

Appendix D

Regulatory References



MARK B HORTON, MD, MSPH
Director

State of California—Health and Human Services Agency
California Department of Public Health



ARNOLD SCHWARZENEGGER
Governor

October 19, 2007

Jocelyn Montgomery, R.N.
Director of Clinical Affairs
California Association of Health Facilities
2201 K Street
Sacramento, CA 95853-7004

Dear Ms. Montgomery:

The California Department of Public Health, Center for Healthcare Quality (CHQ), is pleased to support the California Culture Change Coalition's Person-Directed Dining Pilot Project.

While the health and safety of individuals who live in licensed facilities is everyone's first concern, quality of life and resident preference are equally important. The CHQ staff look forward to the opportunity to work with the Coalition to identify person-directed dining practices that meet regulatory requirements while expanding food choices for residents in nursing homes.

Please do not hesitate to contact me or my staff at (916) 324-6630 if you need any assistance in implementing this important pilot project. I look forward to collaborating with our many partners to make "person-directed" care a reality in California nursing homes.

Sincerely,

Kathleen Billingsley, R.N.
Deputy Director

cc: Next Page

Ms. Jocelyn Montgomery
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cc: Ms. Pamela L. Dickfoss, Chief
Headquarter Operations Branch
Licensing and Certification Program
California Department of Public Health
1615 Capitol Avenue, MS 3001
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DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

Refer to: WCDSC-
February 12, 2008

To: California Culture Change Coalition Person Directed Dining Pilot Project Core Committee
CCCC Contact Person: Jocelyn Montgomery, RN, PHN

From: CMS Region IX Survey and Certification Unit, and the Department of Public Health, Licensing and Certification.

CMS Contact Person: Retired Capt Eloise Beechinor, RD, MPH

DPH Contact Person: Patty Pasquarella, RD, MPH

Subject: Centers for Medicare and Medicaid Service Region IX/ California Culture Change Coalition Person Directed Dining Pilot Project

As the California Culture Change Coalition (CCCC) moves into implementation of the Person Directed Dining Pilot Project, you have requested guidance regarding specific elements of person-directed care that you feel may put providers at risk for noncompliance with regulatory requirements. The main elements that you have asked the Centers for Medicare and Medicaid Services (CMS) Region IX and the Department of Public Health Licensing and Certification (DPH L&C) to comment on are:

- Honoring resident choice when therapeutic diet orders are in place and the residents' choice is not compliant with that diet order.
- Assessing intake and nutritional status of residents who participate in buffet style, family style, and/or free access to a resident refrigerator where portion sizes are not controlled, and the amount and types of food choices the residents makes may not be nutritionally balanced.
- Maintaining reasonable infection control precautions in a family style, and/or resident "snack center" situation where multiple residents may be touching bowls, utensils, and packages of food.

QUESTION 1:

*OBRA regulations support "self determination" and a resident's right to make choices about aspects of their lives that are important to them. Person-directed dining practices such as buffet and restaurant – style menus, and snack centers where residents have an array of food items from which to choose, expand the choices that residents have about **what** (types and kinds of food and fluids) **when**, (various times during a 24 hour day), **where**, (selected physical location such as choice of which dining room, activity room, outside such as on patio, bedroom, corridor, in front of the nurses station, **who** (alone or choice of which other residents, families, visitors, and/or staff), **how much** they want to be served (small or double portions, and/or seconds of some favorite food/s) and **how much** they want to eat (actual*

intake). We anticipate that this may result in some instances where residents with clinically appropriate therapeutic diet orders will exercise their choice to eat types and/or amounts of food (more or less) that are not in keeping with those daily physician ordered diets. The CCCC recognizes that it is the responsibility of the facility to assess, monitor, plan, educate the residents about their risks, and work with the resident to provide care that is consistent with both their needs and their wishes.

- What other actions would the facility be expected to take in this kind of situation in order to have met their regulatory responsibilities to provide care and services to meet that individual's needs?

CMS RESPONSE to QUESTION 1:

CMS and DPH staff responsible for enforcing facility compliance with both the Federal regulations and California licensure laws recognize that it is the responsibility of the facility to **assess** each resident to identify their individual clinical and educational needs, preferences, and dehydration, under-nutrition, pressure ulcer and other dietary risk factors. On going resident assessment may be accomplished when the facility's direct care workers **observe, monitor and report** individual resident's actual food and fluid consumption. The facility is expected to act on their monitoring of on-going resident's independence/dependence to obtain adequate nutrition/hydration and clinical outcomes including but not limited to the presence of illness including wounds, medication effects, appetite/taste changes, depression, pain, difficulty in chewing and swallowing, infection and fever and nutrition and fluid intake through observation, weights, and (if indicated) lab tests. **Based on these assessments**, the facility should offer the residents opportunities to choose food and fluid alternatives that are compatible with their abilities to chew and swallow, dietary needs, and desires. The facility should also **educate** the residents (or their responsible decision-maker), in a manner that they can understand, about the risks and benefits of their healthy or unhealthy food choices and/or refusal of a therapeutic diet, and offer alternative foods and fluids while continuing to provide the therapeutic diet. We also recognize that in order to provide individualized care that meets each resident's needs, facilities will need to re-design their dining systems **with input from residents, staff and family if possible**. Facilities must also ensure that **staff is trained and available to provide individualized assistance**.

In general, for healthy individuals, the diets should follow available food guides. For example, in this population special consideration should be given to adequate sources of calories, protein and dietary fiber. All residents need to be individually assessed to determine if they could benefit from nutrient-dense foods, such as high fiber, additional calories, protein, iron, calcium, and/or other vitamin and mineral rich foods.

