CMS REGION IX/California Culture Change Coalition

The Person Directed Dining Pilot Project Practice Package

A Pilot Project to Enhance Dining Choices for People Living in Nursing Homes

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1. Introduction

The opportunities to make choices and express preferences are fundamental to our basic quality of life. But for a person living in a nursing home, sometimes the choices can be pretty limited. Scheduling demands, the need to maximize efficiency due to limited resources, and concerns about regulatory compliance often take precedent over individualized options in a traditional nursing home. The "culture change movement" seeks to remedy this by finding ways to empower the person receiving services, and/or those who work closest to them, to participate in choices about all aspects of their care. Additionally, culture change facilities adopt a philosophy that puts equal importance on the resident's quality of care and their quality of life; and what is more basic to quality of life than good food available when you want it?

Many providers are interested in making changes that expand the choices their residents have for what and when they eat, but they are not sure where to start. Common barriers to implementing change include concerns about expense, staff resources and how to make those changes without breaking regulatory "rules". In an effort to address some of these concerns and promote the implementation of person-directed innovations in California nursing homes, the California Coalition for Culture Change, in conjunction with the Center for Medicare and Medi-caid Services (CMS) Region IX and California Department of Public Health, Licensing and Certification (L&C), embarked on the "Person-Directed Dining Pilot Project".

In this "Person Directed Dining Pilot Project Practice Package", we have documented the projects, resources, and lessons learned by the eleven participating facilities over the course of the last year as they identified and implemented a new food-related practice in their facilities. Our hope is that this information will inspire and support other providers who are interested in expanding the dining choices for the people in their care. Although some of the information in this package is specific to California, most of it will be applicable to nursing homes through-out the CMS Region IX, and around the country.

Food offers a perfect vehicle for nursing home residents to make choices and enjoy the pleasure of a congenial chat over a snack, an attractive table landscape, or a delicious meal. Food-related activities are inherently rewarding, and a great place to start or add to a facility's repertoire of person-centered care. As James Beard, the great gourmet and cookbook author said; "Food is our common ground, a universal experience." In that spirit, we offer our experiences in person-directed dining to others who are seeking common ground and looking for a way to enhance the enjoyment of the people they serve.

2. The California Culture Change Coalition

Who We Are…

We are an action-oriented collaboration representing providers, resident-advocates, state and federal regulators and direct care workers dedicated to starting a "new conversation" about care in nursing homes. We have joined forces to foster culture change on a broader scale than can be achieved through any one of the organizations' individual efforts.

Our Partners:

- Aging Services of California
- American Association of Retired Persons
- California Advocates for Nursing Home Reform
- California Association of Health Facilities
- California Hospital Association
- California State Ombudsman
- Centers for Medicare and Medicaid Services–Region IX
- Lumetra
- SEIU
- Asian Community Nursing Center
- Kennon Shea and Associates
- Mercy Care Center
- H&M Composite Inc.

Our Vision…

Person-centered care that promotes the dignity of the individuals living and working in nursing homes.

Our Mission…

We seek to transform the culture of nursing homes by building relationship-centered communities that affirm the dignity, autonomy and value of each individual who lives and works there.

Regional Collaborative Strategy

The primary approach to accomplishing the Coalition's vision of transforming the culture of all nursing homes in California is through our Regional Learning Collaboratives. The California Culture Change Coalition is currently working with fifty-three homes in four locations in California to spread the principles and practices o culture change to these homes geographically dispersed all over California. The Collaboratives enroll nursing home "teams" – four to six individuals (selected by the home) representing staff throughout the home. Systemic transformational change does not rest with one individual and working in and with a team minimizes the impact of the loss of any particular manager. The homes are highly encouraged to include managers, charge nurses and at least one certified nursing assistant.

The Collaboratives are based on the Institute for Healthcare Improvement's "Model for Achieving Breakthrough Improvement." Considerable research has shown that learning collaboratives are an effective way to diffuse innovative ideas in healthcare settings, and to support the organizational change processes necessary for their implementation. In the Collaboratives, nursing home teams learn from each other as well as from the facilitators and expert faculty.

In general, this model consists of periodic learning sessions that include an educational component and discussion, the development and monitoring of action plans and interim monthly support meetings that provide opportunities for mentoring and mutual problem-solving related to the implementation of the action plans.

Statewide Conferences

In September of 2007 the Coalition conducted it first set of statewide conferences featuring Carmen Bowman, co-creator of the Artifacts of Culture Change. The "Bridge to the Future" conferences were a resounding success.

In February of 2009, the Coalition will once again host California's only state-wide conferences devoted to culture change entitled "Culture Change; The Heart of Clinical Care". The conferences will feature two national known nurse leaders in person-directed care, Mary Tellis-Nayak and Anna Ortigara, and will be held in Anaheim on February 17 and repeated in Sacramento on February 19.

Learn more about the California Culture Change Coalition

Visit: www.calculturechange.org or Email: info@calculturechange.org

California Culture Change Coalition
3313 Cutter Way, Sacramento, CA 95818
916.736.3285

3. Overview of the Person Directed Dining Pilot Project

Background

The California Culture Change Coalition is committed to the promotion of person-directed care in California nursing homes. In pursuit of this goal, we provide education to the public on the elements of culture change and teach providers about fundamental change through our regional collaboratives. This is a thorough and effective approach, but it takes time. The Coalition also recognizes that the journey to transformational change can begin by simply implementing one person-directed practice in a thoughtful way. This success often starts a chain reaction where providers begin to evaluate all their resident-related practices and then identify new opportunities for creating individualized care. The dining pilot offered the Coalition and a small group of facilities of facilities a chance to "just do it" so we could learn from the experience and provide useful guidance to others interested in taking a "first step".

Pilot Partners

The initial concept for the pilot was developed in April 2007 by the Pilot "Core Group", a subcommittee of the California Culture Change Coalition. The Core Group developed and presented a proposal in July 2007 to the CMS Region IX with a request for their support in the form a recruitment letter, and a promise of consultative participation. The Coalition also invited the California Department of Public Health, L&C's participation. Both regulatory agencies provided the coalition with letters of support, staff contacts, and written responses to practice-related questions, which were documented in a letter format (See Appendix D).

In addition to the participation of the regulatory partners, the Coalition depended on the expertise and time of many volunteers. These volunteers included dietician consultants, a university researcher, clerical support donated by California Association of Health Facilities, and countless hours from the Coalition members. The pilot structure involved a person who acted as "project lead" to manage and direct the project, the pilot Core Group that developed the concept and pilot materials, dietary and research consultants who acted as expert advisors on the project, the pilot participant teams, and a group of coalition members who volunteered to participate as Pilot Project Liaisons.

Pilot Project Liaisons

The role of the Pilot Liaison was to be a regular point of contact to the participant facility for the purpose of monitoring progress and collecting data. Each participating facility was assigned a Liaison who volunteered to schedule and conduct a monthly phone interview with their assigned facility contact person. A script was provided to the Liaisons for these calls, and they submitted written reports on these calls to the Pilot Lead.

The goal of the Liaison structure was twofold; first, to set up a simple, easy system for facility reporting through a structured interview, and second, to provide a regular platform between the facility participant and the Liaison where they could build rapport and have an open discussion of their practice experience. The Liaisons did not act as consultants on the specific pilot project practices, but rather as

data collectors and cheerleaders to their assigned facility. Liaisons were not required to physically visit their assigned facilities, but several did in the course of the six month tracking period.

Recruitment and Retention of Pilot Facilities:

The pilot core group began recruiting nursing homes around the state in October, 2007. Recruitment strategies included:

- The California Association of Health Facilities (CAHF) and Aging Services of California (ASC) publicized the project through their newsletters, email, and word of mouth.
- An announcement of the pilot was made at the Culture Change Accords (the coalition's state-wide conference) in September, 2007.
- Applications for the pilot were distributed at the CAHF Convention in November.
- All members of the coalition and the Pilot Core Group did outreach with providers.

Twelve facilities initially applied and were selected for participation in the pilot. One facility dropped out of the program before initiating their practice due to staffing changes. The remaining eleven facilities completed the pilot.

Provider Participation

The criterion for facility selection was a willingness to commit to the conditions of participation described below: Participation conditions included:

- Participation in a California Culture Change Coalition Regional Collaborative (this was optional and 5 out of the 11 facilities joined Collaboratives).
- Development of an action plan with time frames for the implementation, identification of key stakeholders, communication and training strategies, equipment acquisition, steps to implementation, and quality assurance measures. (Samples in Section 4 "The Practices").
- Communication with L&C District office regarding changes in services related to the selected dining practice (this was accomplished by a one-time phone call).
- Tracking of agreed upon measures as identified in the facility's action plan.
- Monthly reporting of practice progress and findings to the Pilot Project Liaison.
- Participation in quarterly conference calls with all the Pilot participants.
- Final evaluation and exit interview at the Pilot conclusion.
- Agreement to be listed in the final "Practice Package" as a resource to providers looking for more information about their dining practice experience.

Participating providers selected a practice for implementation out of a list including restaurant style, buffet, extended meal times, family style, and snack center or between meal choices. Of that list, the eleven participating facilities selected restaurant, buffet and expanded snack service. Their action plans were developed by the specific facility teams, and these served as the basis for their project implementation and internal evaluation. Provider participants agreed to a six month time frame from January 08 to July 08 in which they planned, implemented, tracked, and reported on their selected practices.

Technical Support

Technical support was provided to participating facilities in three ways:

- The California Culture Change Coalition Regional Collaboratives - Selected facilities were strongly encouraged to participate in the Regional Collaboratives and neighborhood meetings to be organized by the California Coalition for Culture Change.

