Introduction

Dementia is the leading cause of dependency and disability among older people worldwide (World Health Organization & Alzheimer’s Disease International, 2012). It is estimated that 35.6 million people are living with dementia globally, and this number is expected to double by 2030 and triple by 2050 (World Health Organization & Alzheimer’s Disease International, 2012). In 2030, the nursing home (NH) population in the United States is expected to rise to over 3 million residents, with over half of residents having a diagnosis of dementia (Aselage, Amella, & Watson, 2011). When persons with dementia (PWD) reach the end-stages of the disease, 90% are cared for in a NH (Aselage, Amella, & Watson, 2011). Cognitive and functional decline in dementia complicates care and disrupts eating behaviors, which has a detrimental impact on nutritional status and quality of life (QOL) of PWD (Shatenstein, Kergoat, Reid, & Chicoine, 2008). The high rate of malnutrition in nursing homes and in PWD necessitates a thorough examination into the mealtime experience. In an effort to achieve and maintain optimal nutrition status and to preserve dignity and personhood of PWD, it is important to identify factors that influence mealtime for residents in nursing homes.

Dementia

Dementia is not a specific disease but rather a general term used to describe mental decline that is severe enough to interfere with daily functioning. The most common forms of dementia are Alzheimer’s disease (AD), dementia with Lewy bodies, frontotemporal dementia, vascular dementia, and Parkinson’s disease with dementia. The differences between these subtypes are not always clearly defined and often more than one type may
be present (Shadlen & Larson, 2014b). Various disorders and factors can lead to the development of dementia, but age remains the strongest risk factor. It is approximated that the incidence of AD doubles every 10 years after the age of 60 years (Shadlen & Larson, 2014a).

According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, the criteria for dementia includes the following: (1) significant cognitive impairment in one of the following domains: learning and memory, language, executive function, complex attention, perceptual-motor function, social cognition, (2) the impairment must be acquired and represent a significant decline from a previous level of functioning, (3) the cognitive deficits must interfere with independence in everyday activities, (4) in the case of neurodegenerative dementias such as Alzheimer disease, the disturbances are of insidious onset and are progressive, based on evidence from the history or serial mental-status examinations, (5) the disturbances are not occurring exclusively during the course of delirium, (6) the disturbances are not better accounted for by another mental disorder (e.g., major depressive disorder, schizophrenia) (American Psychiatric Association, 2013). Patients with dementia usually present with difficulty retaining new information (e.g., trouble remembering events), handling complex tasks (e.g., balancing a checkbook), reasoning (e.g., unable to cope with unexpected events), spatial ability and orientation (e.g., getting lost in familiar places), language (e.g., word finding), and/or behavior (Shadlen & Larson, 2014b).
Pharmacological Treatment

Pharmacological treatment of dementia disorders mostly target symptoms of the disorder and vary depending on the type, making an accurate diagnosis critical (Shadlen & Larson, 2014b). Cholinesterase inhibitors are a class of drugs developed to treat mild to moderate cases of AD, but are sometimes used in the treatment of vascular dementia or dementia with Lewy bodies (National Institute on Aging, 2013). Cholinesterase inhibitors most commonly prescribed are donepezil, rivastigmine, and galantamine. These drugs may temporarily improve or stabilize memory and thinking skills in some people by increasing the activity of the cholinergic brain network (Press & Alexander, 2014b). Because they do not stop or reverse the progression of AD or other dementias, they may stop working over time (National Institute on Aging, 2014). Side effects of cholinesterase inhibitors may impact nutrition status and include nausea, vomiting, diarrhea, indigestion, loss of appetite, and weight loss (Pronsky & Crowe, 2012).

Memantine, a N-methyl D-aspartate (NMDA) antagonist, is in another class of medications often prescribed to delay the effects of moderate to severe AD (National Institute on Aging, 2014). It is thought that memantine may help to improve memory, attention, reason, language and the ability to perform simple tasks in AD patients (Alzheimer’s Association, 2014b). This drug is believed to work by regulating the activity of the neurotransmitter glutamate, which when in excess causes neuronal cell death. Memantine is sometimes prescribed in combination with a cholinesterase inhibitor (National Institute on Aging, 2014). Side effects of memantine include, dyspnea, dizziness, headaches, constipation, and confusion (Pronsky & Crowe, 2012).
Antipsychotic medications are often used to treat non-cognitive neuropsychiatric symptoms of dementia, which include behavioral symptoms, delusions, hallucinations, and disinhibition (Kales & Gitlin, 2014). The use of these medications in dementia care is not without controversy. The U.S. Food and Drug Administration has not approved the use of pharmacology to manage these symptoms in dementia patients and their efficacy has yet to be proven in randomized control trials (Press & Alexander, 2014a), yet many practitioners still believe that the benefits may outweigh the risks in cases of severe and debilitating symptoms (Press & Alexander, 2014a). Risks of antipsychotic medications include exacerbation of mental health symptoms and increased mortality (Press & Alexander, 2014a). In response to the use of antipsychotic medications in the treatment of dementia disorders, the National Partnership to Improve Dementia Care was established. The mission of this public-private coalition, that includes the Centers for Medicare & Medicaid Services (CMS), consumers, advocacy organizations, providers and professional associations, is to enhance the use of non-pharmacologic approaches and person-centered dementia care practices. Their goal is to reduce the use of antipsychotic medications in nursing home residents by 25 percent in 2015, and 30 percent in 2016 (Centers for Medicare and Medicaid Services, 2014).

There is increasing evidence and support of non-pharmacological treatment of dementia and its symptoms. Non-pharmacologic measures, including behavioral methods, may be effective in reducing agitation and anxiety in patients with dementia, negating the use of antipsychotic medications (Press & Alexander, 2014a). These measures tend to view behaviors as stemming from unmet needs, environmental overload, and interactions of individual, caregiver, and environmental factors; the goals are prevention, symptom relief, and reduction of caregiver distress (Kales & Gitlin, 2014). Despite the fact that non-pharmacological treatment methods are increasingly recognized as a critical aspect of state-of-the-art dementia
care, these strategies have not yet been translated into clinical management and standard clinical care guidelines (Kales & Gitlin, 2014). Making the use of antipsychotic drugs the primary treatment approach in many clinical settings despite concerns of safety and efficacy (Kales & Gitlin, 2014).