If any individual is eating and drinking foods and fluids that are not included within their individual designed therapeutic diet order, the facility, if possible, should **determine if the individual understands of any diet restrictions**. These individual residents should be allowed to dialog and respond to staff and others, with his or her specific reasons about why they are choosing to eat and drink foods that are not included within their individual designed therapeutic diet plan. **A discussion of each applicable resident's specific information should occur with the interdisciplinary team (all appropriate professionals involved) including the resident or resident's representative**. Health care workers would ideally communicate and share information with these residents, families, or significant others in ways that are useful to residents concerning his/her food and fluid consumption choices.

Staff participants may need to be flexible in allowing certain foods prohibited on any resident's dietary restrictions and focus on the role of nutrition in maintaining health in the nursing home's residents. While the facility is required to follow the doctor's orders for a resident's diet, staff participants may need to clarify information to the doctor regarding the resident rights and the role of nutrition in maintaining the resident's health and quality of life.

It is recommended that residents and families receive timely, complete, and accurate nutrition and hydration education information. Ideally residents' would use this information in decision making concerning his/her quality of life, resident rights and quality of care; that is choices and decision -making about what to eat, how much to eat, when to eat, where to eat and with whom to eat. Resident Councils and Family groups are opportunities for input, suggestions, planning, and education for implementation according to residents' choice and preferences regarding all aspects of eating, drinking, and dining. **On-going input should be solicited and considered from capable residents.**

Staff should use observation, active listening to residents with concurrent interviewing, clinical record documentation and information-sharing interventions. These methods must all be employed in an effort to solve any resident specific nutrition/hydration concerns and plan interventions that support the individual towards good clinical outcomes and satisfaction with his/her care including all aspects of the dining experience.

Remember to keep current individual resident assessments and documented evidence of planned interventions for any potential causal reasons (physical or psychosocial) for nutritional status decline, potential for dehydration or decline of lack of improvement in any resident's functional eating abilities. No facility should ever wait for resident weight loss before they act.

Key attributes of Resident –Centered Care:

Sufficient staff time and assistance must be provided to maintain eating abilities. (e.g., allowing residents enough time to eat independently or with limited assistance)

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.

Key is respect for resident-centered values, preferences and expressed needs, including an awareness of quality-life issues, involvement in dining related decision-making, dining with dignity and attention to individual resident's needs and autonomy in food choices.

Health care workers who are consistently assigned to those individual residents need to listen, document any conversations, care conference discussions, and decisions of the resident and/or family regarding nutritional interventions in the individual resident's medical or clinical record and honor resident and family perspectives and choices. Resident and family knowledge, values, beliefs and cultural backgrounds should be known by these involved staff, and/or attempts to obtain this food and fluid history of food likes and dislikes, previous and current nutritional intake, each resident's eating habits and preferences, dietary restrictions, supplements and use of adaptive dining (eating) equipment.) This information should be used for consideration in incorporation into the planning and dining delivery for each resident's participating in the Directed Dining Pilot Project.

A Person - Directed Dining Pilot Project Quality Control System must be in place for monitoring and supervision of staff resulting in good outcomes for both staff and residents, and this system must be effective in identifying the root cause of any nutritional problems such as dental care or disease, dysphasia, ability to chew and swallow mechanically altered food, altered taste, hunger, uneaten meals do to lack of staff assistance, or mobility problems, etc.

It is recommended that each facility determine a system to demonstrate measurable outcomes towards excellence in resident-centered care as experts in implementing the Person Directed Dining Pilot Project.

Staff would be responsible for on going daily monitoring of each resident including any complications for any individual resident on a therapeutic diet and administering corrective actions as needed.

In summary, staff should take into account the resident's clinical condition such as history of being admitted underweight and malnourished, severe congestive heart failure, peripheral edema, history of dehydration, cachexia . Did the facility identify factors that put any individual resident at risk for malnutrition or dehydration? Did staff document any negative consequences and take action to prevent any potential or actual decline?

DPH L&C RESPONSE – ADDITIONAL REMARKS to QUESTION 1:

The provision of service would include the availability residents' food choices, variety, and accessibility as determined by the residents. Meal plans include variations in the number and sizes of meals and snacks as well as accommodation of resident preferences. A health professional's expertise is utilized to incorporate favorite foods; **however, there may be the rare instance when resident's choices can not be integrated.**

The question acknowledges the need for staff training and provision of individual assistance, however since culture changes includes changes for staff, it may be of benefit to identify that the training **should include staff's recognition when to act.** Perhaps in addition to individualized care, there are also benefits to create and establish systemic methods for staff to implement these nutrition approaches. **This would require the facility dietitian's coordination and involvement to ensure policies and procedures are created, are feasible to carry out and are implemented via trained and competent staff within the operational constraints of the facility.**

QUESTION 2:

*What is the CMS and DPH position on **liberalizing diets** to allow for more normalized menus for residents in skilled nursing facilities?*

CMS RESPONSE to QUESTION 2:

CMS Region IX supports the **Position Statement of the American Dietetic Association** that the quality of life and nutritional status of residents in long-term care facilities may be enhanced by liberalization of the diet prescriptions.

CMS advocated the use of qualified Registered Dietitians to assess and evaluate the need for therapeutic diets nutrition therapy according to each resident's individual medical condition, needs, desires, and rights.

Nutrition care must meet both maintenance of the highest practical level of physical, mental, and psychosocial health. It also must promote the highest practical "Quality of Life"; including the resident's satisfaction with the food, meal service and dining experience for each resident residing in these certified Nursing Facilities.