- Question and Answer Support – Participating facilities were invited to "ask the experts" questions related to their pilot project dining practice. These questions were received by the Culture Change Coalition liaison that was assigned to their facility and then directed to the appropriate Culture Change Coalition member or consultant for response (e.g. CDPH, CMS, dietician consultants, culture change experts). Answers were provided by email or phone.

- Monthly Phone Check-in – A Liaison provided monthly phone check-in with each participating pilot facility. During this call they reviewed the status of action plan targets and time frames, reviewed evaluative measures, reported data and discussed general issues, questions, and lessons learned.

On-site consultation was not provided as a facet of this pilot due to limited resources. Reference materials were provided, and a list of resources in addition to some of the actual pilot reference materials are included in this package in Appendix E.

Pilot Measures and Evaluation

The Pilot's goal was to identify practice and implementation guidance which promotes the adoption of dining practices that accommodate resident choice in nursing homes in California. Two sets of measures utilizing qualitative measures were implemented in evaluating the accomplishment of this goal.

The first set of measures evaluated the effectiveness of the Dining Pilot structure and the technical support provided. Data was collected for six months primarily through scripted survey questions asked at the monthly telephone check-in calls conducted by the Pilot Liaisons. Questions solicited the participants' comments on the most and least useful aspects of the Pilot structure, and how they can be improved; what kind of technical assistance they received each month; what were the most useful and least useful aspects of the assistance, and how the technical assistance can be improved. Participants were also be asked to summarize their contacts with their local L & C district office and report any changes related to the action plans developed by each facility team. In general, the initial application process, pilot orientation, and monthly phone calls were identified by participants as the most useful

aspects of the Pilot structure. *Important note: Of the three participating facilities that were surveyed during the 6 month tracking period, none received deficiencies related to their pilot practice.

A second set of measures focused on the impacts of the dining practices introduced in each specific facility. This data was collected through the data collected during the monthly phone calls regarding resources, costs, and customer response and also through a verbal survey administered at the end of the pilot. The surveys collected the reports of the primary facility contact on the impacts of the practice on customer satisfaction and facility operations such as food expenses, food waste, staff management issues, and marketing. The summary of the findings of the monthly calls and the final evaluation are provided in Appendix B.

The Practices – Master Plan for Change

a. Practice One – Restaurant Style Dining

b. Practice Two – Buffet Style Dining

c. Practice Three – Expanded Snack Program

4. The Practices

The following section describes the three practices that were piloted in our project: restaurant style, buffet style, and resident snack center/between meal choices. One of the things that the pilot project taught us is that there is no "one way" to do any of these programs. In fact, we learned that, to be successful, these practices must be tailored to the needs, desires, and resources in each individual setting. With that in mind, we have presented a list of "critical elements" for each facility to consider when implementing one of these practices. They are presented in "check-list" format for quick review and, if used in conjunction with the action plan template (See Appendix C), they will provide a comprehensive practice plan. As a "first step", we recommend that providers start by reviewing the following "Master Plan for Change" before implementing any person-directed changes in their facility.

Master Plan for Change

Change is exciting, but also challenging. These are steps (not necessarily in this order) that we encouraged our Person Directed Dining Pilot Participants to take before actually implemented their practices.

Prepare for Change

a. Assess the situation – Where are you now and where do you want to be?
b. Identify your targets with short and long term goals
c. Identify the lead team members, stakeholders, and champions for change
d. Enlist support from key management
e. Identify regulatory concerns or barriers
f. Define your strategy/action steps
g. Define your method and targets for communication
h. Define your method for monitoring and evaluation
i. Develop policies/procedures, budget and tracking tools
j. Prepare your team and assign responsibilities

2. Manage the Change
    a. Implement the action plan
    b. Make changes in stages
    c. Involve people through open communication
    d. Build key processes (operational and evaluative)
    e. Empower others to act on the vision
    f. Plan for, create and celebrate short-term wins

3. Reinforce the Change
    a. Collect and analyze feedback and key data
    b. Diagnose gaps and manage resistance
    c. Implement corrective actions
    d. Define/evaluate sustainment strategies
    e. Celebrate successes!!!!

RESTAURANT STYLE DINING

Restaurant Style Dining may include any of the following or similar approaches:

- Waiter service taking “orders” table side from individual residents
- Food delivered in “courses” with attractive plates or utensils
- Choices offered of one or more meal components (appetizer, soup, salad, entrée, vegetables, and/or dessert)
- Visual choices offered at tableside with a salad or desert cart
- Food plated in the dining rooms, at a satellite kitchen or in the central kitchen

?	DECISION MAKING TOOL: CRITICAL ELEMENT - RESTAURANT STYLE DINING
	Did you refer to "Master Plan for Change" for initial steps.
	What equipment is needed for restaurant or waiter dining?
	Where will the mobile equipment be parked or stored when not in use? Does it need to be locked?
	Where will restaurant or waiter dining be located? Will residents and staff access this area between meals?
	Is there adequate electrical and plumbing access for your plan?
	Are there any physical plant changes that will be needed?
	What existing equipment can be re-purposed for restaurant or waiter dining?
	Does additional equipment need to be purchased?
	What equpment will be specified for purchase and what is the cost?
	Who will approve the expenditure?
	Can restaurant or waiter dining be operated on an interim basis with existing equipment while waiting for the capital budget?
	Will restaurant or waiter dining operate at all meals, selected meals (i.e., noon only) or only certain meals or days of the week?
	Will it be available to only the residents or also available for family and staff consumption?
	What menu food items and beverages will be offered? Are these the same as the facility menu?
	How many different items will be offered?
	Are these pre-packaged or kitchen prepared items?
	Will these menu food items be available to residents who do not dine in restaurant or waiter dining? (i.e., room trays)
	How will they be displayed on the cart or serving line?
	Will small carts or trays be used to offer resident choices or some meal components? (i.e., appetizer or dessert cart)
	Will any items be pre-set on the dining tables?
	Are there any resident safety concerns such as pouring hot beverages?
	Will menu items be on a rotating or cycle menu or the same each day?
	How will menu be communicated to residents
	Will waiters take orders at the dining table or will menus be pre-selected the day or meal before?
	Will food items for various dietary restrictions be available?
	Will restaurant or waiter dining be limited to residents on unrestricted diets only?
	Do physician ordered diet restrictions need to be evaluated and/or liberalized?
	Who will evaluate and communicate with resident and physician regarding dietary restrictions?
	How will residents on dietary restrictions be identified?
	How will the list of dietary restrictions appear?
	How will items be labeled or designated for various dietary restrictions?
	What is the cost of the items being offered?
	Does the current facility budget cover the anticipated costs?
	How will costs be monitored or reported?

?	DECISION MAKING TOOL: CRITICAL ELEMENT - RESTAURANT STYLE DINING
	What serving utensils or equipment will be needed?
	What glasses, dishes or utensils will be used by the residents?
	What disposable or re-usable items, including napkins, staff uniforms, table linens and clothing protectors will be needed?
	What food safety parameters for time and temperature control apply?
	How will food safety be monitored? (i.e., temperature logs, frequency)
	How will food be protected during transport?
	How will cross-contamination be avoided when serving residents?
	Who will transport residents to restaurant or waiter dining and at what times?
	How many residents will participate in restaurant or waiter dining and how long will it take to serve them?
	What staffing will be needed for restaurant or waiter dining, including which department?
	How will staff be assigned to retaurant or waiter dining?
	What is the cost of staffing restaurant or waiter dining?
	Who will maintain the list of dietary restrictions?
	How will physician ordered diets be communicated and provided?
	Will residents be allowed to choose items not permitted on their dietary restriction?
	How will staff and residents be informed of their righs of choice in dining and foods?
	Will staff be instructed and responsible to redirect residents who choose food items not permitted on their dietary restriction?
	Will staff monitor and document the resident choice/consumption of food?
	Will this be documented in the medical record?
	Where will this be documented in the medical record?
	Will staff track the waste, over-production or shortage of food?
	Do the facility policy and procedures need to be updated and approved for restaurant or waiter dining?
	Are there any forms needed for restaurant or waiter dining?
	Will you do resident satisfaction surveys?
	How often will you do resident satisfaction surveys?
	How will you communicate about the new restaurant or waiter dining? To whom?
	Will you do a pilot test of restaurant or waiter dining?
	When will you begin operation of restaurant or waiter dining?

