“Resident To Have a Thumbs-up Cup at All Meals ….. What Is A Thumbs-up Cup?”
By Angela Hetland, Surveyor

The definition of eating is “the ability to transfer food from the plate to stomach through the mouth.” The definition of feeding is “the process of getting the food from the plate to the mouth.” There are a variety of assistive devices available which can help residents to feed themselves. These devices are also referred to as adaptive equipment. Typically, an occupational therapist will evaluate a resident and determine which type of adaptive equipment is appropriate for a resident. Some examples of adaptive equipment include specially designed eating utensils, cups and plates. Adaptive equipment that is utilized at a meal always should be clean, and caregivers should be knowledgeable in the use of the equipment. The following are a few examples of types of adaptive equipment that may be utilized for residents during mealtimes:

- **Nosey cup** - ideal for people who have oral motor limitations; limited range of motion of the head, neck or upper extremities; or arthritis. This cup is designed to allow the user to drink with little or no shoulder flexion, wrist extension or head/neck movement, even if wearing a cervical collar. The special design of this utensil even allows space for eyeglasses.
- **Maroon spoons** - a shallow, narrow bowl-shaped spoon ideal for residents with poor lip closure, oral hypersensitivity or tongue thrust.
- **Weighted utensils** - can aid in stabilizing a tremulous hand.
- **Curved eating utensils** - angled spoons, sporks, forks, or knives with built-up handles that make them easier to hold and promote easier hand-to-mouth feeding.
- **Scooper plate** - a flat-bottomed plate with a high rim and a reverse curve on one side, that aids in process of scooping food onto a utensil without spilling over the side (available with a suction cup base to avoid skidding).

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Plate guard - ideal for residents with lack of coordination. Guards clip onto any circular dinner plate and provide walls against which food may be pushed onto forks or spoons. Colored bumpers may be used for identification of individuals with dietary restrictions.

Inner-lip plate - ideal for residents with limited muscle control and/or residents with the use of only one hand. The deep inner lip keeps food from sliding off of the plate.

Hole-in-one fork and spoon - utensils that provide several grasping positions by inserting fingers through the hollow center or by wrapping fingers around the outside. Ideal for residents with limited hand mobility.

Built-up handles - knives, forks or spoons with handles that allow residents with a weak grasp, limited hand strength or decreased range of motion to be able to feed themselves independently.

Thumbs-up cup - a thumb grip on either side of the cup which increases leverage of the hand, reduces the possibility of spilling due to trembling, and aids in raising the cup to the lips without wrist motion. Ideal for residents with decreased grip strength, wrist pain and hand deformities.

Dycem (a brand name) - a special mat that can be used underneath a resident’s plate or bowl to stabilize the dishware and to prevent it from sliding while the resident is eating.

How does the use of adaptive equipment relate to the survey process? When surveyors enter a facility and sampled residents are chosen for observation, some of the sampled residents may require the use of adaptive equipment at meals. If a resident has been evaluated appropriately and is care planned to have adaptive equipment at meals, it is an expectation of the facility to provide the needed equipment at mealtimes. As a reference, tag F369 addresses the use of assistive devices. It states, “The facility must provide special eating equipment and utensils for residents who need them.” The intent of the regulation is to ensure residents are provided with assistive devices to promote independence with eating skills, and it is the responsibility of surveyors to determine that the regulation is implemented.

References
http://www.consultgerirn.org/topics/mealtime_difficulties/want_to_know_more/
http://www.adaptivechild.com
HAND HYGIENE
By JoAnn Loep

To protect yourself, wash those germs away. Doctors say it’s the best way to keep colds and flu at bay and help stop the spread of infectious diseases.

In our work, we use our hands constantly. Microorganisms are on everything we touch. Washing your hands is the single most important thing you can do to prevent the spread of disease.

Hand hygiene is defined by the US Centers for Disease Control and Prevention (CDC) as any method that removes or destroys microorganisms on hands.

Disease transmission is hand-to-hand contact, at least for infectious diseases, and by washing your hands regularly, you decrease the spread of disease.

Hand washing also can keep you from becoming infected with bacteria such as Salmonella or E. coli. The CDC says an estimated 76 million Americans are stricken with a food-borne illness each year, and 5,000 die from their illness.

Basic hand washing involving soap and water is a simple affair:
- Start with warm water and wet your hands; after that, dispense the soap into your hands.
- Rub your hands together vigorously for at least 15 to 30 seconds, scrubbing all surfaces of the hands and fingers. To do a thorough job, sing at a reasonable pace either “Happy Birthday” or “Row, Row Your Boat” twice to help you get through your 30-second hand wash. Friction is the key because it dislodges all the germs from the skin surface.
- Rinse your hands briskly in running water to remove the suds and with them the germs.
- Blot your hands dry with clean paper towels, drying all surfaces of your hands, wrists and fingers.
- Use a clean, dry paper towel to turn off the faucet.
- If hands are visibly clean and you just want to make sure that you’re not transmitting germs, then an alcohol-based disinfectant gel will work just fine.