**Dementia & Public Health**

Alzheimer’s disease is currently ranked as the sixth-leading cause of death in the United States (Center for Disease Control, National Center for Health Statistics, 2014) but the accuracy of this ranking has been recently challenged. A new report reveals that the AD is actually the third leading cause of death and that the reliance on death certificates to quantify the impact of the disease has resulted in this gross underestimation (James et al., 2014). Despite the prevalence of dementia and its impact on mortality, funding for AD research from the National Institutes of Health is over 12-times less than that of cancer, the number two cause of death in the U.S. (Alzheimer's Association, 2014a). In 2010, the cost of dementia was estimated to be between $157 billion and $215 billion not including the cost of informal care (Hurd, Martorell, Delavande, Mullen, & Langa, 2013). Furthermore, the cost of dementia care purchased in the marketplace was $109 billion, which is significantly higher than the direct health care expenditures for cancer at $77 billion (Hurd, Martorell, Delavande, Mullen, & Langa, 2013). According to the World Health Organization’s (WHO) report on dementia, “Barriers to the prioritization of dementia include the complexity of dementia care which involves health and social care, the family, and the private and voluntary sectors. This obscures recognition of who should take responsibility, complicates financing, and therefore hinders the process of advocacy and
The WHO’s report calls dementia a global public health priority, highlighting the urgent need for action as there are 7.7 million new cases of dementia worldwide, which equates to one new case every four seconds.

**Dementia & Nutrition**

Malnutrition is any disorder of nutrition status including deficient nutrient intake, over-nutrition, and impaired nutrient metabolism (American Society for Parenteral and Enteral Nutrition, 2002). It is estimated that between 30-85% of long-term care residents are malnourished (Crogan & Pasvogel, 2003) usually due to poor food and fluid intake (Keller et al., 2014). Consequences of malnutrition in older adults include unintentional weight loss, increased infection, impaired wound healing, immune deficiency, development of pressure ulcers, and/or increased risk of falls. Older adults identified as being at risk for malnutrition have been found to have poorer quality of life, are more likely to be admitted to a hospital, and are at increased risk of mortality (Leslie 2011; Merrell et al. 2012; Rasheed & Woods, 2013).

Cognitively impaired institutionalized residents are at an even greater risk for malnourishment and nearly half of dementia patients experience clinically significant weight-loss (Prince, Albanese, Guerchet, & Prina, 2014). Dementia-related weight loss/malnutrition may be the result of both the metabolic implications of the condition and an imbalance between energy intake and energy needs. Evidence suggests that dementia-related brain atrophy may impact brain regions implicated in appetite control and energy balance (Hu, Okamura, Arai, & et al, 2002). Dementia affects many factors that influence an individuals dietary habits (e.g., decreased ability to complete complex
tasks, alterations in taste and smell, diminished ability to differentiate between food and non-food items, chewing and swallowing difficulties) often resulting in an imbalance between energy intake and energy need (Shatenstein et al., 2008). Due to decreased food and fluid intake in many PWD, many health care providers have turned to enteral nutrition support. The evidence does not, however, support the use of tube feeding as it has not been shown to prolong survival, improve function, prevent aspiration pneumonia, reduce the risk of pressure ulcers, reduce the risk of infection, or provide palliation (Academy of Nutrition and Dietetics, 2010). Furthermore, it is the position of the Academy of Nutrition and Dietetics (AND) that the use of hand-feeding should be encouraged over nutrition support for PWD.

**Dementia & Mealtimes**

The concept of mealtime is universally understood across societies and cultures, with food being used in celebration, to establish and maintain group ties, cope with feelings, express emotion and to foster a sense of family and companionship (Aselage & Amella, 2010). Not surprisingly, many nursing home residents consider a mealtime to be a “highlight of the day”. For institutionalized PWD, a mealtime encompasses more than the physical act of eating/feeding, it provides a unique opportunity for social interaction and conversation and an opportunity to remain emotionally engaged to family and friends (Aselage & Amella, 2010).

As the condition progresses, cognitive and functional decline may result in mealtime difficulties, which can greatly impact the nutritional status and quality of life for PWD (Shatenstein et al., 2008). The longer a PWD experiences difficulty at mealtime the more
likely they are to experience adverse outcomes, such as inadequate food intake, unintentional weight loss, aspiration, pulmonary complications, malnutrition and dehydration (Liu et al., 2013). Stress and anxiety has been shown to occur in up to 90% of nursing home residents, which is known to increase as dementia progresses and is commonly exhibited at mealtimes (Whear et al., 2014). The implication of mealtime anxiety and stress is detrimental to the well-being of residents but is also shown to be a major source of stress and strain to care providers (Whear et al., 2014). In a nursing home setting, certified nursing assistants (CNAs) provide nearly all feeding assistance and most often lack the special training required for addressing the unique functional and behavioral challenges associated with feeding dementia patients (Chang & Roberts, 2011).

Behaviors often demonstrated by those with mealtime difficulty include: partial or complete inability to initiate or maintain attention to feeding tasks, inability to get food into the mouth or to keep mouth closed, pooling of food in the mouth, inability to chew or swallow, wandering, pacing, refusal behavior, apathy or indifference (Liu, Cheon, & Thomas, 2013), which can all lead to malnutrition.

**Defining a Successful Mealtime for PWD**

The definition of a “successful mealtime” for PWD will vary depending on the persons functioning capacity and should be tailored to the individual’s needs. Interventions aimed at improving mealtimes for PWD in nursing homes often target the behavioral and psychological symptoms of dementia as these behaviors directly impact food/fluid intake. Therefore, a successful mealtime is most frequently defined as an experience with reduced
agitated, aggressive, and/or refusal behavior, increased social interaction, improved appetite and/or consumption.