CALIFORNIA CULTURE CHANGE COALITION

Regional Collaboratives
CMS Region IX Person-Directed Dining Pilot Project
SAMPLE Action Plan for RESTAURANT STYLE DINING

FACILITY NAME: Rocking Horse Nursing Care Center

Overall Goal: We want to improve: The atmosphere, choices, and social enjoyment of our residents' meal time through providing Restaurant Style Food Service

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
Research and refine program concept	Dietary consultant Director of Dietary Services (DDS) DON Administrator Activity Director Dietary Committee Resident and family representatives Licensing and Certification	Wendy Valley, Administrator	1. Review existing literature on restaurant style dining in nursing homes. 2. Identify and review applicable regulations, physical plant and financial limitations relevant to implementing this program. 3. Identify key stakeholders 4. Meet with key stakeholders for input on program concept. 5. Refine the concept of "restaurant style" in terms of choices, menus, available meal times and days. 6. Revise action plan as needed to incorporate information gained through research 7. Contact L&C (facility supervisor) to inform of practice plan and ask for any input or questions they might have.	Administrator to oversee overall implementation Director of Dietary Services and Activity director act as joint project leads Dining Committee to monitor progress at weekly meeting to review action plan	November 2007
Write policy and procedure for restaurant style dining	Dietary consultant DDS Activity Director DON Administrator Dining, Infection Control, and QI, committees	Sunny Hillside, RD , Dietary Consultant	1. Dietary consultant to coordinate the development of draft P&P. 2. Health and Safety considerations to be addressed in P&P (i.e. safe food handling, liberalizing diets, intake monitoring if indicated) 3. Evaluation component to be included (Tools to track Satisfaction, QI, Costs) 4. Review by key stakeholders	Dietary Consultant to monitor progress of P&P development and report to Dining Committee. DDS and DON to monitor implementation	February 2008

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
			5. Review per company requirements 6. Revise based on feedback 7. Adopt policy and procedures		
Identify target residents and times/days for pilot trial of restaurant style	DDS RD dietary consultant DON Residents Families Direct Care staff Administrator	Tom Tree, Dietary of Dietary Services	1. Resident, family, and direct care staff survey to identify interest in program 2. Dietary consultant, DDS, and nursing review of diet orders to identify residents with potential restrictions. Identify opportunities to liberalize diets when appropriate and offer alternatives as needed to maximize participation. 3. Dining committee review to existing meal structure and identify target times and days for pilot. 4. Dining committee to identify equipment, space, and staffing resources required.	DDS will monitor the conducting of the survey and will compile the results RD and DDS follow up on dietary order changes Dining committee to recommend schedule and purchase schedule for needed items. Dining Committee to monitor progress at weekly meeting to review action plan.	February 2008
Identify and purchase equipment	Administrator DDS Dietary Consultant Activities Director	Wendy Valley, Administrator	1. Identify exact equipment needed, both large (e.g. Steam table, mobile cold cart, crock pots) and small items (e.g. menus, bowls, table cloths, napkins). 2. Modify existing equipment if possible and explore donation sources as much as possible to keep costs down 3. Research relevant fire and safety standards and ensure selected equipment complies. 4. Dining committee to participate in equipment selection 5. Purchase equipment within budgetary constraints	Administrator to delegate selection and purchasing per facility routine Dining Committee to monitor progress at weekly meeting to review action plan.	April 2008

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
			6. Pilot equipment to ensure that it meets the need. 7. Revise as indicated 8. Implement in phases as required by budgetary constraints		
Communication Education	DSD Activity Director SSD Residents Families Direct Care staff DDS Dietary Consultant Dining Committee DON	Dudley Dam DSD	1. Educate direct care, dietary and activity staff on Restaurant style policy and procedures. Teach the method for managing residents preferences, nutritional needs, food sanitation, and documentation of resident's response to program 2. Educate residents and family on availability of restaurant style and ways to communicate feedback on the program 3. Initiate logs for intake and a communication board for staff 4. Plan for multiple dept staff involvement in program (Activities, dietary, and nursing)	DSD to develop communication materials for staff and document in-service Activity Director and Social Services director (SSD) to oversee education of family and residents	March 2008
Implement pilot of restaurant style	DDS Activity Director Direct Care staff Dietary Consultant Dining Committee DON Administrator	Tom Tree, Dietary Services Supervisor	1. Identify times and days for initial restaurant style pilot. 2. Develop staffing plan to ensure efficient and timely order-taking and serving to residents. 3. Implement communication strategy to ensure maximum participation 4. Conduct restaurant style trial at specified times 5. DDS and AD to monitor results daily 6. Resident and family satisfaction surveys to be administer by DSD 7. Program modified as appropriate	Activities director to monitor resident participation daily DDS to monitor intake, snack preferences and food safety issues daily DSD to administer customer satisfaction survey at onset, 1 month, and 90 days. Dining Committee to monitor progress at weekly meeting to review action plan.	April 2008

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
Expand Restaurant Style program	DDS Activity Director Direct Care staff Dietary Consultant Dining Committee DON Administrator	Tom Tree, Dietary Services Supervisor	1. Dining committee to outline expansion plan based on evaluations and budget 2. Goal is to provide restaurant style dining one meal a day, 7 days a week within 90 days	Administrator and DDS to oversee operation on-going. Dining Committee to monitor progress at weekly meeting to review action plan until fully implemented for 90 days. On-going monitoring of health, safety and customer satisfaction with quarterly quality assurance committee reviews done by DON and RD consultant	June 2008

Overall Evaluation	
How will we evaluate overall program?	Weekly review of progress for first 6 months Resident and family satisfaction survey (Specific to dining program and administered to those who participate) quarterly Costs monitoring per month Quality improvement checklist for access, sanitary conditions, adequacy of assistance and supervision, and socialization administered through observation at least once a week.
Who will evaluate?	Weekly review by Dietary Committee Satisfaction Surveys administered by DSD initially, at 30 days and 90 days during pilot period. Annually there after DDS to collect data on food usage and waste - ongoing. Administrator to track and evaluate costs per month. Activity director and DDS to administer QI checklist and report findings to QI Committee quarterly
What was learned?	
How can we make it better?	

BUFFET STYLE MEAL SERVICE

Buffet Style Meal Service may include any of the following or similar approaches:

- Visual presentation of the foods in the dining room or cafeteria for resident to select.
- May include various levels of assistance from facility staff to fill plates, assist with selections, monitor therapeutic diets, promote adequate nutrition and/or carry food plates or trays to the table for residents.
- May include choices of one or more meal components (appetizer, soup, salad, entrée, vegetables, and/or dessert)
- May include a "cooked-to-order" meal component as a choice (e.g. Breakfast eggs, grilled sandwich, stir-fry or toast)
- Buffet service may be used for a single meal per week (e.g. Sunday Brunch) or one meal per day, or several meals per week to all meals served buffet style.

?	DECISION MAKING TOOL: CRITICAL ELEMENTS - BUFFET STYLE DINING
	Did you refer to "Master Plan for Change" for initial steps?
	What equipment is needed for buffet dining?
	Where will the mobile equipment be parked or stored when not in use? Does it need to be locked?
	Where will buffet dining be located? Will residents and staff access this area between meals?
	Is there adequate plumbing and electrical access for your plan?
	Are there any physical plant changes that are needed?
	What existing equipment can be re-purposed for buffet dining?
	Does additional equipment need to be purchased?
	What equipment will be specified for purchase and what is the cost?
	Who will approve the expenditure?
	Can buffet dining be operated on an interim basis with existing equipment while waiting for the capital budget?
	Will buffet dining operate at all meals, selected meails (i.e., noon only) or only certain meals or days of the week?
	Will residents have access or be served by the staff? Will family have access?
	Will it be available to only the residents or also available for family and staff consumption?
	What buffet menu food items and beverages will be offered? Are these he same as the facility menu?
	How many different items will be offered?
	Are these pre-packaged or kitchen prepared items?
	Will these menu food items be available to residents who do not dine in buffet dining? (i.e., room trays)
	How will they be displayed on the cart or serving line?
	Will small carts or trays be used to offer resident choices of some meal components? (i.e., appetizer or dessert cart)
	Are there any resident safety concerns such as pouring hot beverages?
	Will any items be pre-set on the dining tables?
	Will buffet items be on a rotating or cycle menu or the same each day?
	Will staff take orders at the dining table for residents who cannot serve themselves?
	Will food items for various dietary restrictions be available?
	Will buffet dining be limited to residents on unrestricted diets only?
	Do physician ordered diet restrictions need to be evaluated and/or liberalized? Who will evaluate and communicate with resident and physician?
	How will items be labeled or designated for various dietary restrictions?
	What is the cost of the items being offered?
	Does the current facility budget cover the anticipated costs?
	How will costs be monitored or reported?
	What serving utensils or equipment will be needed?
	What glasses, dishes or utensils will be used by the residents?
	Determine the use of disposables or re-usable items, including napkins, staff uniforms, table linens and clothing protectors?

?	DECISION MAKING TOOL: CRITICAL ELEMENTS - BUFFET STYLE DINING
	What food safety parameters for time and temperature control apply?
	How will food safety be monitored? (i.e., temperature logs, frequency)
	How will food be protected during transport?
	How will cross-contamination be avoided when either residents or staff serves from the buffet?
	Who will transport residents to buffet dining and at what time?
	How many residents will participate in buffet dining and how long will it take to serve them?
	What staffing will be needed for buffet dining, including which department?
	How will staff be assigned to buffet dining?
	What is th ecost of staffing buffet dining?
	How will residents on dietary restrictions be identified?
	How will the list of dietary restrictions appear?
	Who will maintain the list of dietary restrictions?
	How will physician ordered diets be communicated and provided?
	Will residents be allowed to choose items not permitted on their dietary restrictions?
	How will residents be informed of their rights of choice and educated of their risks in dining and foods?
	Will staff be instructed and responsible to redirect residents who choose food items not permitted on their dietary restriction?
	Will staff monitor and document the resient choice/consumption of food?
	Will this be documented in the medical record? Where?
	Will staff track the waste, over-production or shortage of food?
	Do the facility policy and procedures need to be updated and approved for buffet dining?
	Are there any forms needed for buffet dining?
	Will you do resident satisfaction surveys?
	How often will you do resident satisfaction surveys?
	How will you communicate about the new buffet dining? To whom?
	Will you do a pilot test of buffet dining?
	When will you begin operation of buffet dining?

