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INSIDE THIS ISSUE

Navigating tax reform in 2019

After speaking with a few subject matter experts about the new tax laws, *PROPEL Long-Term Care Journal* has the good, the bad, and the salvageable for 2019 tax reform. For some long-term care (LTC) facilities, these changes will have significant dollar impacts on 2018 tax returns, while other facilities will slip through the IRS' narrow cracks mostly unaffected. Just as the care plan for each resident should be individualized to his or her care needs, each facility's approach to taxes this year should be customized to its unique situation. Here are a few changes to keep in mind and discuss with your certified public accountant (CPA) before submitting this year's tax return.

IRS Code Section 163(j): Business interest limitation

A rule released by the IRS says that all taxpayers (including personal returns, limited liability corporations [LLC], and corporations) can only deduct up to 30% of their adjusted taxable income in interest expense beginning after December 31, 2017. According to the IRS' notice of proposed rulemaking that will be discussed in a hearing on February 25, 2019, the limitations rule doesn't apply to taxpayers with average annual gross receipts of $25 million or less, meaning that most freestanding skilled nursing facilities (SNF) won't be subject to the limitations.

While many nursing homes are individually owned and operated (think mom-and-pops), "most for-profit structures today have the ownership of the individual SNF as an LLC. This was done to limit liability to the parent holding corporation and to create anonymity for investors. For example, XYZ Homes may own 50 SNFs, but each is structured as its own LLC entity with nothing more than passed-through management costs and other service fees, etc.," says **Reginald Hislop, III, PhD**, owner of H2 Healthcare Consulting. This structure poses two potential benefits to facilities: If one facility has OIG problems, it doesn't end up impacting the rest of the holdings. Secondly, "even though XYZ Homes may have more than $25 million in revenue when combined, the debt/interest expense can be pushed to the individual facility level (and often is)," says Hislop, meaning that the individual facility is eligible to opt out of the limitations rule. This is perhaps the only benefit to operating on extremely tight margins and low reimbursement rates.

LLCs or corporations that own and lease real estate may be eligible for opting out of the interest limitation rule at the cost of forgoing their 100% write-off depreciation, but due to a second stipulation still in proposal form, many SNFs may be exempt. In the proposal, the IRS does not consider an LLC that is owned and leased under common control to be a real estate entity, thereby preventing these

LLCs from opting out of the limitation rules. Companies considered under common control are those that have 50% or more of the ownership belonging to the same person/people.

IRS Code Section 199A: QBI deduction

Kuno Bell, CPA, JD, director of tax at Pease & Associates, LLC, explains that in five to 10 years, based on the trajectory of the U.S. economy, 95% of all government spending will have to be directed to non-discretionary spending (i.e., Social Security, health programs, etc.), essentially leaving the government with no spending budget for all the other economic areas it's responsible for. "To solve this problem, they came up with all these tax cuts to 'superjuice' the economy so that in five to 10 years, the government will have the tax dollars to support its spending rate," says Bell. One of the things developed to help grow the economy was the qualified business income (QBI) tax deduction.

The QBI deduction provides a significant tax benefit to many businesses by allowing them to deduct up to 20% of their income. In other words, qualified businesses don't have to pay taxes on 20% of their income. "For example, if you're a qualified business that makes 1 million dollars, you only have to pay taxes on $800,000. If it works out perfectly, it drops your tax rate from 38% to 29% on that income because you're excluding that 20% piece of it," says Bell.

Determining which businesses are considered a qualified trade has been foggy territory, however. For certain occupations, including lawyers, accountants, medical businesses, athletes, and performers, exclusion is cut and dry. That's right, we said *medical businesses are excluded*. As anyone who's worked in the LTC industry knows, however, services provided in a nursing home or in senior housing go far beyond just medical services. So what qualifies as a medical business?

According to an interpretation released by the treasury department last August, any business that makes more than 5% of their revenue from providing medical services will fall under the medical category, and none of that revenue will be allowed to qualify for the 20% deduction. "In a nursing home, even if the majority (80%–85%) of your revenue is paying for non-medical services such as housing, feeding, and providing activities to keep residents socially active, none of that qualifies for the 20% deduction," says Bell. He adds that the QBI deduction's requirements also exempt a commonly controlled company that leases property or provides services to a disallowed business (such as a medical business) from utilizing the QBI deduction.

