

Restorative Nursing Programs: Now More Than Ever

A Care2LearnEnterprise White Paper
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Overview

Restorative nursing is more important now than it has ever been. The Omnibus Budget Reconciliation Act of 1987 (OBRA) required skilled nursing facilities to identify and act on risk factors to prevent functional decline in residents. OBRA included the legislative mandate for facilities to allow only medically unavoidable declines. Facilities are expected to plan care that will delay any decline in function in the residents. When the Resource Utilization Groups (RUGs) were initiated, restorative nursing programs became part of Medicare reimbursement.

The Resident Assessment Instrument (RAI) Manual for 2010 defines restorative nursing as “nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as is possible” (CMS, 2010). The RAI Manual instructs facilities to begin restorative nursing programs when a resident is discharged from therapy, at admission if the resident has restorative needs and is not a therapy candidate, and at any time during the resident’s stay that restorative needs arise.

In March of 2011, the National Quality Forum released 21 measures for public reporting and quality improvement that will be used at the Nursing Home Compare website. Both short-stay and long-term residents are included in this data. The measures that affect restorative nursing programs are:

- Percentage of residents who need increased help with activities of daily living.
- Physical therapy or restorative nursing for long-stay residents with a new balance problem.
- Percentage of long-term residents experiencing one or more falls with major injury.
- Percentage of low-risk residents who lose control of their bowels or bladder.
- Percentage of long-term residents who have a catheter inserted and left in the bladder.

Restorative nursing programs affect resident quality of life by allowing the resident to be as independent as possible. Restorative nursing programs also affect reimbursement, survey, and resident/family facility choice. These programs are vital to your facility’s success.

Restorative nursing is basically person-centered, whole-person nursing care; the kind of nursing that we practice every time we care for a resident. The difference in a formalized restorative nursing program is that activities of daily living are considered therapeutic modalities. Nursing assistants are trained to instruct, encourage, guide, and assist residents to perform self-care skills with as much independence as possible. Quality of life is a natural outcome of restorative care.

Functional decline, on the other hand, can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers. Functional decline has been described as the “main determinant of quality of life, cost of care, and vital prognosis” (Baztan, 2009). The OBRA legislation and Medicare recognized the importance of preventing decline and created both a legislative and financial incentive to provide restorative nursing programs in skilled nursing facilities.

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Regulations drive reimbursement, a fact of life in long-term care. Reimbursement dictates the amount of resources available for resident care and services. A well-managed restorative nursing program can bring profit to the facility's bottom line. This is one of the ways that good care creates resources for more good care – a positive cycle.



Many of the changes in emphasis that occurred with the MDS 3.0 directly or indirectly relate to restorative nursing. The MDS 3.0 focuses on toileting programs, nutrition (which relates to feeding and swallowing programs), and balance (which can be affected by transfer training and ambulation programs).

For the program to be profitable, attention to, and support for, the restorative nursing must come from the top. The facility administrator, director of nurses, and therapy director must be on board. A facility-wide culture of restorative nursing must be present. If not, the “helpful” housekeeper who does a task *for* the resident instead of *with* the resident will undermine the program.