CALIFORNIA CULTURE CHANGE COALITION

Regional Collaboratives
CMS Region IX Person-Directed Dining Pilot Project
Sample Action Plan for BUFFET STYLE DINING

FACILITY NAME: _Pines on the Bay Skilled Nursing Facilty

Overall Goal: We want to improve: the quality of life of our residents by offering a more Individualized dining experience offering buffet style dining.

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
Research interest in this dining style	Residents, families, staff, corporate office, Registered Dietician, CDPH	Summer Bayside DSS Miller Beach CDPH	Formal and informal surveys from residents, family, and staff for interest in this program. Seek permission from corporate office for capital expenditures. Consult with RD for feasibility of implementation. Consult with CDPH regarding regulations and potential landmines.	Analysis of survey results, and documentation of correspondence with respective entities.	November 2007
	Administrator, Dietary Services Supervisor, Director of Operations	Adam "Woody" Woods Administrator	Formulate itemized list of capitalized and other equipment. Submit list to Director of Operations for approval of spending.	Capital Equipment Request Form	December 2007
Research regulations	Administrator, Dietary Services Supervisor, Registered Dietician, CDPH	Dusty Rhodes DON	Speak with CDPH regarding specific regulations pertaining to this style of dining. Consult with RD to find ways of following regulations	Documentation and copies of pertinent regulations	December 2007
Create Policy and Procedures	Administrator, Dietary Services Supervisor, Registered Dietician	Adam "Woody" Woods Administrator Rocky Lodgepole RD	RD will create program policy and procedure. Administrator and DSS will create all other policies regarding program implementation with approval from RD.	Completion of Policies and Procedures	February 2008
Purchase Equipment	Administrator	Adam "Woody" Woods Administrator	Submit Purchase oorder to Supplier	Purchase Order, Invoices	April 2008

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
Prepare for staffing needs	Administrator, Dietary Services Supervisor, Director of Nursing Services	Summer Bayside DSS Patty Grove DNS	Analysis of staffing requirements to meet all of our residents needs during meal time. Meet with department heads to assess available staff resources. Create positions and assign staff to these positions. (We plan to over-staff initially)	Diagram defining residents needs with allocation of staff	May 2008
Table Top Trial	Administrator, Dietary Services Supervisor, Director of Nursing Services	Adam "Woody" Woods Administrator	Perform a table top trial run of implementation, from food preparation to clean up.	Create schedule of tasks with a time study of all tasks and sub-tasks.	June 2008
Implementation	Residents, families, staff, corporate office, Registered Dietician	Summer Bayside DSS Rocky Lodgepole RD	Implementation scheduled for 2/19/08 breakfast from 0700 – 0900 and every Tuesday and Thursday thereafter. We will increase the amount of days the buffet is offered after the kinks are worked out. Ultimate goal is to offer buffet style dining for at least one meal a day, seven days a week.	RD, Administrator will observe and document implementation process to ensure policies and procedures are being followed, and correct any regulatory deficiencies and violations.	July 2008

Overall Evaluation	
How will we evaluate?	Weekly review of progress for first 6 months Resident and family satisfaction survey (Specific to buffet style dining and administered to those who participate) Monthly Costs monitoring Quality improvement checklist for access, sanitary conditions, adequacy of assistance and supervision, and socialization - administered through observation at least once a week.
Who will evaluate?	Weekly review by Dietary Committee Satisfaction Surveys administered by PAR program DSS to collect data on food usage and waste - ongoing. Administrator to track and evaluate costs per month. Administrator to administer QI checklist
What was learned?	
How can we make it better?	

RESIDENT SNACK CENTER

Resident Snack Center or Between Meal Choices may include any of the following or similar approaches:

- Stationary location stocked with resident choices of snack or beverage items with free access by residents. Location may or may not include a microwave (with appropriate warnings to those who use a pacemaker.) May or may not be accessible to residents on prescribed diets and/or supplements.
- Mobile cart stocked with resident choices of snack or beverage items which are periodically circulated in the facility as scheduled. May or may not be accessible to residents on prescribed diets and/or supplements.
- Resident "store" or vending area where the residents may choose snacks or beverages of choice. Supervision by facility staff (nursing or activities) and access by residents on prescribed diets may or may not be allowed. May be open for resident access 24/7 or hours may be limited or controlled.
- Daily snack menu which may or may not include a rotation of snack items offered.
- Designated areas in facility for a coffee bar, juice bar, ice cream parlor or for blended fruit beverages.

?	DECISION MAKING TOOL: CRITICAL ELEMENTS – RESIDENT SNACK CENTER
	Did you refer to the "Master Plan for Change" for initial steps
	Will you use a mobile cart or stationary snack center?
	Where will the cart be parked or stored when not in use? Does it need to be locked?
	Where is the stationary snack center located? Will residents and staff access this center? Are there resident access issues? Does it need security or locking door?
	Is there adequate plumbing and electrical access for your plan?
	Are there any physical plant changes that are needed?
	What existing equipment can be re-purposed for the snack center?
	Does additional equipment need to be purchased?
	What equipment will be specified for purchase and what is the cost?
	Who will approve the expenditure?
	Can the snack center be operated on an interim basis with existing equpment while waiting for the capital budget?
	Will the snack center operate every day or only certain snack times or days of the week?
	Will the snack center be available at specified times or around the clock?
	Will residents have access or be served by the staff? Will family have access?
	Available to only the residents or also available for family and staff consumption?
	What snack foods and beverages would be offered? How will residents have input into what's available?
	How many different items will be offered?
	Are these pre-packaged or kitchen prepared items?
	How will they be displayed on the cart of snack center?
	Are there any resident safety concerns such as pouring hot beverages?
	Will snack items be on a rotating menu or the same each day?
	Will food items for various dietary restrictions be available?
	Will snack cart be limited to residents on unrestricted diets only?
	Do physician ordered diet restrictions need to be evaluated and/or liberalized? Who will evaluate and communicate with resident and physician?
	How will items be labeled or designated for various dietary restrictions?
	What is the cost of the items being offered?
	Does the current facility budget cover the anticipated costs?
	How will costs be monitored or reported?
	What serving utensils or equipment will be needed?
	What glasses, dishes or utensils will be used by the residents?
	Determine the use of disposables or re-usable items, including staff uniforms and napkins?
	What food safety parameters for time and temperature control apply?

?	DECISION MAKING TOOL: CRITICAL ELEMENTS – RESIDENT SNACK CENTER
	How will food safety be monitored? (i.e., temperature logs, frequency)
	How will food be protected during transport?
	How will cross-contamination be avoided when either residents or staff serves the snacks and educated on their risks?
	How many residents will participate in the snack cart and how long will it take to serve them?
	What staffing will be needed for the snack cart or center, including which department?
	How will staff be assigned to the snack cart or center?
	What is the cost of staffing the snack cart or center?
	How will residents on dietary restrictions be identified?
	How will the list of dietary restrictions appear?
	Who will maintain the list of dietary restrictions?
	How will physician ordered snacks be communicated and provided?
	Will residents be allowed to choose items not permitted on their dietary restriction?
	How will staff and residents be informed of their rights of choice in snacks?
	Will staff be instructed and responsible to redirect residents who choose food items not permitted on their dietary restriction?
	Will staff monitor and document the resident choice/consumption of snack items?
	Will this be documented in the medical record? Where?
	Who will document in the medical record?
	Will staff track the waste of snacks?
	Do the facility policy and procedures need to be updated and approved for the snack cart or center?
	Are there any forms needed for the snack cart or center?
	Will you do resident satisfaction surveys?
	How will you do resident satisfaction surveys?
	How will you communicate about the new snack center? To whom?
	Will you do a pilot test of the resident snack center?
	When will you begin operation of the resident snack center?

CALIFORNIA CULTURE CHANGE COALITION

Regional Collaboratives
CMS Region IX Person-Directed Dining Pilot Project
SAMPLE Action Plan for RESIDENT SNACK CENTER

FACILITY NAME: Spring Valley Care Center

Overall Goal: We want to improve: Set up a Resident Snack Center that expands food choices, quality of life, and the health and well being of our residents by offering them increase access, choices in snack selection, and a social environment in which to enjoy the snack .

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
Research and refine program concept	Dietary consultant Director of Dietary Services (DDS) DON Administrator Activity Director Dietary Committee Resident and family representatives Licensing and Certification	Susy Forest, Administrator	1. Review existing snack programs in state and around country that expand access and choice to residents, 2. Identify and review applicable regulations, physical plant and financial limitations relevant to implementing this program. 3. Identify key stakeholders 4. Meet with key stakeholders for input on program concept. 5. Refine the concept of the snack center 6. Revise action plan as needed to incorporate information gained through research 7. Contact L&C (facility supervisor) to inform of practice plan and ask for any input or questions they might have.	Administrator to oversee overall implementation Director of Dietary Services and Activity director act as joint project leads Dining Committee with monitor progress at weekly meeting to review action plan	November 2007
Write policy and procedure for resident snack center	Dietary consultant DDS Activity Director DON Administrator Dining, Infection Control, and QI, committees	Sam Creek, RD , Dietary Consultant	1. Dietary consultant to coordinate the development of draft P&P. 2. Health and Safety considerations to be addressed in P&P (i.e. safe food handling, restricted diets, safety awareness of hot liquids, intake monitoring if indicated) 3. Evaluation component to be included	Dietary Consultant to monitor progress of P&P development and report to Dining Committee. DDS and DON to monitor	December 2007