**Review of Current Literature on Mealtime Difficulties for PWD**

Research on factors related to mealtime difficulties for PWD in nursing homes can be categorized into one or more of four domains: (1) food/beverage, (2) physical/environmental, (3) staff behavior, and (4) social environment. The food/beverage domain refers to aspects of the mealtime that deal with the preparing and presenting of food and beverage items. The physical/environmental domain includes aspects of the mealtime that are related to the location and physical characteristics of the person, meal and environment. Staff behavior refers to the performance of staff to positively assist with mealtime. The final domain, social environment, includes aspects that promote mealtime not including staff interaction.

**Food/Beverage Interventions**

Therapeutic diets often affect the flavor and variety of the food offered to residents and are often associated with reduced pleasure at meals, decreased food intake, unintended weight loss, and undernutrition (Academy of Nutrition and Dietetics, 2010). It is the position of the AND that the benefits of a less-restrictive diet for residents in LTC favor a liberalized diet over restrictive therapeutic diets (Academy of Nutrition and Dietetics, 2013). For those with advanced dementia, the AND states, “Every effort should be made to remove dietary restrictions and let individual preferences guide the amount and type of food provided” (Academy of Nutrition and Dietetics, 2010).
Much of the recent research surrounding mealtimes for PWD has examined food-service interventions, where pre-plated food was replaced with a bulk system of either family-style or buffet-style meals. These changes were universally found to improve mealtimes for residents including those with cognitive and functional limitations (Barnes, Wasielewska, Raiswell, & Drummond, 2013). Residents displayed more functional independence, increased their nutritional intake, and increased interaction was observed among residents (Altus, Engelman, & Matthews, 2010; Barnes et al., 2013). Family-style meals also had a positive effect on staff. With food presented in serving dishes and placed on the table so residents could help themselves, staff had more time to oversee the events in the dining room and to assist those that required the most support (Barnes et al., 2013). Researchers note that the bulk system is considered a resident-center approach rather than a task-centered approach to mealtimes, which aids in reducing the institutionalized ‘feel’ of the mealtime (Barnes et al., 2013). Desi et al (2007) found that across four different dining rooms, residents provided with a cafeteria-style meal with waitress service had greater 24-hour total energy intake than those receiving pre-plated tray meals, with the greatest increase in energy intake seen in cognitively impaired residents with the lowest BMIs (Desi, Winter, Young, & Greenwood, 2007). Further clinical practice guidelines can be found Appendix A.

**Physical/Environmental Interventions**

Memory problems coupled with cognitive and functional impairments associated with dementia make PWD more vulnerable to environmental influences (Chaudhury, Hung, & Badger, 2013). This area of mealtime research has continued to grow over that last few
decades and has become the focus of many dining interventions for PWD. Findings from past research have influenced existing recommendations to reduce competing auditory stimuli such as televisions, radio, and intercoms to prevent sensory overload during meals (Chaudhury et al., 2013). More recent studies have focused on the effects of music, lighting, dining room ‘feel’, high-contrast tableware, and the number of diners and the size of the dining space.

Numerous studies have shown that music played during mealtime has positive effects on behavioral symptoms of dementia including physical aggressive and nonaggressive behaviors, verbal agitated behaviors, and hiding/hoarding behaviors (Whear et al., 2014). In particular, classical music played during mealtimes was found to be effective in reducing aggressive behaviors (Hicks-Moore, 2005). In a separate study, dinner music also seemed to affect the staff members, who were observed paying increased attention toward residents (Chaudhury et al., 2013).

The literature suggests that lighting is an important component of mealtimes for PWD. Illuminating food and preventing glare is recommended to reduce eyestrain and improve depth perception, which is often compromised in those with dementia (Brush, Meehan, & Calkins, 2002). Light should be uniform and soft; guidelines recommend that the minimum level of ambient light for dining be at least 0.805 watts per square meter (Chaudhury et al., 2013).

An intimate homelike atmosphere is repeatedly shown to improve mealtime experiences, although pinpointing one design style to achieve a universally homelike experience for all residents may be challenging (Chaudhury et al., 2013). Sensory cues such
as the smell of cooking or baking can add to the homelike feel of a dining area and have been beneficial in stimulating resident’s appetites (Desi et al., 2007).

Contrast sensitivity is commonly experienced by those with AD and therefore tabletops, place mats, and dishware should strongly contrast in color to allow for differentiation between these items (Briller et al., 2001). In a study involving residents with severe dementia, high-contrast tableware increased food and fluid intake (Dunne, Neargarder, Cipolloni, & Cronin-Golomb, 2004). Brush et al (2002) also found that oral intake and functional independence improved with the use of dark tray liners.

The number of dining companions and the size of the room have been shown to influence residents dining experience. Controlling noise levels and distractions during mealtime is critical to the promotion of a pleasant mealtime for PWD (Aselage & Amella, 2010). Several smaller dining rooms serving 5-12 residents, as opposed to a large central dining area where all residents gather, is shown to enhance social contact among residents and reduce agitation and restlessness (Chaudhury et al., 2013). Further clinical practice guidelines can be found Appendix B.

**Staff Behavior Interventions**

Most PWD will require some level of meal assistance as dementia progresses. The behavior of staff at mealtime, specifically the quality of the feeding assistant-resident dyad, has been shown to significantly influence intakes (Aselage & Amella, 2010).

Those in the later stages of dementia often exhibit aversive feeding behaviors such as resistance to eating (turning head away, refusing to open mouth or swallow), spitting out food or liquids, keeping mouth open causing food to drop, etc. (Amella, 2004).
Managing and interpreting these behaviors can be very challenging and the manner in which staff responds is critical. When aversive feeding behaviors are construed as refusal without appropriate investigation, feeding attempts conclude too soon, increasing nutritional risk (Aselage & Amella, 2010). Dementia care experts believe that there is meaning behind these behaviors and that they are a form of communication of feelings and needs (Chaudhury et al., 2013). Therefore, careful considerations should be given to potential underlying causes of these behaviors and a variety of approaches employed to attempt to address the resident’s needs (Aselage & Amella, 2010; Chaudhury et al., 2013). Numerous studies have reported that touch, guidance, and overall compassionate care provided by feeding assistants can improve intakes and decrease behavioral symptoms (Aselage et al., 2011). Verbal prompting and giving praise during meals was also shown to increased the amount of food consumed by PWD (Altus et al. 2002 in Aselage 2010).

