



Long Term Care Highlights



North Dakota Department of Health
Division of Health Facilities

JULY 2008

UTILIZING PAID FEEDING ASSISTANTS TO ENHANCE MEALS

Kristen Hoyt, LRD
Health Facilities Surveyor

The Code of Federal Regulations at 488.301 defines a “Paid feeding assistant” (PFA) as “an individual who has successfully completed a State-approved training course . . . and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization.” (Long Term Care Regulations)

A State-approved training course for paid feeding assistants must include, at minimum, eight hours of training in the following: feeding techniques; assistance with feeding and hydration; communication and interpersonal skills; appropriate responses to resident behavior; safety and emergency procedures, including the Heimlich maneuver; infection control; resident rights; and recognizing changes that are inconsistent with residents’ normal behavior and the importance of reporting those changes to the supervisory nurse. (Long

Term Care Regulations) Ongoing competency of paid feeding assistants in these areas should be evaluated and documented at least annually. (Licensing Rules 1684)

Facilities may use PFAs to assist eligible residents to eat and drink at meal times, snack times, or during activities or social events as needed, whenever the facility can provide the necessary supervision. (Interpretive Guidelines) PFAs can assist nursing staff during mealtimes, not only by providing feeding assistance but also by performing other meal-related tasks such as: meal tray delivery/set up/pickup, food and fluid intake documentation, retrieval of substitutions from the kitchen, and delivery of additional foods and fluids between meals. (Bertrand 8)

A PFA must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). This supervision must ensure appropriate feeding techniques, assistance of assigned residents according to identified need, resident rights and dignity, and adherence to safety and infection control practices. This supervision does not necessarily mean constant visual contact or being physically present during meal/snack time (ex., assistance provided in resident room); however, in an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. “Resident call system, includes not only the standard hardwired call system but other means in an emergency situation by which PFAs can achieve timely notification of a supervisory nurse,” not present in the room. (Interpretive Guidelines)

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Who the PFA assists should be determined by a charge nurse, who may wish to consult with interdisciplinary team members, based on his/her current assessment of the resident's condition and the resident's latest comprehensive assessment. (Interpretive Guidelines) This assessment must be documented and the use of the PFAs (ex., may be fed by PFA) included in the residents' plan of care. (Licensing Rules 1682)

PFAs may not be assigned to feed residents with complicated feeding problems, including but not limited to difficulty swallowing, recurrent lung aspirations, and tube or parental/IV feedings. (Long Term Care Regulations) PFAs observed providing assistance to residents with modified texture diets (i.e., ground, mechanical soft, pureed, thickened texture), "reflect possible swallowing...difficulties." (Bertrand 7) To complete an ongoing assessment, any additional or new risk factors or condition changes that may impact the resident's eligibility to be fed by a PFA may be contained in the Resident Assessment Instrument or in other supporting documentation, such as progress notes, diagnoses, consults, etc.

Training of PFAs to monitor for changes in residents' conditions or signs and symptoms of dysphagia is another method of information gathering. In a Centers for Medicare and Medicaid Services (CMS) report on the study of paid feeding assistant programs, researchers stated based on observation... "PFA staff perform at least as well as CNAs in feeding or assisting residents to eat." (Bertrand 6) Although studies have shown CNAs to have rudimentary knowledge of the signs and symptoms of dysphagia (for example, coughing, choking, chewing or oral problems), they did not appear aware of the more subtle but equally important signs such as a wet voice or throat clearing after a swallow. (Pelletier 49)

Based on these studies, training of PFAs to recognize these subtle signs and symptoms is recommended.

In a study completed by Pelletier, a speech-language pathologist, CNAs identified themselves as either a "social" or a "technical" feeder. "Social" feeders focus on meeting both the psychosocial and nutritional needs of residents equally and will not push a resident to eat more. This type of feeder may be viewed as a "slacker" or "chit-chatting." "Technical" feeders focus on adequate nutrition and this type of feeder may be viewed as "force-feeding" residents. Increased awareness of one's beliefs is important when trying to improve one's behaviors. (Pelletier 2)

One training method for CNAs/PFAs includes requiring the trainees to learn three things about the resident he/she is feeding. Researchers have shown that often the topic of conversation centers on food, if there is any conversation at all. (Pelletier 51) In the CMS study of paid feeding assistant programs, previously referenced, one-third of the time, neither CNAs/PFAs offered the resident a substitution when he/she consumed less than half of the meal. (Bertrand 6) Having CNAs/PFAs reflect on these two belief systems, "social" feeding versus "technical" feeding, during training may increase awareness of their own belief system and feeding behaviors and encourage brainstorming for ways to improve their feeding skills. (Pelletier 2)