"The first thing facilities should do is determine eligibility," says **Cynthia J. Heuberger, CPA**, senior tax partner at Hansen, Hunter & Company, PC. "I think right now there's a fair amount of consensus in the industry that nursing home and SNF providers are considered a specified services trade or business, which means they are not going to be able to take this deduction because of the level of healthcare that they're providing," Heuberger's firm was founded 40 years ago to provide services to the LTC and senior housing industry; it currently serves clients ranging from one-off nursing homes to regional providers with facilities in dozens of states.

Heuberger says the number one challenge for facilities this year is tax reform and understanding and implementing what has changed. "One big change is Section 199A, the QBI deduction. There's so much there, and while some guidance has been provided, it's not comprehensive and there are still a lot of unanswered questions," she says.

"Until some of these things end up being litigated, tried, or put in front of the IRS for a revenue ruling, it remains ambiguous," adds Hislop. "It can be hard to understand until organizations and accounting firms start asking for clarifications."

IRS Code Section 461(l): Excess business loss

Heuberger says another change that facilities should be aware of is the excess business loss limitation, which could kick in at the individual owner level. Code Section 461(l) essentially says that you can't use net trade or business losses to offset more than $500,000 (for married filing jointly) or $250,000 (for all other taxpayers) of other income (such as income from investments). Any portion of excess business loss a taxpayer has for that year is disallowed and will become a net operating loss that will be carried forward to future tax years.

"This is a pretty significant change at the owner level because previously you could just wipe out all your income. If you had a large loss flowing through from your business, it wouldn't matter if you had 5 million dollars in capital gain or interest income or dividends—as long as you had enough loss flowing through, you could net those two things at the owner level. That's no longer the case," she says.

What facilities can do to offset potential losses

This year more than ever, it's important that facilities sit down with a trusted professional to determine how tax reform will affect them. "When you're dealing with taxes, there's so much complexity and one little decision can have a significant dollar implication. It can be very difficult to put that into context if you're not dealing with a professional who handles this on a regular basis and can follow through the decisions that are being made on a business level and how those will impact each individual owner. There's still a lot of ambiguity on the new tax law, so staying informed is critical to making the best decision regarding which position to take on your tax returns," says Heuberger.

Although clearly challenging in its complexity, she doesn't see tax reform as a death sentence for all facilities. "I think some of the other changes in the tax law can help mitigate what could potentially be negative impacts on LTC facilities." The following options may be able to offset negative impacts from tax reform for certain facilities if their situation fits the criteria:

- **Bonus depreciation**: Several changes in the rules surrounding bonus depreciation have been updated and may swing in a positive direction for LTC facilities, such as a temporary 100% expensing rule for certain business assets.
- **Accounting method changes**: The rules on who can use a cash method of accounting have changed, for example, and for some taxpayers this could be an option for saving significant tax dollars.
- **Opportunity zone investments**: In the right situation, an opportunity zone investment could help facilities recoup some tax dollars. As defined by the IRS, "an opportunity zone is an economically-distressed community where new investments, under certain conditions, may be eligible for preferential tax treatment. Opportunity zones are designed to spur economic development by providing tax benefits to investors. First, investors can defer tax on any prior gains invested in a Qualified Opportunity Fund (QOF) until the earlier of the date on which the investment in a QOF is sold or exchanged, or December 31, 2026. If the QOF investment is held for longer than 5 years, there is a 10% exclusion of the deferred gain. If held for more than 7 years, the 10% becomes 15%. Second, if the investor holds the investment in the Opportunity Fund for at least ten years, the investor is eligible for an increase in basis of the QOF investment equal to its fair market value on the date that the QOF investment is sold or exchanged."
- **Avoiding common ownership**: If more than one owner is involved, Bell recommends that the percentage be split 51/49 so you can qualify for the 20% deduction on the rental income and are also able to opt out of the interest limitation. For example, if a real estate agency purchases a nursing home building and then leases it to the nursing home operator, as long as the nursing home operator owns less than 50% of the real estate (49% or less), the owners won't be considered related, making them eligible to opt out of IRS Code Section 163(j). In this scenario, the owners could even the economic playing field by working out rent and pay to avoid unfair compensation or return, says Bell.
- **Maintaining high quality results in higher revenue**: Hislop reminds providers that the winners will remain the same in 2019, despite changes to the tax law. "High quality, preferred outlets for narrow networks and bundled payment participants, low readmission rates, high patient satisfaction scores, lower costs of care, and quality environments (i.e., private rooms, good food, free WiFi, etc.) are all things facilities should strive for." How can facilities achieve these winning goals? Hislop recommends the following:
  - Reduce overhead costs, which probably means restructuring any property related leases.
  - Offer in-house therapy programs.
  - Maintain a balanced Medicare census with the