The functional abilities of PWD vary and are dependent on individual characteristics and the stage of the illness. Barnes et al (2013) observed in a number of dining rooms that staff consistently offered unnecessary assistance to residents during meals. Maximizing existing strengths and promoting some level of independence at mealtime are important to maintain dignity in PWD (Aselage & Amella, 2010). In a case control trial of 40 residents with AD, a “Breakfast Club” was created in which residents assisted with breakfast prep and cleanup and then all ate the meal together. This group was lead by a speech-language pathologist who used this as an opportunity to practice cognitive and physical capabilities including memory, reading, decision-making, and communication. This club showed improvements in interest and memory, although there was not a significant improvement in mealtime independence (Whear et al., 2014). Manthorpe (2003) also points out that
isolation from tasks like food prep, cooking and cleanup may be disempowering for PWD and involvement in these tasks could be a meaningful activity that helps to retain some of their functionality and maintain their interest in food (Manthorpe, 2003). Further clinical practice guidelines can be found Appendix C.

**Social Environment Interventions**

Creating a quality social environment during meals can be challenging for nursing homes, but it has been shown to be a very effective strategy to promote successful mealtimes for PWD.

The social environment may be directly or indirectly effected by many of the interventions mentioned above. For example, family-style meals and small group dining interventions were both shown to increase socialization and interaction between residents and staff (Altus et al., 2010; Barnes et al., 2013; Desi et al., 2007). Interventions to the physical environment are especially intertwined with the social aspects of mealtime. For example, social interaction was enhanced when residents ate in smaller groups in smaller dining rooms where background noise and distractions were minimized (Chaudhury et al., 2013). The spatial surroundings are important to consider when promoting interaction at mealtimes (Chaudhury et al., 2013). Seating arrangements at mealtimes in most NHs are based on the level of dependence rather than social compatibility of the residents (Chaudhury et al., 2013). Grouping by the level of assistance required allows staff to assist multiple residents at a time. Although efficient for staff, Chaudhury et al (2013) states that this “assembly line” arrangement reflects an I-It relationship, where the PWD is an object and meals are deemed no more than a task for staff. Geboy (2009) showed that intimacy
and social interaction was best achieved when residents sat in small groups at right angles from one another. Further clinical practice guidelines can be found Appendix D.

Limitations to the Research

Although research on mealtime difficulties for PWD is growing, it remains sparse. Residents who have lost their ability to engage and communicate are frequently excluded from research (Barnes et al., 2013). With a rapidly growing aging population, there is an increased urgency for more research into dementia.

Research into interventions for difficult mealtimes in community dwelling PWD is in its infancy and requires further study. Mealtimes occur multiple times a day and therefore difficulties experienced at meals have the potential to cause the most problems for family and caregivers of PWD. The demand for education and support by families and caregivers will increase dramatically in the coming decades, making research into mealtime solutions for the home setting critical.

The methodological rigor of intervention evaluations to date has systematic challenges and limitations (Chaudhury et al., 2013). These limitations include sample sizes, lack of a comparison groups, and homogeneity of residents. The independent effect of many mealtime interventions is also difficult to measure due to possible confounding variables often not addressed in analysis. For example, changes made to food service or the external environment will inevitably affect social aspects of mealtime, making it difficult to isolate the effect.

This research does not provide insight into how the stage of disease or type of dementia influences mealtime difficulties or the success of interventions. Methodological
challenges mentioned above likely prevent researchers from including these important variables into research. Future research should evaluate these variables as they likely influence mealtime problems and require targeted solutions.

Discussion

In an effort to improve dementia care in the long-term care setting, numerous reports, publications, and training programs have been developed which reflect a new direction in the care for PWD. A universal guiding principle is patient-centered care rather than task-oriented care. According to the National Center for Assisted Living’s Guiding Principles for Dementia Care, the care of PWD should be patient-centered, give special attention to the physical environment and resident safety, and should include continuing education and training in dementia care across all levels of staff. The Alzheimer’s Association’s Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes states that, “Good dementia care involves the assessment of residents abilities; care planning and provision; strategies for addressing behavioral and communication changes; appropriate staff patterns; and assisted living or nursing home environment that fosters community”. Despite the general consensus on what should be done, the quality of care for PWD in NHs remains inconsistent.

A major contributing factor to the discrepancy between recommendations and practice is that regulations vary drastically across the country. Regulations differ from state to state for Alzheimer’s Disease Units, Dementia Units, Memory Centers, and Special Care Units; some states have extensive regulations for NHs while others have no regulations (National Council of Certified Dementia Practitioners, 2014).
Federal staffing policies for NHs are inadequate and also inconsistent across states. Staffing requirements for NHs that participate in Medicare and Medicaid programs require a registered nurse to be on duty eight consecutive hours per day for seven days a week, and a licensed nurse (including the registered nurse) on duty 24 hours per day seven days a week (Kaiser Commission of Medicaid and the Uninsured, 2002). There are not, however, any federal staffing regulations regarding a minimum level of non-licensed staff such as CNAs, who are often primarily responsible for assisting residents with most or all of their activities of daily living in most nursing home settings (Aselage et al., 2011). The Centers for Medicare and Medicaid Services (CMS) recommend that staffing be sufficient to provide at minimum 2.75 hours of care per resident per day and optimally 3.9 hours per resident per day (Kaiser Commission of Medicaid and the Uninsured, 2002). State staffing standards vary enormously. The median total staffing requirement across states is 2.32 hours of care per resident per day, yet the levels range from a low of about eight minutes per resident per day (.14 hours per resident) in Virginia and Alabama to a high of three and a half hours (3.48 hours per resident) in Delaware (Kaiser Commission of Medicaid and the Uninsured, 2002). No state requires staffing levels that are as high as the CMS recommended level of nearly four hours of total staff time per resident per day (3.9 hours per resident).

Numerous studies have shown a positive relationship between favorable outcomes and higher staffing levels, yet regulations remain unchanged and many NHs understaffed (Kaiser Commission of Medicaid and the Uninsured, 2002).