Overall, it's a "Win, Win" situation. Using PFAs helps alleviate some of the responsibilities of an already burdened staff, allowing for a more enjoyable social environment. Observation has shown PFAs are able to spend significantly more time providing feeding assistance to residents, resulting in a lower proportion of residents who eat less than half the meal compared with CNA-assisted residents. (Bertrand 6)

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This combined with the common practice of using existing staff as PFAs allows residents to get to know a staff member “as a person” and vice versa. (Bertrand 9)

References:

Long Term Care Regulations and Interpretive Guidelines, Appendix PP, Advance Copy.

Licensing Rules for Nursing Facilities in North Dakota, 33-07-03.2-16.

Bertrand, R, Hurd, D, Moore, T, Schnelle, J., Shier, V., Simmons, S., Sweetland, R., (2007) Study of Paid Feeding Assistant Programs, Volume #1, Final Report, Abt Associates Inc., <http://www.cms.hhs.gov/CertificationandCompliance/Downloads/PFAFinalReportONLY.pdf>

Pelletier, C. A. (2006, September) Feeding Difficult-To-Fed Patients, Provider, 49-51. <http://www.providermagazine.com/pdf/caregiving-09-2006.pdf>.

Pelletier, C.A. (2004, April 13) Why do CNAs feed as they do?, The American-Speech-Language-Hearing Association Leader, 17, 25. <http://www.asha.org/about/publications/leader-online/archives/2004/040413/040413c.htm>.

CONDUCTING AN INVESTIGATION FOR AN ABUSE/NEGLECT ALLEGATION INVOLVING A CERTIFIED NURSING ASSISTANT (CNA)

Patty Swenson, RN
Health Facilities

The Code of Federal Regulations at 483.13(c)(2) states “The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported **immediately** to the administrator of the facility” who then must report **immediately** to “other officials in accordance with State law through established procedures (including to the State survey and certification agency).” 483.13(c)(4) states, “The results of all investigations must be reported to the administrator... and to other officials in accordance with State law (including to the State survey and certification agency) within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.”

Bruce Pritschet is the contact person within the North Dakota Department of Health. When first contacting the state agency, be prepared to provide the following information: date of allegation, the correct spelling and name of the CNA, CNA registry number and/or social security number, name of the resident(s) involved in incident, name of witness(es), a description of the alleged incident and/or injury, the type of alleged abuse, when the facility started its investigation, what protective measures the facility has put in place and name of the facility contact person.

When making the second contact with the state agency, the facility should include a written statement clearly identifying the result of the investigation and actions taken; for example, what **conclusion** was reached by the investigation team at your facility. Be prepared to send in all investigative documents, including written and signed statements by the CNA, witness(es) and resident (if available). Also include copies of any other documents, or pictures resulting from the investigation. The facility’s conclusion will guide the direction of the department.

When a facility receives an allegation, a number of factors need to occur. Facility policies would direct the facility to thoroughly investigate and, according to 483.13(c)(3), “prevent further potential abuse while the investigation is in progress.” In order for this to occur, prompt and immediate reporting is necessary by facility staff members knowledgeable of the incident. This reporting needs to happen at the time of the occurrence. The timeliness of reporting, the assessment and documentation of any resident injury (“resulting outcome”), and a thorough investigation of all facts related to the

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allegation will be KEY to determine the significance of the allegation. All individuals interviewed, including witnesses, the resident, the alleged, the charge-person at the time of the occurrence (i.e., nurse), and any evidence of injury will help in obtaining a well-supported conclusion.

Depending on the details of the allegation, questions need to be asked pertinent to the allegation. While conducting an investigation, answer who, what, when, where and how.

