charged with reducing number of medications wherever possible. They affect whether a nutritional supplement might be used or real food.

Tag 155 483.10 (b)(4) Refusal of treatment

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.

“Treatment” is defined as care provided for purposes of maintaining /restoring health, improving functional level, or relieving symptoms.

From the interpretive guidelines: The facility should determine exactly what the resident is refusing and why. To the extent the facility is able, it should address the resident’s concern. For example, a resident requires physical therapy to learn to walk again to after sustaining a fractured hip. The resident refuses therapy. The facility is expected to assess the reasons for this resident’s refusal, clarify and educate the resident as to the consequences of the refusal, offer alternative treatments, and continue to provide all other services.

If a resident’s refusal of treatment brings about significant change, the facility should reassess the resident and institute care planning changes. A resident’s refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being in the context of making that refusal.

Tag 151 483.10 (a)(1) Exercise of Rights

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

From the interpretive guidelines: The facility must not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights.

Chapter Six

Current Survey Processes as they Pertain to Food and Dining

Traditional Survey

The nationwide implementation of the Quality Indicator Survey (QIS) will ultimately make the traditional survey process obsolete. However, both survey processes are being used during the transition, which will take several additional years.

New surveyor guidance issued at this time is operative for both survey processes. CMS' has issued new guidance at Tag 242 (Self-determination and Participation) regarding *actively seeking* resident preferences. This would include resident preferences regarding what they eat and when they eat. In addition, there is new guidance at Tags F325 (Nutrition) and F371 (Kitchen Sanitation).

QIS

Within the new QIS process a number of the Pathways, Critical Elements and Interviews touch on food and dining.

The QIS Dining Observation Pathway (20053 9/09), #9 asks:

9. Are resident's desires considered when using clothing protectors?

The new revised Dining Observation Pathway (20053 revised 7/31/09) slated to be released June 2010 does bring up the use of napkins but also still clothing protectors:

- Provide napkins and non-disposable cutlery and dishware (including cups and glasses).
- Consider resident's desires when using clothing protectors.

The Nutrition-Hydration-Tube Feeding Critical Element (20075 6/07) under the Resident/Representative Interview on page 7 guides surveyors to ask "Whether there are any concerns regarding..." many things. However, resident food preferences are not inquired about, although they are under Care Planning.

The Resident Interview and Resident Observation (20050 6/07) includes this question at B Choices:

Are you able to participate in making decisions regarding food choices/preferences?

Time to go to bed, get up and bathing schedule are reflected. There is no inquiry regarding preferred times to eat.

The Family Interview (20049 9/08) includes these questions at B Choices:

Does the facility honor [resident's] preferences and previous life routines, such as when to get up, and go to sleep or when to take a bath?

Does the facility honor [resident's name] preferences on what he/she eats or drinks?

Again, there is no question regarding preferred times to eat.

On both the current (20053 9/09) and newly revised (20053 revised 7/31/09) Dining Observation Pathway, the following question is asked:

16. Does the facility provide meals with no greater than a 14 hour lapse between the evening meal and breakfast (or 16 hours) with approval of a resident group and provision of a substantial evening snack?

The new Dining Observation Pathway (20053 revised 7/13/09) slated to be issued June 2010 identifies and recognizes neighborhoods, households and expanded meal hours:

Meal times and dining room locations should be identified while the team coordinator is conducting the entrance conference. Some nursing homes have "households" or "neighborhoods" that contain a kitchen and dining room and provide expanded meal service hours, such as 7-10 a.m. for breakfast, or food services on a 24-hour basis, seven days a week. Meals may be prepared in the household/neighborhood or catered in, such as occasionally ordering pizza or take-out food. The purpose of meal services in these settings is to provide the residents choices for times to eat and sleep, to offer food choices/preferences, and to provide a more home-like setting.

MDS 2.0

Within the federally required Minimum Data Set assessment in its current 2.0 version, food and dining are mostly reflected in Section K. Oral/Nutritional Status. One item in that section states:

K.4.c. Resident leaves 25% or More of Food Uneaten at Most Meals

Recording food intake is technically not required by regulation. Recording food intake is mentioned by CMS in the guidance for Tag F325 Nutrition, in regards to when there is insidious or sudden weight loss, in particular by "intensifying observation of intake and eating patterns." The MDS requires a 7 day look back period.