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
			(Tools to track Satisfaction, QI, Costs) 4. Review by key stakeholders 5. Review per company requirements 6. Revise based on feedback 7. Adopt policy and procedures	implementation	
Identify resident needs and preferences for snacks available in Snack Center and times of accessibility	Activity Director DDS Residents Families Direct Care staff DSS Dietary Consultant DON Administrator	Sandy Hill, Activities Director	1. Resident, family, and direct care staff survey to identify desired snack choices 2. Dietary consultant, DSS, and nursing review of diet orders to identify potential restrictions. Identify opportunities to liberalize diets when appropriate, and provide acceptable snack alternatives when needed. 3. Administrative review to identify budget parameters and procurement plan. 4. Dietary committee review to identify equipment, space, and staffing resources required.	Activities Director will monitor the conducting of the survey and will compile the results Dining Committee with monitor progress at weekly meeting to review action plan.	January 2008
Identify and purchase equipment	Administrator DDS Dietary Consultant Activities Director	Suzy Forrest, Administrator	1. Identify exact equipment needed, both large (e.g. Refrigerator, mobile cold cart) and small items (e.g. tongs, bowls, blender) and consumables (e.g. napkins, ice, cups). 2. Modify existing equipment if possible and explore donation sources as much as possible to keep costs down 3. Research relevant fire and safety standards and ensure selected equipment complies. 4. Dietary committee to participate in equipment selection 5. Purchase equipment within budgetary constraints 6. Pilot equipment to ensure that it meets the need. 7. Revise as indicated 8. Implement in phases as required by budgetary constraints	Administrator to delegate selection and purchasing per facility routine Dining Committee with monitor progress at weekly meeting to review action plan.	March 2008

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
Communication Education	DSD Activity Director SDD Residents Families Direct Care staff DSS Dietary Consultant Dietary Committee DON	Dudley Dam DSD	1. Educate direct care, dietary and activity staff on P&P and the method for managing residents preferences, nutritional needs, food sanitation, and documentation of resident's response to program 2. Educate residents and family on availability of snack center and ways to communicate feedback on the program 3. Initiate logs for intake and a communication board for staff	DSD to develop communication materials for staff and document in-service Activity Director and SSD to oversee education of family and residents	April 2008
Implement Pilot of Snack center	DDS Activity Director Direct Care staff Dietary Consultant Dietary Committee DON Administrator	Mindy Meadow, DDS	1. Identify times and days for initial snack center operation 2. Develop supply stocking and staffing plan for snack center 3. Implement communication strategy to ensure maximum participation 4. Open snack center at specified times 5. DDS and AD to monitor results daily 6. Resident and family satisfaction surveys to be administer by DSD	Activities director to monitor resident participation daily DDS to monitor intake, snack preferences and food safety issues daily DSD to administer customer satisfaction survey at onset, 1 month, and 90 days. Dining Committee with monitor progress at weekly meeting to review action plan.	May 2008
Expand snack center program	DDS Activity Director Direct Care staff Dietary Consultant Dietary Committee DON Administrator	Sandy Hill, Activities Director	1. Dining committee to outline expansion plan based on evaluations 2. Goal is to provide maximum access to snack center with eventual 24/7 access	Activity Director and DDS to oversee operation on-going. Dining Committee with monitor progress at weekly meeting to review action plan until fully implemented for 90	June 2008

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable
				days. On-going monitoring of health, safety and customer satisfaction with quarterly quality assurance committee reviews	

Overall Evaluation	
How will we evaluate overall program?	Weekly review of progress for first 6 months Resident and family satisfaction survey (Specific to snack center and administered to those who participate) quarterly Costs monitoring per month Quality improvement checklist for access, sanitary conditions, adequacy of assistance and supervision, and socialization administered through observation at least once a week.
Who will evaluate?	Weekly review by Dietary Committee Satisfaction Surveys administered by DSD initially, at 30 days and 90 days during pilot period. Annually there after DDS to collect data on food usage and waste - ongoing. Administrator to track and evaluate costs per month. Activity director and DDS to administer QI checklist and report findings to QI Committee quarterly
What was learned?	
How can we make it better?	

Appendix A

Paricipants List

Appendix A - Participant List

Provider Participants	Liaisons	Expert Consultants	Regulatory Partners
Del Amo Gardens Harumi Takeda, Administrator htakeda@delamogardens.com (310) 378-4233	Jocelyn Montgomery, RN California Association of Health Facilities	Lee Tincher, MS, RD	Capt. Eloise Beechinor, RD, MPH
Downey Care Center Joline Huren, ED jhuren@covenantcare.com (562)923-9301	Bonnie Darwin CA Culture Change Coalition	Sam Ousey, RD	Mary Gessay
Gardena Convalescent Center Brent Wauke, Administrator bwauke@gardenaconvalescentcenter.com (310) 532-9460	Darren Trisel Administrator Asian Community Nursing Home	Linda Handy, MS, RD	Patty Pasquarella
Hi-Desert Continuing Care Center Jason Duckworth, DSS jduckworth@hdmc.org (760) 366-1556	Lee Tincher, MS, RD President, HM Composite, Inc.	Barrie Robinson, MSW	Joyce Sakkinen
Monterey Pines Skilled Nursing David Van Reusen dvanreusen@horizonwest.com (831) 373-3716	Sam Ousey, RD Vice President, HM Composite, Inc.	Project Lead: Jocelyn Montgomery, RN, PHN jmontgomery@cahf.org (916) 441-6400, x 214	
Parkside Special Care Center Ed Long, Administrator elong@sheahealth.com (619) 442-7744	Mary Philip California Department of Public Health		

Provider Participants	Liaisons	Expert Consultants	Regulatory Partners
St. Mary's Medical Center Leanne Young, Recreation Therapist Leanne.Young@chw.edu (415) 750-5655	David Farrell Director of Organizational Development SnF Management		
Scripps Kensington Maureen Beith mbeith@episcopalhome.org (626) 979-5255	Lori Costa Aging Services of California		
Tulare Nursing & Rehabilitation Center Dave Britter, Assistant Administrator dbritter@tularenrc.com (559) 686-8581	Beth Mann California Culture Change Coalition		
Victoria Special Care Center Ryan Krebs rkrebs@sheahealth.com (619) 955-2941 (cell)	Linda Handy, MS, RD Handy Dietary Consulting		
White Blossom Care Center Virend Prasad virend@plumh.com (408) 998-8447	Sister Patty Creedon Mercy Retirement Center		

The Culture Change Coalition would also like to acknowledge the following pilot project supporters

Practice Package Authors:	Lee Tincher, MS, RD, President HM Composite, Inc
	Jocelyn Montgomery, RN, Director of Clinical Affairs, California Association of Health Facilities (CAHF)
Clerical Support:	Leslie Badua, Regulatory Affairs Associate – CAHF
Project Evaluation:	Barrie Robinson, MSW, University of California Berkeley
CMS Region IX:	Captain Steven Chickering, Western Consortium Survey and Certification Officer
	Retired Captain Eloise Beechinor, RD, MPH, Health Quality Review Specialist
	Captain Mary Gessay, MBA, RD, CMS Region IX, Dietitian Surveyor
CDPH Center for Health Care Quality:	Kathleen Billingsley, RN, Deputy Director
	Patricia Pasquarella, Chief Dietary Consultant

Appendix B

Provider Practices Summary

Appendix B – Provider Practice Summary

FACILITY and PRACTICE	CONTACT PERSON	APPROX. COSTS	PRACTICE DETAILS	IMPORTANT OUTCOMES	IMPORTANT LESSON
Del Amo Gardens Snack Cart	Harumi Takeda Administrator	$40-50/week increase for snacks Initial purchase of napkins and cups $240 but will last for several months	- Use existing hydration cart 2x/wk - Display food choices - Announcement via intercom re: time for snack - Distribution staff allowed access to snacks	- Used in marketing plan w/ positive results - Residents eat better/reduce weight loss	- Find inexpensive stores to supply snacks - Ask residents what their preferences are - Perform in-service program for staff - Don't wait for buy-in … just do it!
Downey Care Center Resident Snack Center	Joline Huren Administrator	$20- 30/month increase for snacks	- Placed refrigerator in resident activity area to allow free access - Educated residents re: special diets	Provided resident with more free choice/ independence/control over when they wanted to eat	- New practices don't have to be a big deal - In retrospect, if pilot was more complex, it would have challenged staff - Innovations must come from the top
Gardena Convalescent Snack Cart	Brent Wauke Administrator	$ 300 for cart $90 - 200/mo for snacks	- Offer a variety of snacks - Ringer bell announces cart - Different from regular snacks offered	Both residents & staff enjoyed it Builds relationships between staff & residents	- Keep timing consistent - Keep same snacks that residents like - Have more staff involved in initial planning – buy-in - Go all out right away
Hi-Desert Continuing Care Center Breakfast & Lunch Buffets	Jason Duckworth Dietary Services Supervisor	Cold Cart $1300 $125/month for rental of table linens	- Friday breakfast – Tuesday lunch - Menus passed out in advance; returned to nurses station or kitchen - Same menu for in-room diners - All portions dished by buffet serving staff - Table linens used - Portable steam & cold tables	- Increased attendance in dining room; - Increased customer satisfaction … happier, look forward to meals - Weight gain for some residents - & more	- Purchase rather than rent table linens - Identify favorite food items - Stagger times of service - Use Nutritionist 5 software to analyze food items - Get MD order in advance for therapeutic diets - Cost out equipment - Be realistic about greater food costs - More on-line staff involvement