The alcohol gel will kill up to 99 percent of the bacteria on your skin. Just apply a dab to your hands and rub vigorously until it evaporates. The friction assists the alcohol in killing the germs on your hands.

The CDC recommends washing your hands at these times:
- When you first arrive at work.
- When you enter a resident’s room and when you leave the room.
- Before and after feeding residents.
- Before you put on gloves and after you remove gloves or if gloves rip or tear.
- After contact with blood or any body fluids.
- After touching garbage.
- Before entering a “clean” supply room and getting clean linen.
- Before and after touching meal trays and/or handling food.

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After cleaning a spill.
Before and after drinking and eating, after smoking.
After using the bathroom.
After coughing, sneezing or blowing your nose.
Before leaving the facility and when you get home from work before touching anything or anyone.

Wash hands before resident care. As you move between residents’ rooms, always wash your hands. Taking care of residents means you will get many microorganisms on your hands. Wash your hands before giving care. It will help prevent the spread of disease.

Sources:
“Successful Nursing Assistant Care”, Diana L. Dugan, RN, second edition
“MSN Health and Fitness”, health.msn.com/health-topics
“Guideline for Hand Hygiene in Health-Care Settings”

Q & A on a Missed Assessment

Question: How should we handle a missed assessment? We missed a quarterly due in March and did not discover it until 2 1/2 months later.
Answer: If an assessment has been missed or late, the facility will need to establish an Assessment Reference Date (ARD) now and complete the missed assessment as soon as possible. You cannot go back and recreate the assessment from the missing time period.

If you had missed a quarterly entirely and it is now time to do another one, you do not need to do two; just do the one that is due now and forget the missed one. The time for which there was no valid assessment is considered out of compliance with the requirements, so the sooner a new ARD can be established and the assessment completed, there will be fewer days of non-compliance present. You may also have state-specific requirements that apply to these situations that will need to be considered, so

PLANS REVIEW FEES
By Monte Engel, Building Standards/Life Safety Code

The North Dakota State Legislature recently passed Senate Bill No. 2046. This bill passed with an emergency measure, and so it is effective at this time. The bill granted authority to the Department of Health to charge a reasonable fee for the review of plans for construction remodeling, and installation projects in health-care facilities licensed by our office. This includes licensed hospitals, nursing facilities, and basic care facilities.

We have implemented a plan review schedule of $300 for small projects, $900 for medium-sized projects, and $2,400 for large projects. The size of the project will be determined by our office and is based on the amount of time necessary for the review and ultimate determination of compliance.

Please note that the plans and/or specifications for projects submitted to our office will not be reviewed until this fee has been received.

State licensing rules require our office to review and approve plans and specifications for all construction, remodeling and installations prior to the start of construction. For hospitals, this rule is found in North Dakota Administrative Code 33-07-02.1-02; for nursing facilities it is found in NDAC 33-07-04.2-08; and for basic care facilities, in NDAC 33-03-24.1-03.

Routine maintenance does not require the submission of plans and specifications. Routine maintenance is the repair or replacement of existing equipment, room finishes and furnishings, and similar activities.
please call the Department of Human Services for Case Mix purposes.

Q & A on Section G ADLs

Question: How would you code this for ADL Self-Performance?
- 7-3: 4 4 4 4 4 4
- 3-11: 4 4 4 4 4 4
- 11-7: 4 0 4 4 4 4

Answer: Code “3”. Refer to the RAI Manual page 3-81. To code a 4 it must be all days and all shifts.

Question: How would you code this for ADL Self-Performance?
- 7-3: 8 8 8 8 8 8
- 3-11: 8 8 8 8 8 8
- 11-7: 8 8 8 8 8 8

Answer: Code “8”

Question: How would you code this for ADL Self-Performance?
- 7-3: 8 2 8 8 8 8
- 3-11: 8 8 8 2 8 8
- 11-7: 8 2 8 8 8 8

Answer: Code “2” as the 2 (limited assistance) was three or more times.

Question: How would you code this for ADL Self-Performance?
- 7-3: 0 0 0 0 2 0 0
- 3-11: 0 0 0 0 0 0 0
- 11-7: 2 0 0 0 0 0

Answer: Refer to the middle of Page 3-78 of your RAI Manual. Code “0”. To move from “0” to “1, 2 or 3” the higher level of assistance must occur at least three times.

Question: How would you code this for ADL Self-Performance?
- 7-3: 0 0 0 0 0 0 0
- 3-11: 0 0 0 0 0 0 0
- 11-7: 1 0 0 0 1 0 1

Answer: Refer to Chapter 3 – Page 3-82. Code “1”.

Question: How would you code this for ADL Self-Performance?
- 7-3: 0 0 1 0 0 0 0
- 3-11: 0 0 0 1 0 0 0
- 11-7: 0 0 0 0 2 0 0

Answer: Refer to the third paragraph of page 3-82. Code “1”.

Question: How would you code this for ADL Self-Performance?
- 7-3: 0 0 0 0 0 0 0
- 3-11: 0 0 0 0 0 0 0
- 11-7: 1 0 0 0 2 0 3

Answer: Refer to the third paragraph of page 3-82. The least dependent self-performance is what? Code “1”.