capacity to take care of clinical complexities such as cardiac patients, IVs, dialysis, and sepsis. Because of their clinical acumen, facilities able to provide this kind of care will do well under the Patient-Driven Payment Model (PDPM) and continue to get the bulk of the hospital referrals that require institutional, postacute stays.

In related news: REITs, rents, and revenue

It's difficult to move forward without first looking back and considering lessons learned. We've entered a new year with several big players either "decimated" or on their way out, says Hislop, as a result of low Medicare rates that don't offset increasing labor costs; a demand for SNF and nursing home care coming from a subset of elderly who have Medicaid as a payer source, which infamously pays below cost of care; Medicare Advantage contracts, which typically pay 95% of RUG levels at best and 65% at worst, but require SNFs to contend with dictated lengths of stay, slow payment, and lots of additional paperwork to get paid; and "an insidious cycle" in which rent payments for REIT leases are going up but reimbursement is not. Using HCRManorCare, Genesis, Kindred, Signature, Five Star, and Sava as examples, he warns corporations not to try "saving themselves to a profit"—it's an impossibility, "because the cuts you're making will affect quality and contribute to the never-ending cycle that was the demise of so many big corporations."

Although it will be another rocky year for REITs, says Hislop, he sees an opportunity for them to make gains in 2019 as a result of a restructure in leases away from triple-net to the REIT Investment Diversification and Empowerment Act (RIDEA). The problem with triple-net, says Hislop, was that it created a stream of revenue for the REIT based on rent payments increasing over time, which hurt facilities as rents increased faster than revenues with no value proposition for the facility.

In contrast, "RIDEA creates income that is rent plus a share of net income from the facility, provided that a third-party manager is in place. In this structure, the rent component is low, yet the REIT can increase its income via a 'shared success' formula from a positive net income. The structure promotes the REIT to keep only good facilities, be flexible on rent, and to work with operators to make sure the SNF can perform well and achieve a positive bottom line," he says.

What you need to know about CMS updates to Part B, Part D, and Medicare Advantage plans

Between 2011 to 2016, Medicare fee-for-service drug spending increased from $17.6 billion to $28 billion under Medicare Part B. Medicare Part D total spending has almost doubled from 2010 to 2016, increasing from $77.5 billion to $146.1 billion, with costs projected to increase further, according to the Centers for Medicare & Medicaid Services (CMS). Drug prices for beneficiaries in the U.S. are also on the rise and can be found in places like Europe for up to 80% cheaper, according to NPR. The cause? A market full of hurdles and barriers to creating biosimilars (drugs with the same or similar active ingredients as the original and often available at a reduced price); current laws that prevent vendors from negotiating drug prices; and outrageous prices for essential drugs that treat ever-more-common chronic conditions, such as cancer, rheumatoid arthritis, and hepatitis C.

Lowering drug prices and reducing out-of-pocket costs is part of the president's game plan, an aim the administration is fulfilling by testing several new models that seek to increase competition. However, before you learn about CMS' latest innovations, it's important to first understand the problem on a patient level.

Barrier to affordable drugs in the U.S.

The state of pharmaceuticals in the U.S. may be best looked at in contrast to Europe. According to an article written by NPR, "Why the U.S. Remains the Most Expensive Market for 'Biologic' Drugs in the World," patients in Europe enjoy a selection of dozens of biosimilars (50 altogether), which allows for competition and lower drug prices. Not only do European countries allow for competition, they actually require patients to switch to a

less expensive version of a drug once it becomes available and is deemed safe. In general, the U.S. doesn't allow for such negotiating and competition, which keeps drug prices unreasonably high and prevents alternative options, save for six biosimilars that are currently available.