According to the MDS Active Resident Information Report: Third Quarter 2009, 34.5% of all residents nationally leave 25% or more of their food uneaten (http://www.cms.hhs.gov/MDSPubQIandResRep/04_activeresreport.asp?isSubmitted=res3&var=K4c&date=28). With so many residents leaving that much food uneaten, questions

about the palatability of the food arise. On the other hand, the data also support that it is not every resident that has this problem. Facilities need to have good systems and policies in place to ensure recording intake is completed when needed. When intake is recorded, a good practice identified by Handy is to use printed menus first to mark resident choice and then to record percentage intake for each item eaten (2009).

MDS 2.0 items can be tracked at MDS Active Resident Information Report at:
http://www.cms.hhs.gov/MDSPubQIandResRep/04_activeresreport.asp.

MDS 3.0

The new version of MDS (MDS 3.0) is scheduled to be implemented in October 2010. The K.4.c. item is not included in MDS 3.0. In MDS 3.0, the only question about food posed to the resident is: "While you are at this facility how important to you is...have snacks available between meals?" Although bedtime preference is asked about, preferences regarding times to eat and what to eat are not.

Chapter Seven Other Food and Dining Standards

Food and Drug Administration (FDA)

The U.S. Public Health Service (PHS) began its food protection activities at the turn of the 20th century with studies of the role of milk in the spread of disease. These studies found that effective disease prevention called for comprehensive food sanitation measures from production to consumption. Model codes began to be developed, the first of which was the *Grade A Pasteurized Milk Ordinance – Recommendations of the PHS/FDA* published in 1924.

A new edition of the Food code is developed every 4 years by the FDA. During each 4 year cycle the FDA may issue supplements to the code if necessary, and those supplements are incorporated into the next edition. The FDA accepts recommendations for Food Code modification from any individual or organization, with specific forms and time frames for submission. The Conference for Food Protection covers retail food issues while there are conferences specific to milk and shellfish production. The 2005 edition of the Food Code reflects recommendations made at the 2002 and 2004 Conference for Food Protection. The FDA has an open and democratic process of state by state delegate votes. And the FDA “encourages interested individuals to consider raising issues and suggesting solutions involving the federal-state cooperative programs based on FDA’s model food codes through these organizations.”

The FDA has 75 state and territorial agencies and more than 3,000 local departments whose primary responsibility is prevention of foodborne illness and licensure and inspections of retail food establishments.

Information and history about the FDA were found at the following website:

<http://www.fda.gov/downloads/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2005/ucm123930.pdf>.

The Food Code itself can be found at:

<http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2005/default.htm>.

The CMS guidance at Tags F371 Kitchen Sanitation and F441 Infection Control are not in conflict with the FDA model food code.

Centers for Disease Control and Prevention (CDC)

Originally, CDC was named the Communicable Disease Center when it was established in 1946. Descending from the wartime agency “Malaria Control in War Areas,” the CDC initially focused on fighting malaria by killing mosquitoes. At its beginning, there were fewer than 400 employees, with the majority being entomologists and engineers. There were only seven medical officers on staff. The CDC, now called the Centers for Disease Control and Prevention, celebrated its 60th anniversary in 2006.

Today, the CDC is a global leader in public health and leads our nation in health promotion, prevention, and preparedness. Its public health efforts include prevention and control of infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats. The CDC is globally recognized for conducting research and investigations and for an action-oriented approach. It works with states and other partners to provide a health surveillance system to monitor and prevent disease outbreaks including bioterrorism, implement disease prevention strategies, and maintain national health statistics. The CDC also guards against international disease transmission with personnel stationed in more than 25 foreign countries. CDC is one of the 13 agencies of the U.S. Department of Health and Human Services (DHHS).

CDC guidelines are developed with the help of federal advisory committees. The Federal Advisory Committee Act (Public Law 92-463) provides a mechanism for experts and stakeholders to participate in the decision-making process by offering advice and recommendations to the Federal government as members of advisory committees. Twenty-four federal advisory committees provide advice and recommendations on a broad range of public health issues including an advisory committee on healthcare infection control. That federal advisory committee is called the Healthcare Infection Control Practices Advisory Committee (HICPAC) and its function is described as follows: “The Committee shall advise the Centers for Disease Control and Prevention on periodic updating of existing guidelines, development of new guidelines, guideline evaluation; and other policy statements regarding the prevention of healthcare-associated infections and healthcare-related conditions” (www.cdc.gov/hicpac).