Resident acuity, staffing shortages and high turnover rates cited by nursing homes as barriers to providing adequate feeding assistance to residents needing assistance at mealtimes (Remsburg, 2004). In response to these challenges, the CMS published a rule in
2003 allowing LTC facilities to use paid feeding assistants under the supervision of a registered nurse or licensed practical nurse with the intent of providing nutrition and hydration support to residents who may be at risk for unintentional weight loss and dehydration (Centers for Medicare & Medicaid Services, 2003). Under this ruling, paid feeding assistants may assist only those residents without complicated feeding problems who have been selected as eligible by the charge nurse based on an individualized assessment and the resident’s latest plan of care (Centers for Medicare & Medicaid Services, 2003). Residents with complicated feeding problems such as (but not limited to) difficulty swallowing, recurrent lung aspirations, or who receive nutrition through parenteral or enteral means must be assisted by staff with more specialized training such as nurses and CNAs (Centers for Medicare & Medicaid Services, 2003).

The use of paid feeding assistants is at the discretion of the State, which must establish a mechanism to approve required training programs. A State-approved training course must include at least 8 hours of training in the following:

1. Feeding techniques.
2. Assistance with feeding and hydration.
3. Communication and interpersonal skills.
4. Appropriate responses to resident behavior.
5. Safety and emergency procedures, including the Heimlich maneuver.
6. Infection control.
7. Resident rights.
8. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.
Although the use of paid feeding assistants may address the staffing ratio issues at mealtime, this ruling has been criticized for neglecting to address the complexities of resident needs during mealtime. One study found that paid feeding assistants displayed disinterest, engaged in inappropriate behavior and conversation, and rushed through meals despite training on the importance of making the mealtime a pleasurable experience and providing sufficient time to adequately assist residents (Remsburg, 2004). Opponents of the ruling state that single-task workers may hinder quality care and exacerbate existing staff burden. They argue that adding more unlicensed, minimally trained staff to an existing understaffed facility will require the licensed caregivers to supervise unlicensed staff thus resulting in fragmented care and poor care quality (Remsburg, 2004).

Despite the prevalence of malnutrition in NHs and specifically among residents with dementia, a full-time dietitian is not included among required staff. Federal requirements mandate that NHs must employ a qualified dietitian but that this position can be either full-time, part-time, or on a consultant basis (University of Minnesota Division of Health Policy Management, 2011). For those NHs that do not employ a dietitian, the Federal regulation requires frequently scheduled consultations from a qualified dietitian but does not provide specifics on what defines “frequent” (University of Minnesota Division of Health Policy Management, 2011). Hours required of consulting dietitians vary from state to state. For example, in Alaska, the dietitian must be available not less than once every three-months, in Arizona, the requirement is as often as necessary to meet the nutritional needs of the residents, and in Georgia, the requirement is not less than 8 hours per month (University of Minnesota Division of Health Policy Management, 2011).
Funding and reimbursement for services to PWD also presents a challenge to optimal care in NHs. For example, reimbursement by long-term care payer sources for feeding assistance provided to PWD does not take into account the level of assistance provided; payment is the same for residents requiring total hand-feeding and for residents requiring only to be set up for meals (Aselage et al., 2011). Medicare will not pay for long-term care or assisted living but may cover short-term rehabilitation and stays less than 100 days (Alzheimer’s Association, 2014a). Medicaid covers all or a portion of nursing home costs for individuals with AD who meet income and asset eligibility guidelines but eligibility and benefits vary state-to-state and many NHs do not accept Medicaid (Alzheimer’s Association, 2014a).

State regulations governing NHs also differ between states for the requirements for dementia and AD education. Some states have no requirements, some require two hours of education while others have extensive requirements (National Council of Certified Dementia Practitioners, 2014). Some states require some initial orientation and yearly in-service training for all staff involved in caring for residents with dementia (National Center for Assisted Living, 2010). Research has shown the effectiveness of continuing education for staff in improving care of PWD (Liu et al., 2013) and nearly all recommendations for improving dementia care include continual education for all NH staff (Alzheimer's Association, 2009; Centers for Medicare and Medicaid Services, 2013; National Center for Assisted Living, 2010). Given the increased need for training in dementia care, professional organizations are behooved to incorporate dementia-specific education into their curriculum and/or to partner with NHs and other care facilities to provide this education onsite.
Conclusion

Research and funding for dementia is becoming increasingly important as our older adult population grows and the prevalence of dementia along with it. Improving the care provided to PWD has been acknowledged as a global public health priority and guidelines for providing this care in LTC facilities have been established and endorsed by private, professional and governmental organizations. Findings from research into successful mealtimes for PWD provide additional support to current dementia care practice recommendations for a patient-centered, individualized approach to care. This research also highlights the importance of appropriate staffing levels, staff-resident interaction, and the need for dementia-specific training and education for all members of the NH staff.

Despite the proven effectiveness of these recommendations, NHs often face challenges that hinder appropriate adoption of this care approach. Inconsistent and inadequate federal and state regulations for dementia care education, training, and staffing often result in facilities lacking the fundamental tools needed to provide optimal care. Therefore changes to the policies and regulations governing nursing homes are needed and should be congruent with existing recommendations for optimum resident care. Employment of full-time dietitians, mandatory dementia training programs, and continuous education across all levels of staff is needed to empower NHs to address the complex needs of residents with dementia, especially during mealtimes.
References