DPH L&C ADDITIONAL REMARKS to QUESTION 2:

Any changes to meals and diet order are part of the resident care planning meetings in which the resident and/or family members are included. Typically, the appropriate diet order is based on the intent of the medical care for this later stage of life and resident's choices. The benefit of therapeutic diets should be determined on an individual basis by the physician who is responsible for directing the resident's care and writing the diet order. Physicians are typically responsive to their patient's wishes and requests. **Care for the elderly population supports liberalized therapeutic diets as ordered by the resident's physician and have been successfully incorporated in skilled nursing facilities.** Health professionals can communicate to other care team members any occurrence that compromises a resident's medical condition or safety.

The facility should individually assess when a therapeutic intervention may be appropriate during a decline or a change of condition. **It would be appropriate to see the interdisciplinary team discussion during change of condition/declines as they relate to a less liberalized diet in order to address an acute phase. However, it would also be the facility responsibility to reassess and return to the liberalized diet once the acute phase of the change of condition was over.**

QUESTION 3.

*OBRA and state regulations require that food be stored, prepared and served in a manner that prevents contamination and the spread of food-borne illness. In supporting the practice of moving towards a "home-like" environment, facilities plan to offer residents a chance to serve themselves food in a "family – style" from communal bowls, or from a buffet or salad bar, and/or from a refrigerator where they will have free access to snacks. We recognize that it is the facility's responsibility to ensure that supervision is provided to protect that food from contamination, and/or to replace contaminated food before it is served. We also recognize that staff must ensure that food is **not allowed to cool or warm** to an unpalatable state during*

*the meal or snack service. Additionally we know it is the facility's responsibility to **ensure that the residents do not touch food that is available to other residents with their bare hands** and so proper serving utensils, training, and/or individual packaging must be in place in these situations.*

- *What other actions would the facility is expected to take in this kind of situation in order to have met their regulatory responsibilities to provide safe and palatable food?*

CMS RESPONSE to QUESTION 3:

Staff would be responsible for to ensure that food is served at residents' **preferable temperature** (hot foods are served hot and cold foods are served cold) as discerned by individual residents and customary practice.

Each facility should maintain a **policy and procedures** with a current list of what specific temperature the facility, will serve each food item on the menu and temperatures for each specific food items at when each resident receives their meal.

For example, you might consider such variables as hot foods that cool down rapidly at room temperature. These foods may need to be batched cooked, held and served when residents are ready to eat them in order to maintain palatable temperatures. Another example might be second portions of gravy could be held on the stove, not allowed to cool to unpalatable temperatures on the dining tables., until the residents are ready to serve themselves additional gravy. Soup could be held in a specially designed piece of equipment to hold the hot soup at the resident desired temperature.

DPH L&C ADDITIONAL REMARKS TO QUESTION 3:

The facility's responsibilities are succinctly presented in the question. Additionally, there should be some **form of time and temperature monitoring** to ensure both food safety and/or palatability. For buffets and snack centers, **food protection** is to be considered and for **resident safety** in the placement of hot items.

The development of systems and **training/competence assessment** for staff to implement this new system would be essential to the success of the culture change.

QUESTION 4:

*Are there certain resident- specific practices that the regulators would expect to be implemented such as providing hand sanitizer to residents before meals or refrigerator access, or limiting the access of individuals who **are hepatitis or MRSA positive**?*

CMS RESPONSE to QUESTION 4:

Facilities will need to re-design their dining system with input from residents, staff and possibly families. Person-directed care implies responsibility on the part of residents as well as protection of their rights. Residents should be encouraged to offer their strategies to address food safety and sanitation through a facilitated meeting to plan the resident access portion of

person-directed dining. Residents should review any new policies regarding person-directed dining to assure that they agree with the institution of the policies and to offer other suggestions or refinements. **For the vast majority of residents, simple precautionary steps will minimize the danger from acquiring or spreading pathogens.**

With a new dining system, all processes must be planned before initiation and will include consideration for practices that prevent the growth and spread of pathogens or germs. In keeping with general facility practice, Centers for Disease Control (CDC) **Standard Precautions** must serve as the guide for allowable practice. Monitoring of practice and behaviors is the keystone to success of this part of person directed dining. **Specific monitoring of plans, assignment of responsibility and developing appropriate tracking measures must be included in plans.** Results of monitoring should be shared through the **QAA Committee** and necessary changes made as needed. The person responsible for infection control for the facility should be consulted. Facility staffing levels must be adequate to not only provide for person directed dining, but also to **oversee and monitor the program for safety and effectiveness.**

The following comments are designed to address resident participation in person directed dining activities that include family style dining, self serving of meals or snacks and any food activities that involve groups of residents. **Any new Person-Directed practice must include facility consideration for control of the following: contact precautions and isolation of individuals infected with pathogens transmitted by contact, respiratory isolation of those who might transmit respiratory disease and control of the food environment to prevent environmental contamination.** Specific measures that must be addressed include the following (See Siegel, JD, et al, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007) (<http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>):

1. Identification of individuals “at risk” for transmission of disease and specific plans for those individuals which might include use of mask or gloves.
2. High risk dining or cleaning activities that might need extra steps or protective measures.
3. Choice of dinnerware:
 - a. Regular china or dinnerware implies that strict control of personal use and proper cleaning will be conducted
 - b. Disposable dinnerware as appropriate to resident need and condition
4. Oversight and assignment of responsibility for this new activity must be clear and consistently applied.

Consideration of infectious agents with important infection control implications includes C.Difficile, Multidrug-Resistant Organisms (MDROs) and Hepatitis. Early identification of staff or residents with any of these conditions who are participating in person directed dining is most important in controlling the spread of such infections and implies that appropriate control measures will be taken based on CDC guidelines (www.cdc.gov).

1. **C.Difficile** control requires that any residents identified with this pathogen receive “Contact Precautions” and strenuous environmental control measures. Such residents are not appropriate for participation in person directed dining until cleared of the infection and with orders releasing them to participate in the dining program by their physician.