- **Who** witnessed the occurrence? Have all witnesses provide a written report of what occurred, and interview them. Does the interview yield the same results as the written report? Are there any inconsistencies? If so, can they be clarified? Ask if the witness could have misinterpreted what they saw or heard.
 - **What** does the alleged say occurred? Have the alleged CNA make a written report of what occurred, and interview him or her. Are there any inconsistencies? If so, can they be clarified?
 - **When and where** did the occurrence happen? What were the conditions when the allegation occurred? Was the facility short staffed? Was the alleged showing signs of burnout and/or inappropriate behavior prior to the incident? Have staff members reported this, and has the facility responded to these issues?
 - **What** was the “resulting outcome” or harm to the resident? This is a key component. This “resulting outcome” needs to be observed (at the time the allegation occurred) and documented. In cases of mental or psychological abuse, it may be necessary to utilize the reasonable person concept to determine the extent of the injury.
 - **How** has the facility protected the resident(s) during the investigation of the alleged incident?
- Was the affected resident’s care plan developed to address the resident’s needs and behaviors? What were the approaches?
 - Determine if facility policies and procedures, care plan development for the affected resident, and all annual employee training on Abuse Prohibition were in place prior to the incident. Do changes need to be made?

If you have questions regarding this information or would like more help with investigating potential abuse allegations, please contact the ND Department of Health, Division of Health Facilities.

REPORTING GUIDELINE –

◆Initial Report of Allegation (Immediate)

1. Phone: 701.328.2352
2. Fax: 701.328.1890
3. E-Mail: bprietsch@nd.gov

- Call if you have any questions regarding allegation and/or need to report.
- Written Investigation Report (within five working days).

Mail to: Bruce Pritschet
North Dakota Department of Health
Division of Health Facilities
600 E Boulevard Avenue Dept 301
Bismarck, ND 58505-0200

Fax: 701.328.1890 Attn: Bruce Pritschet
Must be followed by mailing of a signed “Hard copy” of the report.

E-Mail: bprietsch@nd.gov
Must be followed by mailing of a signed “Hard copy” of the report.

MDS Tip Sheet: ITEM H3a

Any Scheduled Toileting Plan

MAY 2008

INTRODUCTION	In response to questions related to MDS coding for item H3a, scheduled toileting plan, the following tip sheet has been developed. Use this MDS 2.0 Tip Sheet to better understand MDS coding rationale for this item.
DEFINITION	Item H3a asks you to indicate whether the resident is on a plan for bowel and/or bladder elimination whereby staff members, at scheduled times each day, either take the resident to the toilet room, give the resident a urinal, or remind the resident to go to the toilet during the 14-day observation period. This item includes bowel habit training and/or prompted voiding.
CLARIFICATIONS	<p>There are three key concepts to consider when coding item H3a:</p> <ul style="list-style-type: none"> ■ Scheduled – means performing the activity according to a specific, routine time that has clearly been communicated to the resident (as appropriate) and to caregivers. ■ Toileting – means voiding in a bathroom, commode or other appropriate receptacle (e.g. urinal, bedpan). ■ Plan/Program – means a specific approach that is <i>organized, planned, documented, monitored and evaluated</i>. All three (3) key components must be present in order to code H3a.
CODING TIPS	<p>Simply providing incontinence care for a resident does not mean that the resident is on a Toileting Plan. The plan must be based on the individualized assessment of the resident's need for a toileting program. Consider the following items when evaluating whether a scheduled toileting plan/program may be coded at H3a:</p> <ol style="list-style-type: none"> 1. The plan should contain an individualized, resident-specific toileting schedule – listed either by hours or around the resident's pattern. [Note: This does not include generic, every two-hour toileting; nor does it include a plan/schedule that is the same for all incontinent residents.] 2. The resident's individualized plan should be clearly communicated and be available and accessible to staff and the resident (as appropriate), via the resident care plan, flow records, verbal and written report, etc. 3. The resident's response to the toileting program and subsequent evaluation should be documented in the clinical record and include when changes have been made, depending on the resident's response. 4. If the resident is coded a "4" (totally incontinent) in item H1, then clinical documentation would need to be present to support the appropriateness of coding item H3a.
CODING EXAMPLES	<p>1) Mr. M., who has a diagnosis of CHF and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding assessment. After completing this assessment, a plan was developed that called for toileting every hour for four hours after receiving his diuretic, then every three hours until bedtime. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will re-evaluate the resident's response to the plan after one month and adjust as needed. This is a scheduled toileting plan. Code item H3a.</p> <p>2) Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the staff for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding assessment indicates no pattern to her incontinence. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every two hours while awake and apply a super-absorbent brief at bedtime so as not to disturb her sleep. This is not a scheduled toileting plan. Do NOT code item H3a.</p>
FOR MORE HELP	<p>The RAI User's Manual for MDS coding is available on the Centers for Medicare & Medicaid website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp. If you need help interpreting MDS coding instructions, contact your State RAI/MDS Coordinator listed in Appendix B of the User's Manual. If you require further assistance, you may submit your question to mdsquestions@cms.hhs.gov.</p>