Question: When a resident is receiving IV fluids, how does that affect coding for item G1h, eating?

Answer: The instructions on page 3-77 of the RAI User’s Manual address g-tube and parenteral nutrition. The last bullet on page 3-81 also addresses eating. In addition, in a clarification, the 2nd bullet point from the bottom of page 3-93 states, "G1h includes receiving IV fluids." When coding G1h for a resident who is receiving one of these nutritional approaches in addition to oral nutrition, all episodes of nutritional intake must be taken into account. Therefore, if a resident received IV fluids that were managed completely by staff and also participated in feeding himself oral nutrition, the correct code for ADL Self-Performance [G1h(A)] would be “3”, extensive assistance.

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Question: Mrs. J. requires weight-bearing assistance of two to get out of the bed daily. Once in the W/C, she is able to transfer to the toilet with extensive assistance of one individual. How would Transfer be coded for ADL Self-Performance and Support?
Answer: Self Performance =3  Support=3
Rational: Toilet transfer is not included in transfer. She required weight-bearing assistance and two people to transfer.

Question: Mr. B. is able to do all of his personal hygiene except for shaving. The barber visited him three times a week to shave his beard. How would personal hygiene be coded?
Answer: Self Performance =3  Support=2
Rational: Resident required staff performance of the task three or more times but not all the time. It took only one staff person to complete the task.

Question: Resident received heavy assistance of two to transfer on/off the toilet. He is able to bear weight partially and required only standby assistance with hygiene (handing of toilet tissue). How would toilet use be coded?
Answer: Toilet Use – movement to / from toilet is covered under toilet use.
Self Performance =3 as needs weight-bearing assist during the transfer but was able to perform other parts of the task. ADL Support=3 as two people were involved.

Question: At his bedside, the resident picks up the urinal, uses it, and puts it back on the table independently, but the staff empties it for him. Or a resident transfers independently from bed to commode, toilets, wipes self, adjusts clothes independently, but the staff empty it for him. Or you flush the toilet for someone. Is this limited assistance?
Answer: Emptying the urinal or commode or flushing the toilet is not a part of the toilet use activity and is not taken into account for coding at all. If the staff places the urinal or commode within reach for the resident, it would be setup help. The correct coding for G1i, Toilet Use, in the scenario described would be Self Performance =0  Support=1.

Question: In regard to personal hygiene. The RAI Manual instructs us to exclude personal hygiene in bathing because it is covered in G2-Bathing. However G2-Bathing does not include washing of the back and hair. Could washing of the back and hair be included in the personal hygiene section, or is it just completely excluded from coding on the MDS?
Answer: Based on the coding guidance for item G1j from the manual, personal hygiene that occurs in the bath or shower is excluded from this item, as it is covered by item G2 Bathing. When reviewing the coding guidance for G2, washing of a resident’s back and hair are excluded from being coded in G2. For MDS coding purposes, the washing of the back and the hair is excluded from all MDS items. It is not captured on the MDS at all.

Question: I have been told it is not correct to capture in section G what happens in therapy. This is because one of the clarification examples on ambulation in the RAI User’s Manual states if a resident is only ambulated in therapy, then ambulating is coded 8/8. Another person told me we should capture what happens in therapy in section G. Which is correct?
Answer: Notice that items G1c, walk in room and G1d, walk in corridor are location specific, but they are not discipline specific. For G1c, walk in room, for example, any time the resident walks in the room during the look back period, that
episode of walking would be taken into account for coding this item regardless of who assisted the resident. Included in this would be episodes of walking in the room with therapy staff. Because it is location specific, the only episodes of walking that would be taken into account for this item are the ones that occurred in the room, not in the hall, not in the therapy room. Walk in corridor would similarly be limited to episodes that occurred in the corridor but would include all episodes that occurred in that location. Refer to the examples in the RAI User’s Manual on page 3-88. For these examples, the activity occurred in the therapy room.

To determine what to code the MDS for these items, pull together all of the episodes of walking in the room (or walking in the corridor) and identify the level of assistance required by the resident for each episode. Code the MDS based on the highest level of dependence that occurred three or more times in the observation period across all episodes. The exception is that the resident would be coded for total dependence only if 100 percent of the activity was done for him 100 percent of the time during the observation period, with no resident participation in the activity whatsoever.

**CERTIFIED NURSE AIDE REGISTRY UPDATE**

By Cindy Kupfer and Rocksanne Peterson

Reminder - If you need to renew your Medication Assistant (Med Aide) license, or your Unlicensed Assisted Person license (UAP), please call the Board of Nursing (BON) 701.328.9777.

The North Dakota Department of Health Department does not have the registry for either of these.

We have received many phone calls regarding renewing Medication Assistants and problems with entering their CNA number. If you are having problems with this, please call the BON.

**QUOTE:**

Slow down and enjoy life. It's not only the scenery you miss by going too fast - you also miss the sense of where you are going and why.

Bobby Cantor

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