2. **MDRO** control is essential and primary to the well-being of all the residents and staff in a facility and any residents identified with MDROs must avoid the person directed dining program until cleared by their physician.
3. **Hepatitis A** can be transmitted via food and water and would preclude participation in person directed dining of a Hepatitis A positive resident or staff until no longer positive, while **Hepatitis B and Hepatitis C are NOT spread by food, water or casual contact. Thus, residents who may be Hepatitis B or Hepatitis C positive should be allowed to participate in person directed dining** and encouraged to follow the same guidelines as any other resident.
(<http://www.jan.wvu.edu/media/hep.html>)

DPH L&C ADDITIONAL REMARKS TO QUESTION 4:

The answer to your question is "no"; there are no resident - specific practices that would be appropriate for residents of a long-term care facility known to be carriers of any pathogen. **Standard ("universal") precautions are appropriate for any resident who can be maintained in a hygienic condition and are able to control or to have contained their secretions and excretions. Those who cannot may have special precautions applied,** but this should be on the basis of their condition, not knowledge or lack of knowledge of their status regarding carriage of any pathogen.

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-07

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)

ATTACHMENT A: Dialogue with Green House Representatives

Following are some questions and answers from the June, 2006, interactive television conference between CMS central and regional offices and leaders of the Green House Project. The questions from CMS staff about certain features and ways of performing tasks in Green Houses were answered by Green House staff. These items are not CMS policy interpretations per se, but are included here to provide examples of the manner in which some nursing homes are providing more individualized care within the regulations.

Green House Q1: How do Green Houses accommodate dependent diners in the dining model?

Answer 1: Staff sit with the elders and assist them directly.

Green House Q2: How many beds is the maximum planned for the design of a Green House?

Answer 2: The early Green Houses were built for 12 beds. The Green House leaders believe that no more than ten beds is ideal, and if they increase it to 12, they will be pushed to go higher. They intend to stay with a design accommodating ten beds.

Green House Q3: The (Green House) presentation referenced the facility having 10 bedrooms, but the building floor plan provided shows that four of the bedrooms had double beds and the remainder of the bedrooms had single beds. If the bedrooms with double beds had two residents, the facility could have 14 residents.

Answer 3: There would only be two residents in a bedroom with a double bed if the elders were a married couple.

Green House Q4: Who administers medications?

Answer 4: Nurses administer medications at Cedars in Mississippi. In Kansas, the Shahbazim can be Certified Med Techs. If allowed by State law, some meds are administered by medication aides.

Green House Question 5: Are all future Green Houses intended to be skilled nursing facilities or nursing facilities (SNFs or NFs)? Are all Green Houses that are operational SNFs or NFs?

Answer 5: For future construction, this is the intent. However, where SNF certification is not allowed, such as due to CON laws in a State, the Green House Project is allowing them to be built as assisted living facilities. As for currently operating Green Houses in Mississippi and Nebraska, they are certified as nursing homes.

Green House Question 6: Do you intend to request any waivers from the federal regulations for future Green Houses?

Answer 6: We intend to comply with all provisions of the federal requirements without requesting any waivers.

Green House Question 7: NFPA 101 - 2000 edition, section 18.5.2.2 exception No. 2 requires fireplaces be separated from patient sleeping areas by a 1-hour fire resistance rating. RO staff asked how their plan met that requirement.

Answer 7: The Green House staff stated that the fireplace shown in the plan was not a working fireplace and therefore, did not have to meet the referenced code section.

**ATTACHMENT B: Four Part Series: From Institutional to Individualized Care
Part One: Integrating Individualized Care and Quality Improvement**

Centers for Medicare and Medicaid Services (CMS)
Satellite Broadcast and Webcast

Friday, November 3, 2006

1:00-3:30 PM EST

PLEASE ADJUST TIMES FOR YOUR TIMEZONE

On November 3, 2006 1:00-3:30 p.m. EST, the Centers for Medicare & Medicaid Services will broadcast a two and a half hour presentation via satellite and Internet on the topic of Integrating Individualized Care and Quality Improvement. This is Part One of a four part series: From Institutional to Individualized Care.

Goals

The goal of this broadcast is to provide a framework and practical examples to help LTC surveyors, providers, and consumers understand and support individualized care.

Objectives

After viewing this program, participants will be able to:

- Identify the roots and key features of individualized care;
- Describe how individualized care is integrated into overall facility operations;
- Describe the continuum of homelessness to home as a roadmap to individualized care;
- Identify various adaptations in care practices where quality of care plus quality of life leads to better clinical outcomes; and
- Describe quality improvement principles and practices that support a holistic approach to transformational change.

Faculty

Cathie Brady, Co-founder, B&F Consulting, Canterbury, CT

Brenda Davison, Director of Nursing, Jewish Rehabilitation Center of the North Shore, Swampscott, MA.

Barbara Frank, Co-founder, B&F Consulting, Warren, RI

Sandy Godfrey, Director of Nursing, St. Camillus Health Center, Whitinsville, MA

Marguerite McLaughlin, Manager of Educational Development, Quality Partners of Rhode Island, Providence, RI

Target Audience

This program is targeted to Regional Office and State Survey agency LTC Surveyors, LTC providers, QIOs and Consumers.

Registration and Viewing Instructions

For individual and site registration and viewing instructions go to:

<http://cms.internetstreaming.com>.

To obtain CEUs for viewing the training program you must go to the above CMS website.