## Domain 1: Food/Beverage
Aspects of the mealtime that deal with preparing and presenting food and beverage items.

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<th>Evidence-based</th>
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<th>Other</th>
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<td>(Expert opinion; No evidence)</td>
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<td>(Expert opinion; No evidence)</td>
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<th>Offer finger foods to maintain eating independence</th>
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<tr>
<td>1. Observe for changes in the resident’s eating habits (i.e., decreased use of utensils, playing with food, or using fingers) that indicate a loss of independence.</td>
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<tr>
<td>2. Serve finger foods at meals/snacks to increase/maintain independence with self-feeding.</td>
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<tr>
<th>Offer food/beverage choices based on family and/or staff recommendation(s)/diet requirements</th>
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<tbody>
<tr>
<td>1. Identify food/beverage options that exist.</td>
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<td>2. Ask family members and staff about resident’s food/beverage preferences/requirements.</td>
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<tr>
<td>-Do not mix food/beverage together</td>
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<tr>
<td>1. At mealtime instruct dietary staff to not mix food/beverage options together on the serving dish.</td>
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<th>Provide food and beverages at appropriate and/or desired temperature</th>
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<tr>
<td>1. Observe resident at meals/snacks to identify whether they have preference or aversion for hot or cold foods. If so, serve only preferred temperature foods at meals/snacks.</td>
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<tr>
<td>2. Maintain appropriate temperature with insulated cup and plate.</td>
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<td>3. Consider reheating food during the meal.</td>
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<th>Serve one food and one beverage at a time</th>
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<tbody>
<tr>
<td>1. Place only one food item in front of resident at a time.</td>
</tr>
<tr>
<td>2. Remove item when resident is finished or displays lack of interest and then place next food item in front of resident.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liberalize diet (residents choose how much food to eat)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At each meal serve food options communally (e.g., large serving dishes with appropriate serving utensils).</td>
</tr>
<tr>
<td>2. Resident can select how much or how little food to eat; portions are not pre-measured, or placed on the tray/plate prior to mealtime.</td>
</tr>
<tr>
<td>3. Staff assists resident with serving if unable to complete task independently.</td>
</tr>
<tr>
<td>4. Resident is assisted with eating if unable to complete</td>
</tr>
</tbody>
</table>
could lead to poor intake and potential weight loss.

**Lift dietary restrictions whenever possible**
1. Remove any dietary restrictions in place for fat, sugar, or calorie content of foods.
*Verify with appropriate medical professional that lifting restriction is allowed.

**Ensure food contrasts with the color of the plate or use**

**Offer food/beverage choices to each resident based on personal preference**
1. Identify and list all viable food/beverage options that exist.
2. Ask residents to choose what items they would/would not prefer to eat/drink.
3. Provide written lists (16 pt.)

| 3. Once all items have been offered once, may offer any refused items again one at a time. |
| Limit number of options available (two) items for food/beverage |
| 1. Identify food/beverage options that exist. |
| 2. Offer no more than two choices to each resident per mealtime. |

**Serve larger meals in the morning and afternoon when resident is more alert**

**Serve 6 smaller meals or provide small snacks between regular meals to residents who seek additional food.**

**Offer course out of traditional order (e.g., dessert course first)**

**Offer foods not traditionally served at that time of the day (e.g., breakfast foods at dinner)**

**Allow/provide outside food from home, favorite restaurant, etc.**

**Modify packaging of food and beverage (e.g., serve Coke in the can/bottle, serve food or beverage in resident’s favorite cup, dish, etc.)**

**If advisable, do not serve fluids at mealtime, promote hydration between meals**

**task independently, with verbal prompts or hand-under-hand assistance.**

**Provide daily menu with “Specials” and “Always Available” items**
1. Identify and list all viable food/beverage options that exist.
2. Ask residents to choose what items they would/would not prefer to eat/drink.
3. Provide written menus (16 pt. (large) font) with choices that are “Always Available” and “Specials” in different colors on the page.
4. “Specials” may include items that are preferred by resident, and appear occasionally (i.e., resident’s...
(large) font) with choices that can be circled by resident; or, researcher can read and circle appropriate choice for resident.

4. Use resident preferences to increase resident interest in mealtime experience.

<table>
<thead>
<tr>
<th>birthday, once per month, etc.</th>
<th>4. Use resident preferences to increase resident interest in mealtime experience.</th>
</tr>
</thead>
</table>

**Offer meal in stages, and not all at once**

1. Serve beverage to resident first, based on personal preference/diet requirement(s).
2. Serve courses of meal in stages:
   - **At a four-course meal:**
     - a) a light first course, such as hot soup or raw fish, stimulates the palate; it is followed by;
     - b) a combination course of cooked food, such as meat, starch, vegetables, and garnish;
     - c) afterward a light course is served, usually a crisp salad tossed with a tart dressing;
     - d) it is followed
by a sweet dessert.

Display food for consumption (i.e. showcase food; e.g., Setup a mock meal tray to display upcoming meal. Presentation should include proper place setting)
Appendix B