There are also several strategies that drug makers have perfected to prevent copycat versions of their drugs from entering the country or gaining market share. These strategies include the following:

- **Rebate traps**: A business tactic in which financial deals are cut to make sure patients can only get a biologic, and not its less expensive biosimilar. A recent example of this tactic involved 2017 allegations from Pfizer that Johnson & Johnson created exclusionary contracts preventing health insurers, hospitals, and clinics from using the biosimilar Inflectra® that Pfizer had created for Johnson & Johnson's biologic, Remicade®. Both drugs are antibodies used to treat multiple chronic conditions, including rheumatoid arthritis, Crohn's disease, and severe or disabling plaque psoriasis.
- **Patent thickets**: A concept that has been said to have negative connotations, patent thickets involve having an overlapping set of patent rights for a drug, making it more difficult for companies to commercialize new drugs or create less expensive biosimilars. Humira®, for example, has more than 100 patents protecting it in the U.S., according to NPR.
- **States dictating when brand-name drugs can be replaced with biosimilars**: State laws were recently amended to make it more difficult for pharmacists and doctors to replace a brand-name biologic with its biosimilar after concerns were raised about generic drugs being created that aren't identical to the original version. While these laws were made stricter for safety reasons, the situation nonetheless contributes to the issue of high drug prices and restrictions on creating less expensive versions.
- **FDA requirements for labeling**: A surprising contributor to lack of access to affordable drugs is the random suffix. To differentiate it from its biologic, the FDA requires each biosimilar to have a random suffix attached to its name. This could increase confusion about the generic drug's quality or similarity to its biologic and deter doctors and patients alike from choosing the less expensive route.

Currently, there are three new models in the pipeline for testing to reduce drug costs for both Medicare and its beneficiaries.

Part B: IPI model

In what CMS calls "[a commitment] to implementing President Trump's blueprint to lower drug costs and reduce out-of-pocket costs for patients," the agency is considering issuing a proposed rule in the spring of 2019 on a new potential model that would test whether increasing competition for private-sector vendors to negotiate drug prices, and aligning Medicare payments for drugs with prices that are paid in foreign countries, improves beneficiary access and quality of care while reducing expenditures. The model, called the International Pricing Index (IPI) model, would start in spring 2020 and operate until the spring of 2025. The public comment period on the advanced notice of proposed rulemaking closed on December 31, 2018.

Roy Edroso, editor for Part B News, explains that under this model, "providers would no longer buy the drugs from manufacturers or their agents; they would buy from vendors specifically limited to the international price model. Providers would be reimbursed by Medicare for their expenses plus, as now, a surcharge.

"The IPI model is compared explicitly with the Competitive Acquisition Program (CAP) model with which CMS experimented between 2006 and 2008. That voluntary program, which allowed doctors to order Part B drugs through private vendors who would then bill Medicare for the payment, was supposed to reduce burden on providers, but it never caught on.

"Under the new plan, as with CAP, CMS is considering commissioning third-party vendors to supply Part B drugs to physicians, but in this case those vendors would be paid according to a scale 'based on international prices.' The scale would involve a formula mix of international 'target price' and the currently used ASP, with target share increasing until it becomes the sole basis for payment in year five. The vendors would then 'compete for physician and hospital business,' according to the rule."

Model participants would include physician practices and hospital outpatient departments that furnish the model's included drugs in the selected model geographic areas, with considerations for including durable medical equipment suppliers, ambulatory surgical centers, or other Part B providers and suppliers that furnish the included drugs. A CMS fact sheet with additional information is available here.

Some skepticism exists about whether the IPI model will actually reduce costs for beneficiaries or instead shift the cost of care directly to patients.

Medicare Advantage health plan innovations

CMS' Value-Based Insurance Design (VBID) model for calendar year 2020 is an update to the VBID model that CMS first launched in 2017 and will test several Medicare Advantage health plan innovations. Eligible Medicare Advantage health plans in all 50 states and territories may apply for the health plan innovations being tested under the VBID model. In addition to currently eligible plan types, Regional Preferred Provider Organizations and all Special Needs Plan (SNP) types—Chronic Condition SNPs, Dual Eligible SNPs, and Institutional SNPs—are allowed to apply to the VBID model. Applications will be open until March 1, 2019. The interventions being tested include the following:

- Value-based insurance design by condition, socio-economic status, or both—non-uniform benefit design to provide reduced cost-sharing or additional supplemental benefits for enrollees based on condition and/or certain socio-economic status (i.e., low-income subsidy eligibility or dual eligibility).
- Meaningful and focused Medicare Advantage and Part D rewards and incentives programs.
- Increased access to telehealth services by allowing plans to propose using access to telehealth services instead of in-person visits, as long as an in-person option remains, to meet certain requirements for the provider network.
- Timely, coordinated approaches to wellness and healthcare planning, including advance care planning. This is a required component for all VBID-participating Medicare Advantage plans.