Webcast Information

This program will be available for viewing up to one year following November 3, 2006 at

<http://cms.internetstreaming.com>

Continuing Education Units (CEUs)

The Centers for Medicare & Medicaid Services has been reviewed and approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET). To obtain CEUs for viewing the training program you must go to the CMS website

<http://cms.internetstreaming.com>

Satellite Technical Specifications

This broadcast will be available on C and Ku Digicipher bands. Specific satellite technical specifications will be available at

<http://cms.internetstreaming.com> or

can be obtained by calling 1-800-401-9387.

Handouts

A train-the-trainer manual will accompany this broadcast. The manual with relevant handouts will be available after October 23, 2006 at <http://cms.internetstreaming.com>

Copies:

Copies of this program, and the accompanying train-the-trainer manual and handouts, can be obtained from the National Technical Information Services at 5285 Port Royal Road, Rm. 1008, Sills Bldg. Springfield VA 22161. The phone number is (703) 605-6186.

Copies of featured segments used in this broadcast from Culture Change in Long – Term Care: A Case Study created by the American Health Quality Foundation can be purchased in its entirety by calling Imageworks at telephone number: 619-239-6161

JOIN THE CMS WEBCAST AND SATELLITE CONFERENCE!

Four Part Series: From Institutional to Individualized Care
Part One: Integrating Individualized Care and Quality Improvement

Webcast and Satellite Broadcast

Friday, November 3, 2006

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Presenters and Topics

Time	Topic	Presenter
1:00-1:10	Introduction to Show, Participants, and Goals	Marguerite McLaughlin Manager of Educational Development, Quality Partners of Rhode Island,
1:10- 1:15	Welcome	Thomas Hamilton Director of the Survey and Certification Group in the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services
1:15-1:25	Historical Perspective on Individualized Care's Roots in OBRA '87 and the recent work of the QIOs to advance it.	Barbara Frank Co-founder, B&F Consulting Cathie Brady Co-founder, B&F Consulting Marguerite McLaughlin, BS, MA
1:25-1:50	Introduction to the Holistic Approach to Transformational Change <ul style="list-style-type: none"> ○ Workplace and Care Practices ○ Transforming Bathing ○ Environment ○ Leadership ○ Family, Community, and Government 	Marguerite McLaughlin, BS, MA Cathie Brady, MS Barbara Frank, MPA
1:50-2:10	The Importance of Home <ul style="list-style-type: none"> ○ Home vs. Homelessness 	Cathie Brady, MS

Time	Topic	Presenter
2:10-2:40	Individualizing Care and Routines <ul style="list-style-type: none"> ○ From Institutional to Individual Care ○ Impact on residents ○ Impact on and perspective of staff ○ The “how” of change from a DoN 	Barbara Frank, MPA Sandy Godfrey Director of Nursing, St. Camillus Health Center
2:40-3:15	Integrating Individualized Care and Quality Improvement <ul style="list-style-type: none"> ○ Risk Prevention to Health Promotion ○ Harm caused by chair alarms – clip of family member who is retired DoN ○ Reducing falls by replacing alarms with individualized care, interview with DoN 	Barbara Frank, MPA Cathie Brady, MS Brenda Davison Director of Nursing, Jewish Rehabilitation Center of the North Shore
3:15-3:20	Quality Improvement Principles and Processes for Transformational change	Marguerite McLaughlin, BS, MA Cathie Brady, MS
3:20- 3:30	Your Systems Create Your Outcomes, Closing	Barbara Frank, MPA Marguerite McLaughlin, BS, MA

Faculty Biographical Information

Cathie Brady, MS, has over 25 years experience providing services and advocating for the elderly in a variety of settings. Her work has included organizational development, strategic management, adult education and training, and systems change work. Prior to co-founding B & F Consulting, she worked with the Paraprofessional Healthcare Institute; she held the position of Executive Director of the Department of Aging Services for the city of Bristol, CT; and before that she was, for ten years, the Regional Long-Term Care Ombudsman for Eastern Connecticut. As the Regional Ombudsman, she piloted a new approach to the Ombudsman program that helped the state support the implementation of OBRA '87 and she played a key leadership role in the work of Breaking the Bonds, a collaboration among providers, consumers, practitioners, regulators and state agencies to reduce restraint use and support individualized care practices. Cathie has a master's degree in Organizational Management from Eastern Connecticut State University. At B& F Consulting, she assists nursing homes interested in being better places to live and work. Her work integrates workforce retention, individualized care and quality improvement. She helps management, supervisors and staff build systems and skills to support ways of working better together. She works with intermediaries such as state workforce development organizations, QIOs, provider trade associations and practitioner organizations. She is currently working with Quality Partners of Rhode Island, the national support center for the nursing home work of Quality Improvement Organizations as they engage in a nationwide initiative to improve the nursing home caregiving and workplace culture. She also provides readiness training to regulators and advocates interested in supporting the transformation from institutional to individualized care.

Brenda Davison, RN is Director of Nursing at the Jewish Rehabilitation Center of the North Shore in Swampscott, MA. She has over twenty years of long term care experience. She has worked at various levels, including front line nurse and nursing team leader. As a Director of Nursing in another building, she brought the nursing home through the transition to OBRA compliance in 1990 – 1991. Brenda's background of working at various levels gives her insight into what her staff needs to be comfortable in taking on a challenge of being resident-centered and giving individualized care. She is able to operationalize changes effectively because she has the ability to understand both what residents need and her staff need. She works through the process of change in a way that focuses on staff understanding why they need to take on a change and how to take it on; and she takes it on by hearing from staff what they need, what their concerns and ideas are, and having that guide the process. In 2005, Brenda began to re-examine the usefulness of alarms in a long-term care setting and found that alarms in her building, instead of preventing falls, were actually contributing to an increase in falls. She began the process of alarm elimination. She did this in a systematic way that gave her staff, her residents, and family members the comfort level needed to challenge the long-held practice of using alarms as a falls prevention measure. To date, she has eliminated alarms in three out of four units and found significant reductions in falls as a result. In place of alarms, staff individualizes their care and attention to residents. Staff now realize that had been responding to alarms and not to residents and their needs. She is now speaking national and has been an instructor for the QIOs about her experience.