FACILITY and PRACTICE	CONTACT PERSON	APPROX. COSTS	PRACTICE DETAILS	IMPORTANT OUTCOMES	IMPORTANT LESSON
Monterey Pines Breakfast Buffet	David Van Reusen Administrator	Cold Cart $ 700 Slight increased food costs	- Buffet style at breakfast - Extended meal hours allowing residents to sleep in - Residents encouraged to walk thru line & make selections - Menu at table for those who can't walk - Started with 2 days/ wk and expanded to 7	- Steady numbers of residents coming to the dining room - Improved staff morale - Residents excited about eating	- Keep list of social dining program participants and adjust for drop-ins - Get staff buy-in from the beginning - Anticipate physical accommodations in dining room - Liberalized diets became an issue – need to educate residents re: choices - Get full support from corporate for changes & costs
Parkside Special Care Restaurant Style Dining	Ed Long Administrator	Equipment costs including table settings, CD for dining room music, gardening supplies, and washer for table linens: ~ $2000 Food costs increase not significant	- Created new dining room for more high functioning residents - Began w/ lunch, expanded to 3 meals/day, 7 days/week - Menu selection not appropriate for most residents (Alz) – food served in courses to lessen agitation - Ceramic boats filled w/ pureed food w/ piping bags - Music, flowers, linens, flameless candles	- Reduction in resident agitation - Better quality of life for residents (calmer, better appetites) and improved staff morale - Noise reduced in dining room - Increased water consumption - Improved appetites, weights seemed to stabilize - Very positive feedback from families, et al	- Quality of life was improved for all residents - Can expand to main dining room with same benefits - Met goal earlier than planned; residents were less agitated, full buy-in from all departments - Involvement of administrator, nursing and DR managers

FACILITY and PRACTICE	CONTACT PERSON	APPROX. COSTS	PRACTICE DETAILS	IMPORTANT OUTCOMES	IMPORTANT LESSON
St. Mary's Medical Center Restaurant Style Dining	Leanne Young Recreation Therapist	None reported	- Changed from original family style dining and snack because there was too much food waste, maintaining temperature was a problem; limited choices that were to be transported on a steam table - Activity (dining) room enhanced w/ music - Residents served their meals by volunteers who bring trays with pre-served food, transfer food to table, remove trays	Increased socialization; increase in social skills	- Learned residents' reasons for not attending dining room: self-conscious about disability, incontinence … asked volunteers to eat w/ them in room - In-service CNAs re: patient orders, etc - Should have been a designated CAN for the program - Develop strategy to encourage residents from their rooms; staff to offer personal invitations to residents - Meet new residents early and invite them to participate
Scripps Kensington Snack Cart/Between meal coffee	Barbara Calderone Director Staff Development	None reported	- Snacks passed out twice daily by CNAs & activity staff - Hot coffee available in kitchen at all times	Residents: nice to be listened to; variety, more like home Staff: a burden at first, but later they enjoyed it and the positive interaction with residents	- Problem solve how to prevent residents w/ dietary restrictions from accessing the cart rather than eliminate the process - Problem solve how to prevent residents from burning themselves when pouring hot liquids - Poll residents re: snack choices - Simpler is better - Keep at it – don't give up - Involve resident council in planning process

FACILITY and PRACTICE	CONTACT PERSON	APPROX. COSTS	PRACTICE DETAILS	IMPORTANT OUTCOMES	IMPORTANT LESSON
Tulare Nursing & Rehab Snack Cart	Dave Britter Assist. Administrator	$ 1500 for cart	- Determine sample list of alert & oriented residents - Gather, count & respond to choices made by residents w/ appropriate cart options - Compare pricing of packaged vs non-packaged goods	Residents love it	- Anticipate staffing challenges - In-service staff re: cart "movement", importance of getting residents out of their rooms to socialize - Conduct period surveys re: types of foods residents would like on cart - Use of Lazy Susan on each table didn't work; staff is re-evaluating usage - Get liberalized diet orders
Victoria Special Care Snack Cart/Breakfast Cart/Popcorn Cart	Ryan Krebs Dietary Manager	No significant costs	- Mobile cart built by Maintenance - Snacks circulated early PM 3x/wk to residents, staff, families - Introduced 2 other cart services: hot breakfast at 8:30 7x/wk and popcorn cart used on days snacks not served.	- Improved quality of life and choices for residents (could stay in bed if desired) - Family appreciation of new environment – resident being catered to more, snacking w/ family very pleasant - Staff more productive from having snacks too - Weights have stabilized by offering food throughout the day when hungry	- Be persistent – continue implementing in spite of barriers such as staff resistance - Don't let go of the intent to make change - Better interdepart-mental communication to get early buy-in from all

FACILITY and PRACTICE	CONTACT PERSON	APPROX. COSTS	PRACTICE DETAILS	IMPORTANT OUTCOMES	IMPORTANT LESSON
White Blossom Care Center Buffet dining Breakfast Club	Virend Prasad Dietary Supervisor	Mobile steam table - $1000 Beverage Cart - $300 Table ware and settings $1350 Uniforms for wait staff $400 1 FTE Cook	- Changed initial WB Bistro idea to breakfast club - New program was breakfast club every other Wednesday cooked in front of residents; residents order at their table; china, table centerpieces - Idea came from resident dining committee	- Residents came out of their rooms - Weight stability - More involvement by residents in other types of activities - Better marketing	- Teamwork important – other staff essential for setting up and cooking - Support from administrator & DON - Consider putting liberalized diet order on patient's chart and on menu ticket (done by computer) - Consider staff having change of uniform for breakfast club - Buy full size table cloth, cut it and hem it.

Appendix C

Sample Policies, Menus & Forms

Sept. 18, 2007

Policy and Procedure Dietetic Service – Buffet Service

It is the intent of this policy to provide safe and sanitary food practices while optimizing the quality of life of residents through providing choices in the dining service recognizing our residents as a highly susceptible population.

1. Buffet meals will be provided under the supervision of the Dietary Department Supervisor or Cook. The menu must be followed or amended only upon approval of the RD/FSS as evidenced by an initialed change in menu.
2. The guidelines from the 1993 FDA Food Code, 2000 California Code of Regulations and HACCP will be utilized in food handling and/or the Model Food Code (Hot food holding greater than or equal to 140 degrees F. Cold foods holing at 41 degrees F or below). [Roasts may be held according to the 2000 California Code of Regulations: danger zone 135 degrees F.]
3. Foods under preparation must not be out longer than 2 hours. If the foods must be out greater than 2 hours, the food must be brought down to 41 degrees or less. High risk foods will be cooled and monitored on the COOL DOWN LOG HACCP procdures. **Foods will not be held on the buffet longer than 2-3 hours. Never add new food to older food that has been sitting on buffet or food bar. Food must be discarded after 4 hours.**
4. **All food pans on the buffet holding high risk items will be monitored by the cook/FSS. Temperatures of high risk items will be documented before transport to the buffet noting the time of service. High risk foods outside acceptable holding temperature ranges will be raised to temperature or discarded as appropriate. ONLY pasteurized whole eggs or pasteurized whole egg products will be utilized. Raw or uncooked high risk items will not be served; (i.e., oysters, raw shrimp, sushi, raw fish, steak tartare, raw seed sprouts.) ONLY use pasteurized juice, milk, eggs. Unopened packages cannot be re-served.**
5. Sneeze guards or similar protection should be provided. Must use food approved containers.
6. Food bars or buffets should be broken down and cleaned and sanitized after each meal. Dietary department is responsible for assigning tasks and assuring cleanliness.
7. Staff should monitor residents to assure that unsafe practices do not occur (such as reaching into food and then putting it back on the food bar).
8. Staff member serving follows appropriate infection control procedures and appropriate portion sizes to honor Residents' requests.
9. Buffet dining menus are non-therapeutic. Staff will read diet cards for special needs such as food allergies, adaptive equipment, fluid restrictions, etc. Resident will choose menu items and beverages as offered by server.
10. A designated staff member asks each participant in the dining room their preferences and serves items to Resident's requests. Diet textures will be honored for safety.
11. Appropriate food transport equipment is utilized to ensure potentially hazardous foods are maintained at safe temperatures to help prevent food borne illness.

1990 Fruitdale Avenue San Jose CA 95128 Phone: 408.998.8447 Fax: 408.288.9812

White Blossom Care Center

Enhanced Dining Policy and Procedure

Policy Statement

The facility will promote quality of life through an enhanced dining program where residents have a liberalized opportunity to meet their nutritional needs

Policy Interpretation and Implementation

1. The dining program will be referred to as the WB Bistro.
2. The WB Bistro will be held Monday through Friday for lunch unless an alternate lunch program is coordinated by the dietary department.
3. Residents will be informed of the program on admission and during staff rounds.
4. ALL residents are welcome to the WB Bistro as long as they are able to dine independently and their prescribed diet allows for liberalization as determined by their physician.
5. Residents wishing to dine in the Bistro must inform the nurse supervisor who will in turn communicate with their physician and obtain an order stating, "MAY HAVE NON-THERAPEUTIC DIET BUFFET ONCE A DAY" for residents with dietary restrictions or with prescribed therapeutic diets. Residents on regular diet and without restrictions may participate without an order.
6. Once an order is obtained, the nursing supervisor will advise the Activities Department who will in turn add the resident on the DINING SEATING CHART and inform the resident.
7. A roster of all residents attending the Bistro will be posted at the corresponding NURSING STATION Calendar Log/Book and will be updated and posted by Dietary Supervisor every Tuesday.
8. Dietary supervisor will check and audit Resident's orders every Monday and will submit to Nursing Supervisors a list of residents needing PO for lunch buffet. Dietary supervisor will report in stand up every TUESDAY the results of the audit.