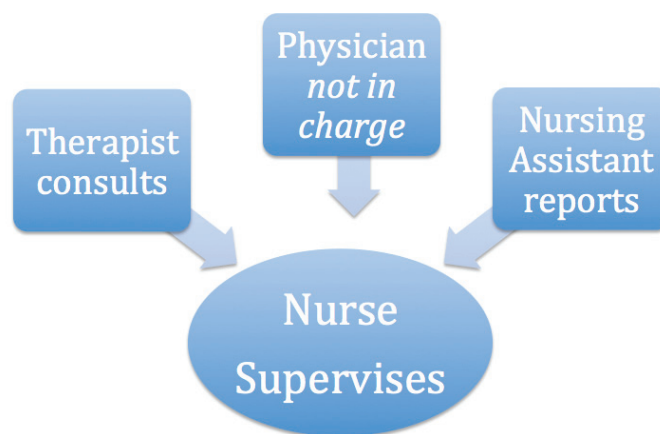
Nuts and Bolts

Nurses, not physicians or therapists, order restorative nursing programs. Therapists work with nurses as consultants. However, restorative nursing is not rehabilitation therapy. Rehab and restorative nursing are complements to one another, but not the same. Residents work to keep the skills they learned in therapy in restorative nursing programs, so there is some crossover. Therapy is based more on the medical model, while restorative nursing programs are, by definition, based on the nursing model. Therapy is faster-paced, and significant progress must be made in a fairly short time. Restorative nursing, on the other hand, focuses on maintaining function in a long-term, ongoing process. Improvement is hoped for but not required.

The need for rehabilitation is generally triggered by an acute illness or injury. Restorative nursing bases treatment on restoring or compensating for skills lost through chronic disease, disuse, or other physiological factors. There is usually not an acute episode that drives the restorative nursing process.

Restorative nursing programs are most often begun when a resident is discharged from skilled physical, occupational, or speech therapy. But the reality is that most residents, by the very nature of their needing nursing home care, are restorative nursing candidates. CMS believes strongly that restorative nursing programs are appropriate for almost every resident. Quoting from the RAI Manual:

Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.



Restorative nursing requires a comprehensive assessment of each resident. A combination of the MDS, staff input, and other assessments are used to identify residents. Indicators that the resident may be a restorative nursing candidate include:

- Incontinence without a toileting plan
- Decline in late-loss ADLs (bed mobility, eating, transfer, toilet use)
- Indwelling catheter
- Falls
- Decline in range of motion

The resident should have an identified deficit and be at risk for a functional decline. Unlike therapy criteria, the resident does not have to show a potential for significant improvement, although that is always to be a goal if possible. Preventing decline alone is a sufficient justification for a restorative nursing program.

Exercises, treatment, and activities in any restorative nursing program are **planned, scheduled, and documented** in the clinical record.

“Reduced Physical Function” is discussed in the restorative nursing section of the MDS/RUG IV. The categories begin with P: PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, and PE2. Two or more restorative nursing services determine the higher category. Restorative nursing programs include:

- Ambulation
- Amputation, prosthesis care (Dentures are not considered prostheses.)
- Bed mobility
- Bowel training¹
- Communication training
- Dressing, grooming training
- Eating, swallowing training
- Range of motion – active².
- Range of motion – passive²
- Splint or brace application
- Transfer Training
- Urinary Toilet training¹.

MDS rules for restorative nursing are specific. Restorative nursing care must be given 6 days per week. At least 15 minutes of care are required to qualify for one day of reimbursable care. However, care may be given throughout the day to add up to 15 minutes. For example, a resident might receive passive range of motion for 10 minutes on the day shift plus 5 minutes on the evening shift. In order to place residents in higher RUG groups, some categories require two restorative nursing programs, with a total of 30 minutes per day of restorative care. The 15-minute increments cannot be figured by adding time from different programs. For example, it is not acceptable to add 5 minutes of active range of motion to 5 minutes of passive range of motion with another 5 minutes of splint assistance to make up the required 15 minutes of treatment for the day.



1,2 -These services count as one service even if both in the category are given (both urinary and bowel training, for example, if given together, are still considered one service).

Restorative nursing programs can be offered in groups. However, the groups cannot be larger than four residents per caregiver.

The RUG categories listed below reimburse if restorative programs are provided.

Rehabilitation Low RUG (RLA, RLB)

- Skilled rehabilitation services 15 minutes a day, three days per week minimum
- AND restorative nursing, two services six days per week.

Interestingly, the rehab low category (RLB) can often pay more than rehab medium (RMB). RLB requires an ADL index of 11 to 16. In fact, RLB may also pay more than some special care categories. Don't let the "low" mislead you; it refers to the amount of rehab, not necessarily the reimbursement.