Barbara Frank, MPA, has thirty years experience in national, state, and local long-term care and workforce development work. For 16 years she directed policy and program work for National Citizens' Coalition for Nursing Home Reform in Washington, DC. In that role, she helped support the development nationwide of the Long-Term Care Ombudsman Program. She directed a Robert Wood Funded Project, The Consumer Perspective on Quality Care: The Residents' Point of View which shared with the Institute of Medicine Committee valuable information about residents' experiences and perspectives as they developed the report used as the basis for OBRA '87. She facilitated the Campaign for Quality through which providers, consumers, practitioners, and regulators developed consensus on a platform to translate the Institute of Medicine report into national law. She was then NCCNHR's

representative to the federal government stakeholder deliberations on the development of the regulations. Barbara was part of a team that designed and delivered training to surveyors on the implementation of OBRA'87 and she taught about OBRA'87 in training programs in dozens of states. She then served for 4 years as Connecticut's State Long Term Care Ombudsman from 1993 – 1997 and convened a collaborative process among providers, consumers, regulators, and practitioners to provide educational support to providers in reducing restraint use and implementing individualized care. From 1999-2004, she directed policy and program work in Massachusetts for Paraprofessional Healthcare Institute, where she developed and staffed the Direct Care Workers Initiative, a coalition of consumer, provider, and labor organizations working together to improve support for direct care workers. In 2004, she and Cathie Brady formed B&F Consulting, through which they have worked with Quality Partners of Rhode Island to support Quality Improvement Organizations in integrating individualized care, clinical quality improvement, and workforce retention. Barbara works directly with individual nursing homes supporting their change process. She uses this on-the-ground experience as a springboard for development of educational material for providers, surveyors, consumers, QIO staff, and other practitioners on how to improve their care outcomes by individualizing care to residents and support to staff. Barbara co-authored “Nursing Homes: Getting Good Care There” and “Health Care Workforce Issues in Massachusetts.” She has an MPA from the Kennedy School of Government.

Sandy Godfrey, RN, is Director of Nursing at St. Camillus Health Center in Whitinsville, MA, where she has worked in various positions over for the last eighteen years, including seven years as Director of Nursing. She began her nursing career in 1967 She was a clinical instructor in nursing at St. Joseph's Hospital School of Nursing in Providence, RI and has worked in lots of different health care settings over the years, including both acute and long-term care. When the Roman Catholic Order of St. Camillus decided to close the facility, she and the administrator, Bill Graves, organized local community businessmen to share with them in a plan to keep St. Camillus open and operating as a non-profit organization. They both currently serve on the Board of Directors. In 2004, soon after the successful transition, Sandy and Bill decided to embark on changing the culture from institutional to individualized care. One of the first places they started was with the morning routine. To succeed in individualizing residents' mornings, they put in place, at the staff's request, consistent assignments so that staff would know residents well enough to follow the residents' natural rhythms. Sandy describes initial hesitations about making the change because their resident outcomes and survey results had always been good. She worried about weight loss and other care issues emerging if she shifted from the tried and true of what the staff were doing. Key to her success was an open leadership approach that allowed staff, residents and families to identify any concerns and be a part of trying out solutions. Now residents awake of their own accord, eat breakfast according to their life-long patterns, and are much happier. She is a national speaker on her efforts and is forging forward with individualizing other aspects of care and life at St. Camillus.

Marguerite M. McLaughlin, MA is Manager of Educational Development at Quality Partners of Rhode Island. Ms. McLaughlin has 21 years of experience in long-term care specializing in individualized care/culture change, and dementia care. She is responsible for the oversight of the national Pilot Project “Improving Nursing Home Culture”, an initiative to bring Individualized Care to the nation’s nursing homes. As Lead Coordinator for that effort, she teaches and trains nationally and develops materials that integrate a holistic approach with clinical care. She earned a Masters degree in Holistic Counseling and applies this knowledge to individualized care and organizational culture.

In addition to her responsibilities at Quality Partners, Ms. McLaughlin serves as Instructor at the Community College of Rhode Island, in Warwick, Rhode Island, where she teaches aspiring health care professionals. While serving as Program Director for the Alzheimer’s Association, Rhode Island Chapter, Marguerite had the opportunity to train staff throughout the state, develop special care units using a person directed approach and counsel families through the hardship and difficulties experienced while caring for loved ones. She additionally worked with surveyors in developing an environmental assessment of special care units. She began her long-term care career as a Recreational Therapist at the

Saint Elizabeth Home in Providence, Rhode Island, and served as Regional Director for the Village Retirement Community. She received her Bachelor's of Science degree in Recreation from Springfield College, in Springfield, MA, and holds a Master of Arts degree in Holistic Counseling from Salve Regina University, in Newport, RI.

Four Part Series: From Institutional to Individualized Care
Part One: Integrating Individualized Care and Quality Improvement

Satellite Broadcast
TECHNICAL FACT SHEET

DATE: November 3, 2006

TEST TIME: 12:30 – 1:00 p.m. EST
11:30 – 12:00 p.m. CST
10:30 – 11:00 a.m. MST
9:30 – 10:00 a.m. PST

PROGRAM TIME: 1:00 – 3:30 p.m. EST
12:00 – 2:30 p.m. CST
11:00 – 1:30 p.m. MST
10:00 - 12:30 p.m. PST

**WEBCAST TROUBLESHOOTING
NUMBER:** 703-812-8816

**SATELLITE TROUBLE
NUMBER:** 410-786-3618

CMS Digital Network: Channel 712

Individuals and Sites outside of the CMS satellite network who wish to set up a site for this program or view this broadcast via webcast should go to <http://cms.internetstreaming.com> to register. Handouts can also be found at that website.