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Offer to play suitable dining music based on resident’s personal preference</strong></td>
<td><strong>Increase visual stimulation with greater light intensity</strong></td>
</tr>
<tr>
<td><strong>Recorded Music</strong></td>
<td>1. Turn on lighting in dining area to highest possible setting.</td>
</tr>
<tr>
<td>1. Ask resident what type of music they prefer.</td>
<td>2. If possible, raise room blinds/open shutters to allow natural light to enter dining room.</td>
</tr>
<tr>
<td>2. If resident is unable to select music preference, offer names of popular performers/genres based on resident's age (e.g., music from 1920s, 1930s, 1940s, etc.)</td>
<td>3. If room remains dark, place lamps in room as close as safely possible to resident/table.</td>
</tr>
<tr>
<td>3. List performer names/genres provided by resident on a sheet.</td>
<td><strong>Reduce ambient noise</strong></td>
</tr>
<tr>
<td>4. Compile data for all residents, and determine most to least desirable music.</td>
<td>1. Ask staff to keep conversations meal-focused before entering the dining area; request that staff do not engage in non-mealtime conversations.</td>
</tr>
<tr>
<td><strong>Suitable dining music with live musicians (when feasible)</strong></td>
<td>2. If guests are present, ask staff to speak in “quiet tones” when assisting residents with mealtime tasks.</td>
</tr>
<tr>
<td><em>Live Music “to fit the food and the mood”</em></td>
<td><strong>Arrange seating to make entry/exit easy for staff and resident</strong></td>
</tr>
<tr>
<td>1. Ask resident what type of music they prefer.</td>
<td>1. Organize dining room seating with clear paths for entry and exit.</td>
</tr>
<tr>
<td>2. If resident is unable to select music preference, offer names of popular performers/genres based on resident's age (e.g., music from 1920s, 1930s, 1940s, etc.)</td>
<td>2. Create clusters of seating with attractive and “traditional” dining room seating.</td>
</tr>
<tr>
<td>3. List performer names/genres provided by resident on a sheet.</td>
<td><strong>Increase olfactory response by blowing fan from dining room into hallway</strong></td>
</tr>
<tr>
<td>4. Compile data for all residents, and determine most to least desirable music.</td>
<td>1. Place fan at entrance of dining room to waft smells from meal prep area.</td>
</tr>
<tr>
<td>5. Offer selections during</td>
<td><strong>Use visual cues (e.g., maître d signpost) at entrance to dining room</strong></td>
</tr>
<tr>
<td><strong>Evidence-based</strong></td>
<td>1. Place sign labeled “Dining Room” in front of entrance.</td>
</tr>
<tr>
<td><strong>Other (Expert opinion; No evidence)</strong></td>
<td>2. Use easel or large (cardboard) item with “Today’s Specials” on board.</td>
</tr>
<tr>
<td><strong>Evidence-based</strong></td>
<td>3. Place picture of meal on board (can be stock photo).</td>
</tr>
<tr>
<td><strong>Other (Expert opinion; No evidence)</strong></td>
<td><strong>Actively gardening</strong></td>
</tr>
<tr>
<td><strong>Increase visual stimulation with greater light intensity</strong></td>
<td>1. Encourage residents to participate in gardening activities.</td>
</tr>
<tr>
<td>1. Turn on lighting in dining area to highest possible setting.</td>
<td>2. Provide residents with gardening tools and materials.</td>
</tr>
<tr>
<td>2. If possible, raise room blinds/open shutters to allow natural light to enter dining room.</td>
<td>3. Encourage residents to engage in planting and harvesting activities.</td>
</tr>
<tr>
<td>3. If room remains dark, place lamps in room as close as safely possible to resident/table.</td>
<td><strong>Use visual cues (e.g., maître d signpost) at entrance to dining room</strong></td>
</tr>
<tr>
<td><strong>Reduce ambient noise</strong></td>
<td>1. Place sign labeled “Dining Room” in front of entrance.</td>
</tr>
<tr>
<td>1. Ask staff to keep conversations meal-focused before entering the dining area; request that staff do not engage in non-mealtime conversations.</td>
<td>2. Use easel or large (cardboard) item with “Today’s Specials” on board.</td>
</tr>
<tr>
<td>2. If guests are present, ask staff to speak in “quiet tones” when assisting residents with mealtime tasks.</td>
<td>3. Place picture of meal on board (can be stock photo).</td>
</tr>
<tr>
<td><strong>Arrange seating to make entry/exit easy for staff and resident</strong></td>
<td><strong>Increase olfactory response by blowing fan from dining room into hallway</strong></td>
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<td>1. Organize dining room seating with clear paths for entry and exit.</td>
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<td>2. Encourage residents to engage in planting and harvesting activities.</td>
<td>3. Place picture of meal on board (can be stock photo).</td>
</tr>
<tr>
<td>Mealtimes that are most desired.</td>
<td>Use high-contrast tableware 1. Use tableware that will contrast with tablecloth, placemat, etc.</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Use high-contrast tableware</strong> 1. Use tableware that will contrast with tablecloth, placemat, etc.</td>
<td><strong>Serve meals at the same time, same place and same seating arrangement every meal</strong></td>
</tr>
<tr>
<td><strong>Simplify table settings by removing unnecessary or unused tableware, centerpieces, etc.</strong></td>
<td><strong>Define eating space with a placemat</strong></td>
</tr>
<tr>
<td><strong>Posture</strong> 1. Seat patient at 90-degree angle to the table. 2. Ensure hips are at 90-degree angle from torso. 3. Ensure legs/feet are at 90-degree angle from knees.</td>
<td>“Culture Change”: Flexibility with mealtimes 1. Identify what times residents can eat each meal by interviewing administrative staff. 2. Offer residents a choice of times for dining based on the facility’s capabilities. 3. For residents who cannot independently choose what time to eat, staff should assess alertness of resident. 4. When client appears to be alert staff will assist resident to/in the dining area.</td>
</tr>
<tr>
<td></td>
<td><strong>Mimic formal dining with tablecloths, utensils, regular plates, bowls, and cups</strong> 1. Set table with tablecloth (linen and/or paper). 2. Place utensils in “proper” positions around plate.</td>
</tr>
<tr>
<td><strong>Cover physical tray with napkin to disguise</strong> 1. If tray service is used, place linen/paper napkin over tray. 2. Set tray same as table (see Diagram 1. Traditional Table Setting).</td>
<td><strong>Culture Change</strong>: Flexibility with mealtimes 1. Identify what times residents can eat each meal by interviewing administrative staff. 2. Offer residents a choice of times for dining based on the facility’s capabilities. 3. For residents who cannot independently choose what time to eat, staff should assess alertness of resident. 4. When client appears to be alert staff will assist resident to/in the dining area.</td>
</tr>
<tr>
<td><strong>dining environment</strong></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>1. Open kitchen where residents can see food prepared.</td>
<td></td>
</tr>
<tr>
<td>2. Allow residents to assist with meal preparations.</td>
<td></td>
</tr>
</tbody>
</table>
## Domain 3: Staff Behaviors

### Performance of staff to facilitate mealtime.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based</td>
<td>Evidence-based</td>
</tr>
<tr>
<td>(Expert opinion; No evidence)</td>
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</tr>
</tbody>
</table>

### One-to-one ratio of staff/volunteer to feeding-dependent resident

- **Maintain eye contact** (throughout entire mealtime)

### Provide verbal prompts when assisting with meals

**Option #1**
1. Get attention of resident by touching resident on the hand;
2. Ask resident to use the fork to pick up food on the plate

**Option #2**
1. Get attention of resident by touching resident on the hand;
2. Pick up food with fork and hand fork to resident;
3. Prompt resident to eat with fork.

### Assistance provided by staff familiar to resident

- **Allow 30-40 minutes of staff to resident assistance** (for residents who are more impaired)

### Invite residents to join meal prior to mealtime

1. 10 minutes before mealtime staff should approach resident in a positive, friendly manner and invite resident to join the group for lunch.
2. As staff is available (and if possible), extend the invitation to join the group at lunch.