Part D Payment Modernization model

The Part D Payment Modernization model will begin January 2020 and will test the impact of a modernized Part D payment structure that creates new incentives for plans, patients, and providers to choose drugs with lower list prices in order to address rising federal reinsurance subsidy costs in Part D.

Currently in Part D, once a patient's prescription drug spending is high enough for the patient to enter the final phase of the benefit, known as the "catastrophic phase," Medicare is responsible for 80% of drug costs. This introduces perverse incentives and leaves plans with little reason to negotiate lower costs for the highest-spending patients. Under the new model, which takes effect for the 2020 plan year, participating plans will take on greater risk for spending in the catastrophic phase of Part D, creating new incentives for plans, patients, and providers to choose drugs with lower list prices.

According to a CMS fact sheet, the enhanced VBID model will test a new series of service delivery approaches for Medicare Advantage plan beneficiaries for the 2020 plan year, including:

- Allowing plans to provide reduced cost sharing and additional benefits to enrollees in a more targeted fashion, including customization based on chronic condition, socio-economic status, or both, and even customization for benefits not primarily related to healthcare, such as transportation
- Bolstering the rewards and incentives programs that plans can offer beneficiaries to take steps to improve their health, permitting plans to offer higher-value individual rewards
- Increasing access to telehealth services by allowing plans to use access to telehealth services instead of in-person visits (as long as an in-person option remains) to meet a range of network requirements, including certain requirements that could not previously be fulfilled through telehealth

Program Prep

Program time

Approximately 30 minutes

Learning objectives

- Identify nonpharmacological approaches that can be applied to common dementia behavior symptoms
- Understand general care strategies for dealing with residents living with dementia
- Participate in the different components of interdisciplinary dementia care
- Explain how to improve nutrition by implementing effective mealtime strategies
- Define the CNA's role in resident activities

Preparation

- Review the material on pages 8-12 of this inservice
- Duplicate pages 8-12 of this inservice for participants
- Gather equipment for participants (e.g., an attendance sheet, pencils, etc.)

Method

- Place a copy of the packet and a pencil at each participant's seat
- Conduct the questionnaire as a pretest or, if participants' reading skills are limited, as an oral posttest
- Present the program material
- Review the questionnaire
- Discuss the answers

Answer Key

1. c
2. d
3. c
4. d
5. a
6. b
7. a
8. b
9. d
10. a

Inservice

Dementia care: Nonpharmacological approaches to behavior management

As the staff member who interacts the most with the resident, the CNA plays an important role in dementia care. Each resident with dementia must receive the appropriate care to address his or her unique needs.

As federal regulations for nursing homes and skilled nursing facilities (SNF) mandate that providers reduce the amount of antipsychotics prescribed to residents, understanding nonpharmacological approaches to behavior management for residents living with dementia is essential to provide quality care and avoid citations.

This inservice will discuss the **importance of understanding the root cause of dementia behavior symptoms,** including several **nonpharmacological approaches to common behaviors and general care strategies to keep in mind** when caring for residents living with dementia.

This lesson will also **explain why collaboration is essential to providing person-centered care** and outline **how the CNA can participate in an interdisciplinary care approach.** Lastly, we will **review the CNA's role in the resident's nutrition and activity program.**

Dementia care: Nonpharmacological approaches to behavior management

The best way to minimize dementia behavior symptoms is to get to the bottom of why the resident is feeling that way in the first place. Let's look at some behaviors that are common in residents with dementia, followed by nonpharmacological approaches that can help ensure a person-centered dementia care program in your facility.