Satellite Coordinates

Analog C-Band: IA5 (Formerly Telstar 5: T5 or T1) 97° West				
Transponder	Polarization	Channel	Downlink Freq.	Audio
9	vertical	9	3880 Mhz MHz	6.2/6.8

Guidance for Locating Downlink Sites

In general, there are 2 major formats for satellite transmission - digital and analog. CMS uses both analog and digital formats, CMS's Digital network is a closed network which can only be viewed by its ten regional offices and several State survey agencies in regions VIII, IX, and X. The Digital format that CMS uses is called Digicipher. CMS is also capable of transmitting and receiving programs in KU-band and C-band analog. Ku-band and C-band have been in use for many years, can be received by thousands of 'steerable' analog dishes nationwide. C-band is the oldest transmission signal and the most widely used. NOTE: This is NOT 'video conferencing,' which is carried by telephone lines.

Locating an Analog Downlink Site

Potential Analog Downlink Sites: There are thousands of steerable analog downlink dishes nationwide at public schools, colleges, libraries, hotels, television stations, restaurants, private residences, etc. A few calls should locate one near you.

Here are some places to start calling:

- Your Local Cable and Satellite Television Provider: Contact your local cable/satellite television distributor, which is probably listed under "Television -- Cable & Satellite." Ask to speak with the programming staff and inquire about their willingness to simulcast the broadcast on your area's public access channel. Advise them that this broadcast is free of charge. Satellite television distributors may be able to provide you with a list of public institutions such as libraries, community centers, health care centers, and public schools that subscribe to their services. You may also wish to contact your local public TV station and ask that they download and air the program on their station.
- Public Libraries: Larger public libraries are a good place to check for satellite downlink facilities. Check library listings in the local government section of the blue pages of your local telephone directory.
- Educational Institutions: Universities, community colleges, and large public high schools often have satellite downlink capabilities.
- Hotels and Business Centers: Large hotels that frequently host conventions in business districts, may be able to receive satellite broadcasts. These hotels may charge a fee for viewing.
- Health Care Facilities: Many hospitals and health maintenance organization (HMO) offices have satellite reception capabilities.
- Copy Centers: Commercial office supply centers may also have satellite capabilities.

What Information Do I Need to Give the Site Contact Person?

When you contact an analog site, you will need to give the contact person the satellite coordinate information. The coordinates for the broadcast should be made available from the Central Office contact approximately 30 days prior to the broadcast. Here is the information you will need to provide:

- Transmission Type:
- Satellite:
- Orbital Location:
- Transponder:
- Polarity:
- Downlink Frequency:
- Satellite Help Hotline:
- Broadcast Schedule:
- Test Signal:
- Broadcast Title:

Reserving a Downlink Site

You will need to know what to ask the person who answers the phone, who may or may not be the best person at that organization to help.

If the facility has an analog satellite:

You are interested in viewing a satellite C-band and/or KU band analog broadcast and you understand that this facility may have that capability. You should have the satellite coordinates for reference. Some satellite dishes can't be pointed to all satellites.

You should also ask:

- If the facility can receive the broadcast, is the viewing room open to the public and not reserved for another use at the time of the broadcast?
- If the viewing room is available, how many people will it hold, and is there any fee for its use?
- Will the facility let you phone or fax your questions in to a toll free number?
- You should point out that this broadcast is open to the public and employees of the hosting facility with an interest in the topic are welcome.
- As a courtesy, you should offer the hosting facility a list of the people who will attend.
- Are there any special arrangements necessary for entry to the site?
- It is your responsibility to arrange for sign language interpretation if you anticipate that individuals with hearing impairments will attend.

If you find a site, you should be prepared to perform as site coordinator.

Typically, site coordinators will:

- Locate a suitable location.
- Promote the event locally.
- Direct individuals to register if necessary.
- Download material (e.g., sign-in sheet, evaluation, participant guide) if available
- Ensure that participants sign in on the day of the event.
- Distribute copies of the participant guide and handouts to participants the day of the broadcast.
- Assist participants with the use of the distance learning equipment.
- Receive instructions from the broadcast director regarding any activities they may be asked to facilitate.
- Encourage active participation in event activities.
- Record the broadcast for office use.
- Encourage participants to complete the evaluation form available at <http://cms.internetstreaming.com>