The Guideline for Hand Hygiene in Healthcare Settings – 2002, was developed by the CDC's HICPAC, in collaboration with the Society for Healthcare Epidemiology of America (SHEA), the Association of Professionals in Infection Control and Epidemiology (APIC), and the Infectious Disease Society of America (IDSA).

Guidelines currently being developed are: Guidelines for Infection Prevention and Control in Healthcare Personnel; Guidelines for the Prevention of Intravascular Catheter-Related Infections; Guideline for the Prevention and Management of Norovirus Gastroenteritis Outbreaks in Healthcare Settings; and Pediatric Infection Prevention: Gap Summary. More information regarding the posting of guidelines in development open public comment periods will be discussed at the HICPAC meetings and posted on the website.

And as is with the FDA Food Code, CMS' guidance at F371 and F441 also does not conflict with CDC guidelines.

The Stage Model

The Stages Tool developed by Les Grant and LaVrene Norton is a stage model of culture change in nursing facilities. This tool assesses the degree of culture change from an organizational development perspective in four stages: Stage I - Institutional model, Stage II - Transformational model, Stage III - Neighborhood model and Stage IV - Household model. It describes the organizational status of Decision Making, Staff Roles, Physical Environment, Organizational Design and Leadership Practices in each. The tool speaks to the respective dining practices in each stage (also explained in Chapter Two). The tool is available at culturechangenow.com. The **Culture Change Staging Tool** is a web-based questionnaire that assesses 12 key culture change domains. It determines for a facility, based on the facility's responses, what its highest model stage is of the four stages identified in the Grant and Norton Stages Tool. This tool is available at myinnerview.com.

Artifacts of Culture Change

The **Artifacts of Culture Change** is a tool designed to capture the concrete changes homes make that reflect a changed culture, changes in attitude, policies and practices to be more resident-directed. A full report called **Development of the Artifacts of Culture Change Tool** explains the rationale for developing the tool, the point scale, and includes a large Source Information table. The Source Information gives background for each item, where it exists around the country, as well as any research found which supports it. The Development report and the Artifacts tool itself are both available at pioneernetwork.net.

NHRegsPlus

The Hulda B. and Maurice L. Rothschild Foundation provides funding for the NHRegsPlus searchable website, which contains a repository of State nursing home regulations for each of the 50 States. It allows the user to search through all 50 States' requirements per sections such as dietary services. Most States' licensure regulations and waiver/variance process (if there is one), can be accessed directly from the site. The website, housed at the University of Minnesota, contains a wealth of information and can be accessed at: <http://www.hpm.umn.edu/NHRegsPlus>.

Chapter Nine Moving into New Territory

The nursing home setting presents many issues in the areas of food and dining and serving the individual. The table has now been set for the *Creating Home II* national symposium February 11, 2010. We invite you to join us and share what you think. Experts have been invited to share their experiences. Everyone is invited to come and share their own wisdom on these subjects at this event. Together we will create a welcomed and needed national dialogue about what needs to happen next. As Linda Roberts, registered dietitian and long term care consultant said at her 2009 Pioneer Network session on dining, "we are in new territory."

We invite you to pull up a chair to the table. This is the "menu item" of most interest to all of us: transforming our thinking and our systems to where the person and her/his individualized preferences are in the forefront.

What will your role be in cutting the paths in this new territory? What will you stand for? What are you willing to "take on?" Will it be volunteering to speak at a nursing course in your community? Will it be developing a research study? Will it be taking it on personally to educate just one physician? Will it be leading a committee in your facility? Thank you for what you have done, for what you are doing and what you will do.

And let this be what we stand for:

"The life of a nursing home resident...should be as similar as possible to the life he or she would choose to lead at home"
(Pearson, Hocking, Mott and Riggs, from *Journal of Advanced Nursing*, 1993).

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Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

DATE: May 29, 2009

TO: State Survey Agency Directors

FROM: Director, Survey and Certification Group

SUBJECT: Food Procurement at 42 CFR 483.35(i)(1)(2), Tag F 371, and Self Determination and Participation at 42 CFR 483.15, Tag F 242

Memorandum Summary

This memorandum clarifies that:

- The language at 42 CFR 483.35(i), Tag F 371 “Procure food from sources approved or considered satisfactory by Federal, State or local authorities” is intended solely for the foods procured by the facility. A revision has been made to the interpretive guidelines at F371 to further clarify this intent;
- Foods accepted by residents from visitors, family, friends, or other guests are not subject to the regulatory requirement at F 371; and
- Residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices at §483.15, F 242, Self Determination and Participation.