"DINNER BUNCH" POLICIES & PROCEDURES

Written on: January 24, 2008
Ryan Krebs, Director of Dietary Services
Parkside Special Care Center

- Dinner will be served for up to twelve (12) selected residents at 5:00 pm in the Parkside Living Room; list of residents may change according to level of appropriateness; list is posted behind living room door.
- Living Room must begin to be cleared of residents from afternoon activities beginning at 4:20 pm, or as soon as afternoon activity is finished.
- Three (3) tables must be set up in the living room **(Assigned CNA, Act. Assist. & Laundry (weekends)** with twelve (12) chairs at the table by 4:45 pm, or as soon as residents are cleared from the living room.
- Tables are to stay set up after dinner for following activity and for morning breakfast.
- Tablecloths, linen napkins, candles, cd's, etc. will be kept in the locked, glass cabinet located in the Resident Living Room.
- Keys to the cabinet will be issued to Activities Supervisor and Assistant, Maintenance Supervisor, Dietary Supervisor, and Laundry.
- Table set-up **(Assigned CNA & Act. Assist.)** will include tablecloths, matching linen napkins at each chair, three (3) battery operated candles, and fresh-cut flowers, which will be provided on a rotating weekly basis by the **Parkside staff.**
- **CNA on duty** will provide warm wash cloths for resident hand washing prior to and after meal being served.
- Service and supervision of dining will include, but is not limited to, **one (1) CNA and one (1) Activities Department employee**.
- Bus tubs will be provided to remove dirty dishes when dining is finished; cart, dishes and soiled linens must be returned to the appropriately department immediately after dinner is finished **(CNA on duty)**
- Spot removal cleaner must be applied by **CNA and Act. Assist.** to tablecloths and placemats prior to placing in bags to be laundered.
- After breakdown is complete, carpet and dining area must be spot cleaned **(Assigned CNA & Act. Assist.)**
- If desired, **CNA on duty & Act. Assist.** may request one (1) dinner from the kitchen prior to service, to be eaten in the living room with residents after all residents are served; meal satisfaction forms will be provided by the Dietary Department for staff to evaluate meal

POLICY & PROCEDURES

SUBJECT: PERSON DIRECTED DINING PILOT PROJECT: RESIDENT SNACK CENTER

APPROVED FOR: Del Amo Gardens Convalescent Gardena Convalescent Center

 2/14/08

PURPOSE:

- This facility's purpose is to provide quality of care to the Residents by honoring residents' food preferences and choices and meet nutritional needs.
- It is facility's desire to improve quality of life in food choices by offering a resident snack cart, which will allow residents to have snacks in a social environment where they may be able to enjoy more of their daily life in a skilled nursing facility.

POLICY:

- Facility will have snacks available to residents at certain time of the day, on a set day(s) of the week.

PROCEDURE:

Handling/Manning of the Carts:

- Snacks to be handled by Facility Staff (Activity Staff, C.N.A., R.N.A., Licensed Nursing Staff).
- Snack Cart (s) will be handled by Facility Staff (Activity Staff, C.N.A., R.N.A., Licensed Nursing Staff).
- A designated staff member will offer snacks to residents in regards to preferences and requests. Diet textures will be honored for safety.
- Staff shall bring the snack cart (s) throughout the facility at a designated time to offer residents the choices of snacks.
- When snacks are not being passed, the snack cart(s) will be stationed at a designated area.
- Staff manning the snack carts will be responsible for documenting residents' acceptance and refusal of the snacks.

Equipment:

- There will be one cart providing a variety of snacks and nourishments chosen by the residents.
- Appropriate food transport equipment is utilized to ensure potentially hazardous foods are maintained at safe temperatures to help prevent food borne illness.
- A binder will be on the cart to provide guidance on texture, physician orders and preferences of residents'.
- Kitchen area will be designated for preparation of food (and storage of carts).
- The cart(s) should be cleaned and sanitized after use. Dietary department is responsible for assigning tasks and assuring cleanliness.

Snack Choices:

- Residents will review snack choices at monthly resident council meeting.
- Social Service/Designee will review snack choices with family members during family meetings.
- Dietary Supervisor/Designee to interview residents regarding snack preferences upon admission and quarterly thereafter or as needed.

Infection Control:

- Residents will ask for staff assistance when obtaining snacks.
- Staff should monitor residents to assure that unsafe practices do not occur (touching food and putting it back, etc.).
- Staff will use facility protocol of food handling
- Sneeze guards or similar protections should be provided. Must use food approved containers.

Training of Staff:

- New hires will be oriented on the Resident Snack Center Program.
- Current Staff will be in-serviced regarding Resident Snack Center Program once a year.
- Staff designated to handle snack center will be further trained on the following:
    1. Resident roster list which will be in a binder, stating resident's dietary orders.
    2. Documentation on whether residents took and consumed snacks.

*This policy may be changed by the Administration at any time.

"SILVERWARE ROLLING" POLICIES & PROCEDURES

Written on: February 20, 2008
Ryan Krebs, Director of Dietary Services
Rene Jones, Activities/Social Services Director
Parkside Special Care Center

- Silverware activity should be done in an appropriate area for residents to be free of distractions, such as the empty dining room or the living room, if other activities are not being conducted at the time.
- Rotating departments will be chosen by Activities Director. A schedule for the departments' days will be consistent. It is the responsibility of the individual Department Supervisors to decide who will be most appropriate to perform the activity at the allotted time. This should be done at the beginning of the shift, so the responsible staff member is aware of the time and activity.
- Two residents will be chosen by the Activity Director to participate in the activity. If these residents are not able, or are uninterested in participating, communicate with the Activities Director who might participate instead.
- Times for the activity must be a priority to ensure readiness for mealtimes. Scheduled times are as follows:

    - 10:30am (for lunch)
    - 3:30pm (for dinner)
    - 7:00pm (for breakfast)

- Staff member must have 14 matching napkins (from Laundry or cabinet in living room) and 14 sets of spoons and forks (from Dietary Department).
- Staff member must wash hands, and assist residents in washing hands prior to activity
- Gloves must be worn for entire activity. Seat residents at a clean, sanitized, clutter-free table (refer to Helping Programs Policy for complete details)
- Once activity is completed, take rolled silverware on a service tray to Living Room for next meal period. Place in locked cabinet.
- Staff member must fill out Activities Evaluation Form by the end of their shift and return it to Ryan Krebs, Director of Dietary Services.

Sensory Hand Washing

Activity Purpose and Objectives:
Sensory hand washing is intended for sensory pleasure, cleanliness, appetite enhancement, awakening and stimulation, reminiscence, and to re-create an environment like a luxurious restaurant or first class travel.

Equipment:
2 containers (rubber dishpans or similar, one labeled "clean" one labeled "soiled")
Plastic bags to line the "soiled" container
Washcloths
A 2-liter plastic beverage container, (like for serving juice or ice tea)
Optional zipper-top linen bag to keep sensory washcloths separate in the laundry
Towel Warmer: http://www.medspadirect.com/product.php?productid=2070
Materials: Lemon extract, liquid hand soap

Program in Detail
Prepare

1. Wash your own hands before program preparation.
2. Assemble materials and equipment.
3. Place a plastic liner (and optional linen bag) into the "soiled container".
4. Mix in the beverage container, 2 liters of water, 2 tsp. of lemon extract and 2 tsp. of liquid soap.

Wet the washcloths

5. Place 20 washcloths flat in the base of the "clean" rubber dishpan.
6. Dampen washcloths pouring over and in between cloths the water with lemon and soap.
7. Fold each washcloth in half then roll each into a cylinder shape. Squeeze each washcloth slightly to squeeze out some of the excess water onto the cloths below.

Warm the washcloths

8. Warm washcloths in the UV towel warmer for at least 2 hours.
9. Refill the washcloths, steps 1-7 at the times of_____,_____and_____for the next uses.

Test and use the washcloths

10. Test the center of a washcloth to assure safe, comfortable temperatures.
11. Offer a washcloth to each participant.
12. Invite participants to wipe their hands and face, and take a deep breath in, to enjoy the scent of the lemon.
13. Avoid touching participants hands and cloths while passing out clean cloths.
14. Demonstrate to participants, using exaggerated movements.
15. Ask Participants to put soiled cloths into the "soiled container".
16. Repeat washing your own hands if the soiled cloths or if you inadvertently touch dirty cloths or participants during program.
17. Direct soiled cloths to laundry services for handling according to laundry procedures.
18. Return equipment and materials to storage areas.

Shut off UV Towel

19. Towel warmer must be completely emptied and shut off_____(after dinner.)

Precautions: Take cautions with citrus or soap allergies, observe infection control procedures.

Hi-Desert Continuing Care Center

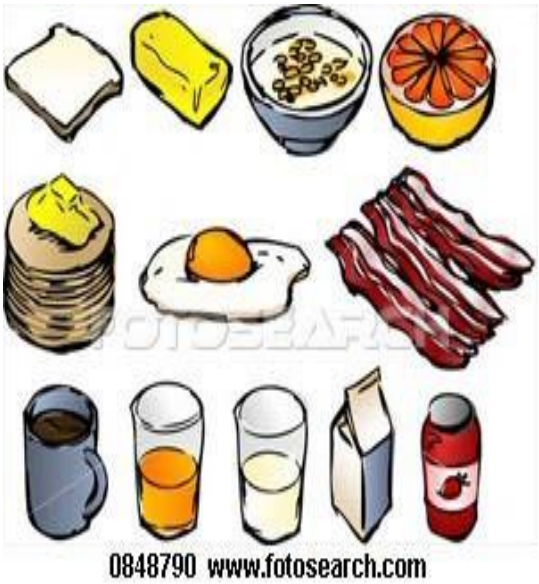
Breakfast Buffet

Please mark whether you will be attending in the Dining Room or eating in your room. If eating in your room, please circle your choioces of food and beverage items. Thank you!