- Caring for a resident who is constantly walking:
  - Provide an environment with seating areas along a walking path that includes objects the resident can stop and manipulate
  - Introduce the resident to a room with a calming atmosphere that includes music, lighting, and rocking chairs (e.g., a multisensory or massage room)
  - Engage the resident in conversation about what he or she is seeking or looking for
- Managing a resident who is hitting, yelling, or performing other compulsive behaviors:
  - Provide a calm environment with structured activities such as sorting, folding, and matching
  - Use small group activities
  - Offer a favorite snack
- Addressing disruptive, demanding behaviors or catastrophic reactions such as crying or anger:
  - Provide achievable activities in small, simple steps
  - Include the resident in small group activities
  - Use short and repetitive activities that can be stopped if the resident becomes overwhelmed
  - Involve the resident in familiar activities such as occupation-related tasks
  - Use slow exercises such as tapping and drumming
- Dealing with a resident who goes through others' belongings:
  - Conduct activities that include sorting, stacking, or other organizational tasks
  - Provide rummaging areas in plain sight that include a dresser or a chest of drawers with clothing or other items
  - Place removable "Do not disturb" signs for residents' doors whose rooms are being rummaged through
- Caring for a resident who is withdrawing from previous activity:
  - Conduct an activity outside of the room just before or after meals
  - Invite the resident to activities, accompanied by a trusted family member
  - Provide opportunities to participate in activities that emphasize the resident's history, such as a sport or cultural activity
  - Plan an outdoor activity
- Dealing with a resident whose lack of personal safety awareness may cause self-injury:
  - Involve the resident in smaller group activities
  - Use activities that are soothing such as music or talking about personal skills (e.g., baking, gardening)
  - Make sure the resident isn't being left unmonitored at the nurses' station. Sometimes staff believe there is increased surveillance at this location, but in reality, staff at the nurses' station are often preoccupied with other tasks, such as documentation
- Caring for a resident who experiences delusions or hallucinations:
  - Focus on familiar activities and provide verbal reassurance to decrease stress and improve awareness of actual surroundings

As a CNA, you will be expected to identify which approaches should be used to address specific behaviors. Focus on the following tips:

- Increase pleasant and desirable experiences for the resident
- Assist the resident in achieving his or her highest potential for participation in any task
- Recognize early signs and triggers of agitation to avoid a negative event

- Use communication, validation, and distraction techniques when necessary
- Be aware of communication perceptions such as body language, gestures, facial expressions, and tone of voice
- Be aware that effective approaches may change as the resident's dementia progresses
- Avoid making assumptions; even with a diagnosis of dementia, a resident may be able to communicate his or her needs in one way or another

The CNA's role in communicating with other team members

There is a distinctive gap in communication between nursing and other departments. Everyone will need to work together to close this gap by using a collaborative approach to communicating. For example, when a resident is receiving services from therapy or other disciplines for a dementia-related condition, CNAs must be aware of the following:

- The reason for the services, such as therapy, and how the services relate to the diagnosis of dementia
- The treatment or approaches being used for the dementia symptom or behavior
- The approaches that should be used between other services, while CNAs are caring for the resident, to reinforce and strengthen the efforts of those services
- The specific approaches for specific dementia behaviors

CNAs must also:

- Communicate observations to the nurse to effectively manage pain, fatigue, and nutrition
- Promptly communicate any physical or cognitive declines or improvements to the nurse
- Participate in rounds for a resident to discuss improvements or declines and to review the resident's care plan with the other interdisciplinary team members
- Report changes to the nurse

All approaches and interventions implemented by the interdisciplinary team must be cognitively appropriate to improve functioning or prevent declines in residents. For example, a resident who does not have the cognitive ability to know when he or she needs to use the toilet may benefit from a toileting schedule that ensures the resident is taken to the bathroom at his or her usual toileting times. On the other hand, for a resident who does know he or she needs to use the toilet but does not know how to get there or accomplish the task, prompting the resident by asking "Do you need to use the toilet?" and then taking the resident there may be the best approach.

In addition to these methods, the approach you take toward the resident is equally significant. Residents with dementia often respond to body language, posture, and tone of voice. If the resident feels rushed, anxiety may result. If the resident feels negative nonverbal cues from you, he or she may become aggressive. Use single-step directions to allow time for the resident to accomplish a task, rewarding him or her by saying he or she did a good job.