The Centers for Medicare & Medicaid Services (CMS) regulation at 42 CFR 483.35, Tag F 371, states that foods procured by the facility must come from sources approved or considered satisfactory by Federal, State, or local authorities. The surveyors should use the regulation and interpretive guidelines at F 371 when determining how the facility acquired food for resident consumption. This regulatory requirement does not expand beyond the scope of the intent to monitor how the facility procures food for the nursing home resident population.

The surveyor(s) should not use the food procurement regulatory language at F 371 to monitor any food(s) provided by visitors, friends, family members, or resident guests which the resident has chosen to accept. The facility does have a responsibility under the food safety regulatory language at F371 to help visitors to understand safe food handling practices (such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees F.) and to ensure that if they are assisting visitors with reheating or other preparation activities, that facility staff use safe food handling practices and encourage visitors and residents who are contributing to food preparation in the facility to use these safe practices as well.

A clarification has been added to F371, which CMS has released as an advance copy along with revisions to several quality of life and environment tags, with an issuance date of June 17, 2009.

The CMS regulation at §483.15, F242 protects the resident(s) right to choose to accept food from visitors, family, friends, or other guests (e.g., facility-sponsored activities such as a community pot luck). This regulation states, “the resident has the right to make choices about his or her life in the facility that are significant to the resident.”

When the survey team determines that a facility has not allowed a resident or residents to choose to accept food from any friends, family, visitors or other guests, the team should consult the regulation and guidance at F 242 to determine if the resident(s) rights have been violated.

For questions regarding this memorandum, please contact Debra Swinton-Spears at (410) 786-7506 or e-mail at debra.swinton-spears@cms.hhs.gov.

Effective Date: This clarification is effective immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: This information should be shared with all appropriate survey and certification staff, surveyors, their managers, and applicable staff.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Appendix B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

DATE: December 21, 2006
TO: State Survey Agency Directors
FROM: Director, Survey and Certification Group
SUBJECT: Nursing Home Culture Change Regulatory Compliance Questions and Answers

Memorandum Summary

This memorandum provides the State Survey Agencies and CMS regional offices with:

1. Responses we have made to inquiries concerning compliance with the long-term care health and life safety code requirements in nursing homes that are changing their cultures and adopting new practices;
2. Summarizes questions and answers from a June, 2006 CMS Pic-Tel conference with leaders of the Green House Project (*Attachment A*); and
3. Provides information about an upcoming series of 4 CMS culture change satellite webcasts (*Attachment B*).

Following are regulatory questions that have been sent from culture change organizations from 2004 to date, along with our answers:

Question 1: Tag F368 (Frequency of Meals): You request a clarification that the regulation language at this Tag that “each resident receives and the facility provides at least three meals daily” does not require the resident to actually eat the food for the facility to be in compliance. You also ask for clarification about the regulatory language specifying that there must be no more than 14 hours between supper and breakfast (or 16 hours if a resident group agrees and a nourishing snack is provided). You state that some believe this language means all of the residents must actually eat promptly by the 14th hour, which makes it difficult for the facility to honor a specific resident’s request to refuse a night snack and then sleep late.

Response 1: The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at Tag F242, Self-determination and Participation. You are correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complains about the food items provided. If a resident is

sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident to eat when they awaken (such as continental breakfast items) if they desire any food before lunch time begins.

Question 2: F370 (Approved Food Sources): You ask if the regulatory language at this Tag that the facility must procure food from approved sources prohibits residents from any of the following: 1) growing their own garden produce and eating it; 2) eating fish they have caught on a fishing trip; or 3) eating food brought to them by their own family or friends.

Response 2: The regulatory language at this Tag is in place to prohibit a facility from procuring their food supply from questionable sources, in order to keep residents safe. It would be problematic if the facility is serving food to all residents from the sources you list, since the facility would not be able to verify that the food they are providing is safe. The regulation is not intended to diminish the rights of specific residents to eat food in any of the circumstances you mention. In those cases, the facility is not procuring food. The residents are making their own choices to eat what they desire to eat. This would also be the case if a resident ordered a pizza, attended a ball game and bought a hot dog, or any similar circumstance. The right to make these choices is also part of the regulatory language at F242, that the resident has the right to, “make choices about aspects of his or her life in the facility that are important to the resident.” This is a key right that we believe is also an important contributing factor to a resident’s quality of life.