_____Dining Room _____Room

Breakfast Buffet every Friday in the Dining Room and served on Trayline 7:00 – 8:00 a.m.

The food/beverages offered are:



Bacon

Sausage

Denver Omelet Bake

Biscuits & Gravy Mini

Potato Pancakes

Cheese Blintz

Fresh Fruit

Frozen Strawberries

Whipped Topping

Orange or Apple Juice

Coffee (Regular, Decaf)

Assorted Milks

CALIFORNIA CULTURE CHANGE COALITION

Regional Collaboratives
CMS Region IX Person-Directed Dining Pilot Project
Action Plan

FACILITY NAME: _____

Overall Goal: We want to improve: _____

_____

_____

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable

SPECIFIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved within and outside the organization?	PERSON RESPONSIBLE: Who will be ensure this deliverable is completed?	ACTION STEPS: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING PROGRESS: Who will monitor? How will we monitor?	TARGETED DATE FOR COMPLETION: For each deliverable

Overall Evaluation	
How will we evaluate?	
Who will evaluate?	
What was learned?	
How can we make it better?	

Appendix D

Regulatory References

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

MARK B HORTON, MD, MSPH
Director

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

cc: Ms. Pamela L. Dickfoss, Chief
Headquarter Operations Branch
Licensing and Certification Program
California Department of Public Health
1615 Capitol Avenue, MS 3001
Sacramento, CA 95814

Ms. Mary Phillip, Chief
Professional Certification Branch
Licensing and Certification Program
California Department of Public Health
1615 Capitol Avenue, MS 3300
Sacramento, CA 95814

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*

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

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 identity 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.

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

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.

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

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

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 are 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
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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** ○ **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** ○ **Home vs. Homelessness**	**Cathie Brady, MS**

Time	Topic	Presenter
2:10-2:40	**Individualizing Care and Routines** ○ **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** ○ **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 care-giving 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 (FormerlyTelstar 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
*F 242 Self Determination and Participation (Resident right to choose activities, schedules, and health care, make choices about aspects of life)	72527 Patient Rights 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	---Person centered dining programs are about ensuring there are choices, based on resident interests and preferences
*F 325 (Revised 9/1/2008) Maintains Nutritional Status and Receives a Therapeutic diet when there is a nutritional problem	72315 (h) Each patient shall be provided with good nutrition, hydration	---Resident has a right of choice even if it means not following a restrictive diet order (F 242 Self determination) ---Preventing or denying residents on restrictive diets from participate in dining programs and snacks may be a dignity/rights issue
F 365 Food prepared in a form designed to meet individual needs	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	---Facility staff should make efforts to (and document): • 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
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) 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)	72335 (a) (c) All regular and therapeutic diets shall be prescribed by a person lawfully authorized to give such an order 72339 Dietetic Service-Therapeutic Diets – Therapeutic diets shall be provided for each patient as prescribed, served with supervision and/or consultation from dietitian. 72335 (7) Food shall be served with appropriate eating utensils and in a form to meet individual needs	---Ensuring food choices have safe modified textures and thicken liquids as assessed for needs in all food activities ---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)

OBRA F TAGS/TITLE 22 THINKING POINTS

	72315 (g) Nursing Service-Patient Care	
*F 246-7 Reasonable accommodation of individual needs & preferences	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	---CA state-specific restrictions against unlicensed staff who are not CNAs, or under certain conditions Nursing Assistants providing ADL assistance to SNF residents
F 310 Activities of Daily Living : Maintaining eating ability		---Plan dining experiences and menus that serve to meet the recommended dietary allowances for the age group served
		---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
F 369 Assistive Devices	72329 Nursing Service-staff-Nursing service personnel with the qualifications determined by the Department to provide the necessary nursing services	---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)
		---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
	72341 Menus written, if any meal served varies from the planned menu, the change and reason for change shall be noted in writing	---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)
		--The intent is met when dining "opportunities" (such as snacks or open dining hours) are planned to meet the requirement for no more then 14 hours and yet allow resident choices (F 242 Self determination)

OBRA F TAGS/TITLE 22 THINKING POINTS

*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) *F 364 Food that is palatable, attractive, and at the proper temperature *F 368 Frequency of Meals: No more then 14 hours between a substantial evening meal and breakfast *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 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)	72335 (7) Prepared & Served: Attractive & palatable meals, in which nutritive values, flavor and appearance are conserved 72335 Dietetic Service-Food Service-Not less then 3 meals daily, not more than a 14 hours span between the last meal and the first meal of the following day 72349 9c) (2) All food shall be of good quality and procured from sources approved 72345 Dietetic-Sanitation 72351 Personnel trained in basic food sanitation techniques	---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 -The intent for ensuring safe food handling and infection control and following facility's policies & standards in the industry-applicable in all dining areas ---Refrigerators: In pantry & resident rooms need temperature monitoring, food labeling & dating, and throw away oversight ---Food Safety: • 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 ---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 ---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

Summarized by Linda Handy, MS, RD lindahandy29@hotmail.com Participant on CA Coalition for Culture Change, Dining Pilot 2008

Appendix E

Resources

RESOURCES FOR PERSON DIRECTED DINING & ACTIVITIES

Free CMS Videos on Culture Change, Person Directed Dining, Enhanced Dining, Activities

NOTE: It is important for dietitians, dietary managers, & activity staff to be informed and receive the same training as surveyors (many of these are listed as mandatory)

Step One: You have to register (name) and get a pass word: Any one may
http://cms.internetstreaming.com/courses/
Step Two: On the home page, go to Courses Index, logon. Keeps status of current viewing.
Scroll down to Archived Webcast (video on demand)
Step Three: Review the topics of interest, select one, CE (usually .1--.3/one hour viewing)
Step Four: Click on the webcast, watch it, then complete the evaluation
Step Five: You can print/& save Certificate of Continuing Education (date viewed)

Four Mandatory Topics on Culture Change:
11/3/06 From Institution to Individual Care Part 1 Integrating Care & Quality Improvement
5/4/07 Part 2 Transforming Systems to Achieve Better Outcome
5/18/07 Part 3 Clinical Studies in Culture Change (Dining)
9/14/07 Part 4 The How of Change

3/16/07 How to Enhance the Quality of Dining Assistance in Nursing Homes
4/7/06 Nursing Home Journal Vol III: Surveying Activities Requirement-Introduction of New Activities Guidelines; Handouts on revision, compliance, severity of noncompliance; Enhanced Activities Guide

Accessing Regulations & Surveyor Guidance :www.cms.hhs.gov->Click on Regulations/Guidance->Click on Manuals->Go to right hand and scroll to "Internet Only"->Go to Publications: 100-07 State Operations Manual (SOM)->Scroll down to "Appendices"->Appendix" P" are the most current OBRA Regulations and Interpretive Guidance for each tag (IG revision for F 371 Sanitary Conditions and F 325 Nutritional Status/Weight Loss will be available soon); Appendix" PP" are the survey protocols for surveyors (Ex: Pg. 50-61 are Hydration, Unintended Wt Loss, Dining)

Care Plans for Culture Change: Interdisciplinary & Resident-Directed by Sue Newell, Roseann Virgil, Ruth Rauscher; Activity/Therapeutic Recreation Services SURVEY-MADE- EASY: www.TRTIPS.com

The Dining Experience b y Wayne Toczek, teaching tale on culture change, www.innovaservices.info

Life Happens in the Kitchen, by Linda Bump; In Pursuit of the Sunbeam, and many books, training seminars, hands on sharing articles by Action Pact www.culturechangenow.com

Household Matters: A Good Life 'Round the Clock, many training manuals, shared experiences & stories www.Pioneernetwork.net

Rethinking the Dining Experience in Long Term Care by Shellee Rolorff, Oct 2006, to access and other valuable articles: www.dmaonline.org ->publications->Dietary Managers Magazine-> Past articles,index-2004-2007 >scroll to Meal Delivery (Cooking Demos—Resident Recipes; Resident Buffet Service-Power of Choice; Holiday Ideas)

Liberalization of the Diet Prescription Improves Quality of Life for Older Adults in Long-Term Care. December 2005, American Dietetic Association, www.eatright.org ->publications->position papers (abstract and read only), pdf and ADA Journal articles available to ADA members

*This list was developed by Linda Handy, MS,RD www.handydietaryconsulting.com lindahandy29@hotmail.com (3/08)

Participant on the California Coalition for Culture Change & Person Directed Dining Pilot Project 2008

Additional Recommended Websites

CMS Sharing Innovations in Quality – Culture Change

http://siq.air.org/Resources.Aspx?Source=Topic&ID=5

CMS sharing Innovations in Quality – Artifacts of Culture Change Tool

The Report, *Development of the Artifacts of Culture Change Tool*, can be obtained by clicking on the following link: http://siq.air.org/PDF/artifacts.pdf

The *Artifacts of Culture Change Tool* **can be obtained by clicking on the following link:** http://siq.air.org/PDF/artifacts-cc.pdf

California Culture Change Coalition: www.calculturechange.org

Pioneer Network: www.pioneernetwork.net

Action Pact: www.culturechangenow.com

CAHF Nurses Council: www.cahf.org/nurses