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MDS Tip Sheet: ITEM M5c Turning/Repositioning Program

SEPTEMBER 2007

INTRODUCTION	In response to questions related to MDS coding for item M5c, turning/repositioning program, the following tip sheet has been developed. Use this DAVE 2 Tip Sheet to better understand MDS coding rationale for this item.
DEFINITION	Item M5c asks you to indicate whether there has been a continuous, consistent program for changing the resident's position and realigning the body during the 7-day look back period.
CLARIFICATIONS	Program – means a specific approach that is <i>organized, planned, documented, monitored and evaluated</i> .
CODING TIPS	<p>Simply using a standard turning schedule whereby residents are turned every two hours does not constitute a turning/repositioning program that would allow you to code Item M5c. Consider the following when evaluating whether a turning/repositioning program may be coded at M5c:</p> <ul style="list-style-type: none"> • The turning/repositioning plan/program is specific as to the approaches for changing the resident's position and realigning the body. This plan/program is organized and planned. • Progress notes, assessments, or other documentation (as dictated by facility policy) supports that the turning/repositioning plan/program is monitored and evaluated over time to determine the effectiveness of this intervention. <p>The frequency with which position changes are performed must be based on the individualized assessment of the resident.</p>
CODING EXAMPLES	<p>1) Resident Martha James has a diagnosis of right-sided hemiplegia from a previous stroke. She has received rehabilitation and is able to assist in some of her care and positioning. As part of her assessment, it was noted that while in bed Martha is able to tolerate pressure on each side for approximately three hours before showing signs of the effects of pressure on her skin. Staff assist her to turn every three hours while in bed. When she is up in her wheelchair, it is difficult for her to off-load the pressure to her buttocks. Her assessment indicates that her skin cannot tolerate pressure for more than one hour without showing signs of the effect of the pressure when she is sitting, and therefore, Martha is assisted hourly by staff to stand for at least one full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident's response to the interventions. This is a turning/repositioning plan/program. Code Item M5c.</p> <p>2) Resident Mary Jenks has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of her care. Her care plan states that she is to be turned and repositioned, per facility policy, every three hours. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no assessment of the resident's response to turning and repositioning. This is not a turning/repositioning plan/program. Do NOT code Item M5c.</p>
FOR MORE HELP	The RAI User's Manual for MDS coding is available on the Centers for Medicare & Medicaid Services website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp . If you need help interpreting MDS coding instructions, contact your State RAI Coordinator listed in Appendix B of the User's Manual. If you require further assistance, you may submit your question to mdsquestions@cms.hhs.gov .

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Long Term Care Highlights

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RAI Updates

*By Joan Coleman
State RAI Coordinator*

The Centers for Medicare and Medicaid Services (CMS) posts the Long-Term Care Facility Resident Assessment Instrument User's Manual updates, the MDS coding Tip Sheets, and information related to MDS 3.0 on its website at: [http://](http://www.cms.hhs.gov/NursingHomeQuality-Initiatives/NHQIMDS20.asp#TopOfPage)

www.cms.hhs.gov/NursingHomeQuality-Initiatives/NHQIMDS20.asp#TopOfPage

CMS just released a MDS coding Tip Sheet dated May 2008, in response to questions related to coding Item H3a: scheduled toileting plan. And in September 2007, they released a MDS Tip Sheet on Item M5c: turning/repositioning program. These MDS Tip Sheets were developed to clarify questions related to coding these particular items.

Have you downloaded all your Long-Term Care Facility Resident Assessment Instrument User's Manual updates so your manual is current? Since December 2002, updates have occurred in August 2003, April 2004, June 2004, June 2005 August 2005, November 2005, December 2005, January 2006, March 2006, June 2006, March 2007 and January 2008.

QUOTES:

We cannot seek or attain health, wealth, learning, justice or kindness in general. Action is always specific, concrete, individualized, unique.

By Benjamin Jowett

Happiness is nothing more than good health and a bad memory.

By Albert Schweitzer



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600 E. Boulevard Ave., Dept. 301
Bismarck, N.D. 58505-0200
Phone: 701.328.2352
Fax: 701.328.1890
Website: www.ndhealth.gov

Terry L. Dwelle, M.D., MPHTM, State Health Officer
Darleen Bartz, PhD, Chief, Health Resources Section
Bruce Pritschet, Director, Division of Health Facilities
Lucille Torpen, LTC Program Manager
Cindy Kupfer, Newsletter Design