Question 3: Tag F354 (Registered Nurse): “Can the traditional DON role be shared with several registered nurses with each nurse responsible for one or more households or clusters?”

Response 3: The interpretive guidelines (i.e., Guidance to Surveyors) already contain this language: “The facility is required to designate an RN to serve as DON on a full time basis. This requirement can be met when RNs share the position. If RNs share the DON position, the total hours per week must equal 40. Facility staff must understand the shared responsibilities.” Thus, the position can be shared; however, a comprehensive set of duties and responsibilities of a DON is not specified in the regulations or interpretive guidelines. We interpret this role to encompass not only general supervision of nursing care for the facility, but oversight of nursing policies and procedures, overall responsibility for hiring/firing of nursing staff, ensuring sufficient nursing staff (F353), ensuring proficiency of nurse aides (F498), active participation in the quality assurance committee (see Tag F520), and responsibility to receive and act on communications from the pharmacy consultant about medication problems (Tags F429 and F430). A facility that desires to have various people share the DON position would need to consider how these DON duties will be fulfilled in a shared position. As long as these duties are fulfilled, we would consider the facility in compliance with F354, whether or not the position is being shared.

Question 4: Tag F521 (Quality Assessment and Assurance): You ask whether the regulatory responsibility for this committee to “meet” can be fulfilled if the physician member is not physically present, but is participating through alternate means, “such as conference calls or reading minutes/issues and giving input.”

Response 4: Yes, participation can be achieved through means of telephone conferencing, however, we do not accept the alternative of the physician merely reading documents before or after the meeting. We believe the purpose of these meetings is to provide a forum for discussion of issues and

plans, which cannot be adequately fulfilled if the physician is merely reading and commenting on documents, since this does not allow for the interchange of ideas.

Question 5: (HIPAA and Principles of Documentation): You express concern that the Statement of Deficiencies that surveyors write, which is a publicly posted document, may violate a resident’s right to privacy, since the details may identify a specific resident to the public.

Response 5: We have received other comments on this issue, and have provided guidance to our State Survey Agencies and CMS regional offices on our interpretation of this issue in our Survey and Certification (S&C) memorandum #04-18. All our S&C memoranda are stored on the CMS website for public access at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp>

Question 6 (Handrails): Could the interpretive guidelines explain that handrails are not necessary at the very ends of the hallways on the very small sides of the door? This would allow for filling these unused areas with live plants, for instance, without obstructing egress and handrails would still be available up to the end of each hallway.

Answer 6: The purpose of the handrail requirements at Tag F468 is to assist residents with ambulation and/or wheelchair navigation. They are a safety device as well as a mobility enhancer for those residents who need assistance. The survey team onsite would need to observe the responses of residents to the placement of objects that block the portion of the handrails that is at the end of a hallway. They would also interview residents to gain their opinion as to whether the objects in question are interfering with their independence in navigating to the places they wish to go.

Question 7 (Resident Call system): Could the resident call system (F463) regulation that requires calls to be able to be received at the nurses’ station be changed to also include nurses’ work areas and direct care workers, as well as the nurses’ stations? Many homes moving away from the institutional model are replacing nurses’ stations with normal kitchens, living room and dining room areas, and using systems whereby resident calls connect directly to caregivers’ radio/pagers. Because it is harder to change the text of regulation, could the phrase “at the nurses’ station” be removed from the following sentence in the Interpretive Guidelines: “The intent of this requirement is that residents, when in their rooms and toilet and bathing areas, have a means to directly contact staff at the nurses’ station.”

Answer 7: We agree that it is desirable for residents and/or their caregivers or visitors to be able to quickly contact nursing staff when they need help. To meet the intent of the requirement at F463, it is acceptable to use a modern pager/telephone system which routes resident calls to caregivers in a specified order in an organized communication system that fulfills the intent and communication functions of a nurse’s station. We will make a change in the Interpretive Guideline to reflect this position.

Question 8 (Posting of Survey Results): Would CMS consider adding to the posting requirements at Tag F156 [42 CFR 483.10(b)(10)], text similar to that stated in Tag F167 about posting of survey results, “...or a notice of their availability?” Although this may just be trading one posting for several, some homes really want to create a homey environment without so many postings and many homes are placing postings into a photo album or binder to minimize the institutional look of so many postings.