The CNA's role in nutrition

Poor nutrition and lack of hydration can contribute to an increase in behavior symptoms and physical declines. The result could include falls, pressure injuries, malnutrition, dehydration, and other preventable conditions. Addressing poor appetite can be a challenge since the person with dementia may no longer recognize food, have a decreased sense of smell and taste, have poor-fitting dentures, or experience side effects from medications. However, there is an untapped potential to improve nutrition by implementing the following mealtime strategies:

- Limit distractions and serve meals in a quiet environment
- Keep the table setting simple to eliminate distraction; avoid using patterned tablecloths
- Be flexible on food preferences, since a person with dementia may develop new preferences or reject old ones
- Allow enough time to enjoy the meal; do not rush the resident to finish eating
- Make mealtime a social event; talk with the resident
- For those residents who forget they have eaten,

consider providing more than one session of each meal, such as eggs and toast first, then cereal later in the morning

- Ensure you are familiar with the care plan interventions for adaptive equipment, such as serving food in bowls, providing utensils with large handles, or using plate guards
- Serve healthy snacks in between meals
- Use a "food first" approach prior to giving liquid supplements from the meal tray
- Sit and eat with the resident, providing cues and demonstrating how to eat
- Ensure the resident has good posture during meals to aid in swallowing

The CNA's role in activities

As a CNA, you will encounter multiple opportunities to contribute to dementia care with person-centered activity approaches. Too often, facilities do not investigate the root cause of dementia's behavior symptoms, resulting in approaches that are ineffective or that could get the facility cited (i.e., overmedication). Boredom, meaningless activities, loneliness, and helplessness can contribute to distressing behaviors. Meaningful activities as an approach to managing dementia symptoms can decrease distressing behaviors and eliminate the need for antipsychotic medication. In between activity programs, take the initiative to provide a meaningful activity, referring to the care plan for person-centered approaches.

All behavior is purposeful

Dementia care team meetings should include discussions on the effectiveness of approaches and the sharing of creative ideas to further support residents with dementia. Above all else, CNAs must exhibit patience and believe that communication with these residents is possible. Always remember that a resident with dementia may communicate through behaviors, so all behavior is purposeful.

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Quiz

Dementia care: Nonpharmacological approaches to behavior management

Directions: Read each question carefully, then determine the best answer. Check the corresponding box on your answer sheet. Do not write on this posttest.

1. To encourage residents with dementia to eat during mealtime, which of the following strategies should be used?
    a. Decorate the table with a bright, patterned tablecloth
    b. Encourage residents to remain quiet and focus on eating their food at mealtimes
    c. Serve food before giving liquids to residents
    d. Both a and c

2. Which of the following can contribute to distressing behaviors in residents with dementia?
    a. Boredom
    b. Meaningless activities
    c. Loneliness
    d. All of the above

3. If you provide negative, nonverbal cues to a resident with dementia, he or she may express _____as a result.
    a. many emotions
    b. regret
    c. aggression
    d. happiness

4. Addressing poor appetite in a resident with dementia may be difficult because:
    a. Residents with dementia usually can't answer questions
    b. He or she may have poor-fitting dentures
    c. He or she may no longer recognize food
    d. Both b and c

5. The best way to minimize a resident's dementia behavior symptoms is to:
    a. Find out why the resident is feeling that way
    b. Assume the behavior is a result of the disease
    c. Recommend to the physician that the resident be put on antipsychotics
    d. Ask the resident to stop acting that way

Quiz

6. When caring for a resident who is constantly walking, a recommended care approach involves the following:

a. Letting the resident get it out of his or her system

b. Engaging the resident in a conversation about what he or she is looking for

c. Introducing the resident to a brighter, louder environment to distract him or her from leaving the room

d. None of the above

7. Poor nutrition and lack of hydration can contribute to an increase in behavioral symptoms and physical declines.

a. True

b. False

8. For residents who display disruptive behaviors such as crying or anger, involving them in large group activities is a recommended care approach to reduce these behaviors.

a. True

b. False

9. A resident with dementia who has the cognitive ability to know when he or she needs to use the toilet but who cannot remember how to get to the restroom would benefit from:

a. A toileting schedule

b. A map of the facility

c. Less water intake to avoid accidents

d. A prompt from the CNA asking the resident if he or she needs to use the toilet

10. Recommended dementia care approaches may change as the disease progresses.

a. True

b. False