OBRA F TAGS/TITLE 22 THINKING POINTS

OBRA F Tags	California Code Title 22	Thinking Points
<p>*F 242 Self Determination and Participation (Resident right to choose activities, schedules, and health care, make choices about aspects of life)</p> <p>*F 325 (Revised 9/1/2008) Maintains Nutritional Status and Receives a Therapeutic diet when there is a nutritional problem</p> <p>F 365 Food prepared in a form designed to meet individual needs</p> <p>F 366 Substitutes offered of similar value (Probe: Observe trays to assure that food is appropriate to resident according to assessment and care plan. Ask the resident how well the food meets their taste needs, is offered substitutes)</p> <p>F 367 Therapeutic diets must be prescribed by the attending physician (Resident receives and consumes foods in appropriate form and/or the appropriate nutritive content as prescribed by a physician & assessed by IDT team)</p>	<p>72527 Patient Rights</p> <p>To be fully informed, to be afforded the opportunity to participate in plan of care, to be encouraged & assisted to exercise rights, right to refusal</p> <p>72315 (h) Each patient shall be provided with good nutrition, hydration</p> <p>72335 (a) (3) Patient food preferences shall be adhered to as much as possible and substitutes for all food refused shall be from appropriate food groups</p> <p>72335 (a) (c) All regular and therapeutic diets shall be prescribed by a person lawfully authorized to give such an order</p> <p>72339 Dietetic Service-Therapeutic Diets – Therapeutic diets shall be provided for each patient as prescribed, served with supervision and/or consultation from dietitian.</p> <p>72335 (7) Food shall be served with appropriate eating utensils and in a form to meet individual needs</p>	<p>---Person centered dining programs are about ensuring there are choices, based on resident interests and preferences</p> <p>---Resident has a right of choice even if it means not following a restrictive diet order (F 242 Self determination)</p> <p>---Preventing or denying residents on restrictive diets from participate in dining programs and snacks may be a dignity/rights issue</p> <p>---Facility staff should make efforts to (and document):</p> <ul style="list-style-type: none"> • liberalize restrictive diets, • ask residents regarding their preferences, • offer appealing foods that comply with the ordered dietary restrictions/diet manual (such as no concentrated sweets, no added salt), • educate/guide residents (not control) for choices, • clearly explain risk if dietary restrictions are not followed • monitor for nutritional status decline when they are non-compliant, and • inform/counsel resident <p>---Ensuring food choices have safe modified textures and thicken liquids as assessed for needs in all food activities</p> <p>---Ensuring assistance with adaptive equipment, set up help, and assistance is provided as assessed for need in all food activities (and accommodation of needs F 246)</p>

OBRA F TAGS/TITLE 22 THINKING POINTS

<p>*F 246-7 Reasonable accommodation of individual needs & preferences</p> <p>F 310 Activities of Daily Living : Maintaining eating ability</p> <p>F 369 Assistive Devices</p>	<p>72315 (g) Nursing Service-Patient Care</p> <p>Each patient requiring help in eating shall be provided with assistance when served, adaptive equipment in accordance with identified needs, to encourage independence in eating</p> <p>72329 Nursing Service-staff-Nursing service personnel with the qualifications determined by the Department to provide the necessary nursing services</p> <p>72341 Menus written, if any meal served varies from the planned menu, the change and reason for change shall be noted in writing</p>	<p>---CA state-specific restrictions against unlicensed staff who are not CNAs, or under certain conditions Nursing Assistants providing ADL assistance to SNF residents</p> <p>---Plan dining experiences and menus that serve to meet the recommended dietary allowances for the age group served</p> <p>---Ensure that residents who chose alternative dining patterns to the planned menu (such as sleeping in and not eating breakfast or skipping one of the 5 meals per day meal pattern) are offered substitutions and are monitored for nutritional status</p> <p>---Challenges with extended dining hours, buffets, chaffing dishes: Staff should take frequent temperatures to maintaining palatability/safety (hot at 135 degrees F or above, cold at 41degrees F or below)</p> <p>---Note: The revised F 371 with new surveyor investigative protocol for kitchen observation stated 135 degrees F for top of danger zone per the change in the Food Code 2005</p> <p>---Residents should be encouraged to report unpalatable foods; frequent replenishing of hot foods to conserve nutritional value/color, reheating of hot food to 165 degrees F if held over 2 hours (per current Food Code)</p> <p>--The intent is met when dining “opportunities” (such as snacks or open dining hours) are planned to meet the requirement for no more than 14 hours and yet allow resident choices (F 242 Self determination)</p>
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OBRA F TAGS/TITLE 22 THINKING POINTS

<p>*F 363 Menus and Nutritional Adequacy (Assure that the meals served meet the nutritional needs of a resident in accordance with the recommended dietary allowances)</p> <p>*F 364 Food that is palatable, attractive, and at the proper temperature</p> <p>*F 368 Frequency of Meals: No more than 14 hours between a substantial evening meal and breakfast</p> <p>*F 371 (Revised 9/1/2008) Sanitary Conditions (based on current Food Code which is the standard in the industry) and Food from approved sources</p> <p>F 441 Infection Control (Measures for preventing infection, orientation of all new facility personnel to the infection control programs and periodic updates for all staff)</p>	<p>72335 (7) Prepared & Served: Attractive & palatable meals, in which nutritive values, flavor and appearance are conserved</p> <p>72335 Dietetic Service-Food Service-Not less than 3 meals daily, not more than a 14 hours span between the last meal and the first meal of the following day</p> <p>72349 9c) (2) All food shall be of good quality and procured from sources approved</p> <p>72345 Dietetic-Sanitation</p> <p>72351 Personnel trained in basic food sanitation techniques</p>	<p>---Resident has the right to have foods from outside or brought in by the family. But staff should ensure that these are safely handled, labeled and dated if leftover or stored in refrigerators</p> <p>-The intent for ensuring safe food handling and infection control and following facility's policies & standards in the industry-applicable in all dining areas</p> <p>---Refrigerators: In pantry & resident rooms need temperature monitoring, food labeling & dating, and throw away oversight</p> <p>---Food Safety:</p> <ul style="list-style-type: none"> • Monitoring the time when cold and hot • Potentially Hazardous Foods (PHF – e.g. dairy, meats) are out of temperature control (4 hours or see Food Code for specifics); • leftovers must be reheated to 165 degrees F <p>---Buffet Style Dining: Consideration for safe food handling, maintaining temperatures, sneeze guards and covered individual food items, defining safe food handling when staff serving residents who display infectious behaviors</p> <p>---No bare hand contact with ready to eat for highly susceptible population (Food Code): Have assistants & activity aides wear gloves if handling food or reduce bare hand contact Note: Requiring gloves seems to be a conflict between the intent to protect highly susceptible residents and “home-like” dining; and the case probably could be made that gloves should not be required for staff who dine with residents</p>
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