### Eliminate all tasks not related to mealtime to reduce resident distraction

**Conversation-Related**
1. Ask staff prior/during meal to keep conversations meal-focused in dining area.
2. Encourage staff to speak with residents about the meal, in addition to offering prompts for eating/drinking.
3. Request that staff praise residents for completing tasks well and encouraging them to repeat.

### Routinely ask residents “How is everything?” during mealtime

**Process-driven approach**

### Encourage resident-to-resident interaction regarding resident’s personal interests (i.e., staff help to model appropriate mealtime conversation)

“(Name resident) did (name activity) this morning. Would you like to ask him/her more about that?”

### Use dining prompt cards to stimulate conversation during meal

**Task-Related**
1. Ask staff to not use personal devices during mealtime.
2. Limit all non-mealtime related

### Have cook/prep staff ask resident about mealtime

Have cook come out to residents and converse with each table.
Use verbal prompts when assisting with meals

Task-Related
“-This (name of food) looks tasty. Here is some (name of food).”
“-May I give you this (name of food; do not force resident to eat)?”
“-Try to chew before you swallow.”
“-Try to swallow before you take another bite.”
“-Would you like me to/Can I help you cut (name of food)?”
“-We’ll do this together now (hand-over-hand assistance).”

To Encourage Independence
“-Try to use your fork?”
“-Would a spoon be easier?”
“-Try to eat (name of food) while it’s still warm (cold, etc.).”
“-Would you like more (name of food)?”

lunch 5 minutes prior to the meal.
3. If resident is unreceptive to invitation staff should prompt:
   “-We are having (name of food) and I know you like this.”
   “-Your friend (name person) is joining us, and I’m sure they would like to sit with you.”
   “-You haven’t eaten in a while, why don’t you try the (name of food) today?”
   “-The (name of food) smells delicious.”

Provide meals at an earlier time (staggered mealtimes) for those requiring more assistance with eating or who require more time

Ensure that the resident has his/her dentures and glasses, is properly positioned, and can see and reach the tray

Allow resident to view food prior to conversation/activity between staff.
3. Limit in-and-out dining room traffic of staff (and others, as possible) during mealtime.

“How was the (name of food)?”
“Is there anything I could do to make it better next time?”

Staff Mealtime
With Resident to Model Behavior

Bussing of Table/End of Meal Service
1. Ask staff to place cleared plates, utensils, etc. in area not close to table.
2. Ask staff to not bus residents’ dishes before all residents are finished at a table.

Reduce staff-caused noise
1. Encourage staff to quietly place used dishes in receptacle, or;
2. Place dishes in dishwashing trays instead of bin (if possible).

Avoid providing medications and medical care (nonessential) during mealtime

Identify medications and administration schedule that impact: (1) affect,
“Would you like (name a condiment)?”
“Here’s a fork if you need one. I thought you might like to use your fork...it’s right here.”
“Would you like a bite of this or a sip of (name drink)?”

| Allow staff members to dine with residents | meal. (e.g., walk resident past the tray line) | Ask residents to help with meal preparation as capable (highly individualized) | (2) consciousness, (3) appetite, (4) gastrointestinal comfort, (5) dry mouth
Assess hydration status to determine if fluids need to be pushed during meal |

Use “Hand-over-hand” technique to initiate and self-feeding
### Domain 4: Non-Staff Social Environment

**Performance of non-staff to promote mealtime.**

<table>
<thead>
<tr>
<th>Evidence-based</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Assigned seating at the table at every meal (this is also under physical environment)</strong></td>
<td><strong>Level of Resident Interaction and Seating Arrangements</strong></td>
<td><strong>Social Milieu and the Mealtime Process (Do male residents sit with female residents?)</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Using Individual Verbal Prompts** | **Interpersonal** (Orientation to Person/Place/Time) | **Seating:**  
1. As much as it's possible, residents should be able to sit where they choose.  
2. Staff assesses which residents are “friendly” to each other.  
3. Effort is made to seat residents together according to social preferences and interests.  
**“Friendly Dining”**  
1. Contact family caregivers/volunteers to invite to meal.  
2. Offer at least two days/times to attend meal with resident.  
3. Provide meal to guest, but do not ask them to help resident with eating.  
**Using Appropriate Verbal Prompts**  
1. Provide family caregivers/volunteers with a list of specific verbal prompts that will encourage resident to engage in mealtime activities.  
2. Prompts include: |
| **Assigned seating at the table at every meal (this is also under physical environment)** | **Using Individual Verbal Prompts** | **Interpersonal** (Orientation to Person/Place/Time) | **Using Individual Verbal Prompts** |
| **Assigned seating at the table at every meal (this is also under physical environment)** | **Level of Resident Interaction and Seating Arrangements** | **Social Milieu and the Mealtime Process (Do male residents sit with female residents?)** | **Social Milieu and the Mealtime Process (Do male residents sit with female residents?)** |
| **Using Individual Verbal Prompts** | **Interpersonal** (Orientation to Person/Place/Time) | **Seating:**  
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<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a favorite meal here?</td>
<td></td>
</tr>
<tr>
<td>Do you like to cook?</td>
<td></td>
</tr>
<tr>
<td>What do you like to cook?</td>
<td></td>
</tr>
<tr>
<td><strong>Social/Recreational Activities</strong></td>
<td></td>
</tr>
<tr>
<td>How much did you enjoy (name activity) before the meal?</td>
<td></td>
</tr>
<tr>
<td>Are you looking forward to (name activity) after the meal?</td>
<td></td>
</tr>
<tr>
<td>What's your favorite activity here?</td>
<td></td>
</tr>
<tr>
<td>Who do you enjoy doing (name activity) with?</td>
<td></td>
</tr>
<tr>
<td>If you could choose a new activity, what would it be?</td>
<td></td>
</tr>
<tr>
<td>How do you do (name of new activity)?</td>
<td></td>
</tr>
<tr>
<td>*For more impaired residents, these questions can be modified to reflect what the resident did do, versus what they think about.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Interpersonal</td>
</tr>
<tr>
<td></td>
<td>b. Meal-Related</td>
</tr>
<tr>
<td></td>
<td>c. Social/Recreational Activities</td>
</tr>
</tbody>
</table>