Answer 8: The purpose of the posting requirements at both F156 and F167 is for residents and any other interested parties to be able to know the information exists, and to easily locate and read the information without needing to ask for it. What you request above, namely one posting that advises the public of what information is available to meet requirements of both Tags, is acceptable, as long as the information itself is in public and easily accessible, such as in a lobby area in a marked (titled) notebook or album. This includes the following information:

- “A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit;” (F156)
- “Written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits;” (F156) and
- The facility, “must make the results available for examination in a place readily accessible to residents and must post a notice of their availability.” (F167)

Question 9 (Hallway Width): Does the 8 feet requirement (at LSC Tag K39) continue to be necessary since evacuations are no longer done via wheeling a person out of the building in a bed? Could 6 feet meet the requirement? If 6 feet sufficed, this would again refer back to our question regarding the requirement for handrails when something else such as a bench might take up the other 2 feet.

Answer 9: The 8 foot corridor width is a requirement of the Life Safety Code (LSC). Corridors remain a route to use in internal movement of residents in an emergency situation to areas of safety in different parts of the facility. This movement may be by beds, gurney or other methods which may require the full width of the corridor. We do not believe it would be in the best interests of the residents to reduce the level of safety in a facility.

Question 10 (Tag K72 and Exits): In regard to LSC Tag K72 (no furnishings, decorations, or other objects are placed to obstruct exits or visibility of exits), can secured unit doors be disguised or masked with murals, etc.? Staff typically will be the ones to use these doors in the case of emergency and will know where they are. By disguising exit doors, resident anxiety of wanting to go out them may decrease.

Answer 10: The life safety code allows some coverings on doors, but not concealment. The code also specifically forbids the use of mirrors on a door. It is a judgment call by the survey team as to what would be considered concealment of the door, but in general the door must still be recognizable by a non-impaired person (such as a visitor). The code does not allow the removal or concealment of exit signs, door handles, or door opening hardware.

Question 11 (Dining Together): Is it permissible for staff and residents to dine together?

Answer 11: There is no federal requirement that prohibits this. We applaud efforts of facilities to make the dining experience less institutional and more like home. Our concern would be for the facility to make sure that residents who need assistance receive it in a timely fashion (not making residents wait to be assisted until staff finish their meals).

Question 14 (Candles): Can candles be used in nursing homes under supervision, in sprinklered facilities.

Answer 14: Regarding the request to use candles in sprinklered facilities under staff supervision, National Fire Protection Association data shows candles to be the number one cause of fires in dwellings. Candles cannot be used in resident rooms, but may be used in other locations where they are placed in a substantial candle holder and supervised at all times while they are lighted. Lighted candles are not to be handled by residents due to the risk of fire and burns. If you would like to discuss this issue, you may contact James Merrill at 410-786-6998, or via email at james.merrill@cms.hhs.gov.

Question 15 (Tablecloths): Are cloth tablecloths and napkins permissible in nursing homes?

Answer 15: There is no regulation that prohibits it and, in fact, the use of these items is greatly preferable to the use of bibs, as bibs can detract from the homelike attractiveness of the dining room setting.

Beginning November 3, 2006, (see attached) CMS is broadcasting a 4-part series on culture change through fiscal year 2007. Three of the broadcasts, produced by the Quality Improvement Organizations (QIOs), will highlight culture change principles and outcomes from the QIO scope of work. The other broadcast, produced by CMS, will explore changes being made to medical and nursing care practices and policies in terms of compliance and the survey process.

We are including information on the series for your convenience. We believe this broadcast series will be of interest to providers and other stakeholders, as well as State Survey Agencies. We encourage States, CMS regional offices, and QIOs to consider setting up joint viewing opportunities for survey personnel, stakeholders, and nursing home staff when possible. As with all CMS broadcasts, these broadcasts may be viewed either live via satellite or internet, or via internet for a year after each broadcast.

For questions concerning this memorandum, please contact Karen Schoeneman at (410) 786-6855 or via e-mail at kschoeneman@cms.hhs.gov.

Effective Date: Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum, and disseminate the information to affected providers.

Training: The information contained in this announcement should be shared with all nursing home surveyors and supervisors.

/s/

Thomas E. Hamilton

Attachment

cc: Survey and Certification Regional Office Management (G-5)