Low Rehabilitation plus Extensive Services (RLX)

- Skilled rehabilitation 45 minutes/week minimum
- AND 3 days any combination of 3 rehabilitation disciplines
- AND Restorative nursing 6 days/week, 2 services
- AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease
- AND ADL score of 2 or more

Behavioral Symptoms and Cognitive Performance

- Cognitive impairment BIMS score 9 or less, or CPS score 3 or more
- OR hallucinations, delusions
- OR physical or verbal symptoms toward others, other behavioral symptoms, rejection of care, or wandering
- AND ADL score 5 or less

This category requires restorative nursing services. The number of restorative nursing services provided determines the categories BB1, BB2, BA1 and BA2. Two or more services determine the higher category.

Documentation

The care plan must include **objective, measurable goals**. The care plan must show that a nurse periodically evaluates the resident's progress, and changes the care plan if needed. Some facilities use a separate restorative nursing care plan, while others incorporate restorative programs into the primary care plan through the care area assessment process. The care plan will note the duration (minutes) and frequency (6 days per week). Remember that flow sheets and other documentation must match the care plan.

Objective, measurable interventions must be documented in the care plan as well as the resident's medical record. The care plan meeting must document assessment of progress, goals, and reassessment of duration or frequency of treatments. Documentation must include "periodic evaluation by a licensed nurse". The RAI Manual states that, if the state's practice act agrees, the licensed nurse may countersign progress notes written by the restorative aide or assistant once the program has been established for the resident.

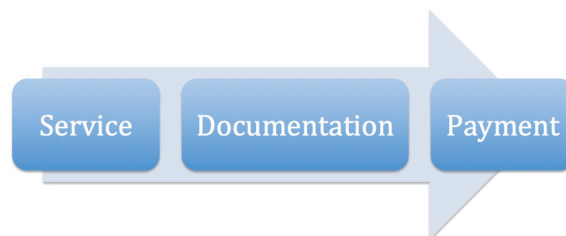
Your facility may have forms in place for restorative nursing documentation. The form is generally based on checking off the restorative activities (bowel program and ambulation, for example) and noting minutes. States and surveyors often drive how these forms look. Some states allow a weekly checklist that the nursing assistant signs with a verification statement. Other states and surveyors require flow sheets. There is no federal requirement for flow sheets. Be sure to verify your state requirements and surveyor preferences before instituting a new form.

Flow sheets are a good tool for efficient documentation. The problem is that many times there are gaps in the flow sheets. Trying to go back and chart for care given last week is chancy, at best. It is hard for a restorative nursing assistant

to remember the specific minutes of care given a week ago, much less the resident's response to care. Auditing flow sheets each shift has proven to be successful in many facilities.

Many facilities now use MDS codes to describe the resident's self-performance abilities and the amount of support provided for documentation of ADLs. This can be an excellent strategy for ensuring consistency in documentation. It also makes documentation easier, with only one scale to remember in ADL documentation.

It is important to document refusal of care, or medical withholding of care, in a narrative note. Also be sure to document all information needed to show that the restorative nursing care provided was adequate and met nursing standards. This might include bowel movement and appetite specifics. Also, be aware that the MDS, comprehensive though it is, does not always capture the specific resident information you may need for some restorative nursing programs. Additional assessment forms may be needed to fill in these gaps. Some states even require a statement from the restorative nurse as to why the specific restorative nursing program was judged to be appropriate for the resident. It will be necessary in these states to document the resident's deficit and/or need for maintenance. Lack of this documentation can sometimes result in lack of payment.



Reassessment and documentation for long-term care residents must be done quarterly. The quarterly assessment is a detailed overview of the resident's abilities and current status. Progress over the quarter should be noted, using objective data from the beginning and end of the quarter. This is the time to analyze the resident's condition. Did she progress? If not, why? If an approach is not working, replace it with another approach to try for better results.

The RAI manual states "Nursing assistants/aides must be skilled in the techniques that promote resident involvement in the activity". Training is an important part of any restorative nursing program. Nursing Assistant programs in schools often do not cover restorative nursing in great depth. Most facilities have a training program for restorative nursing. Nursing assistants may be compensated for completing training and passing competency tests so they can become restorative nursing assistants (RNAs).

The Restorative Nurse

The Restorative Nurse is the lynchpin of the entire restorative nursing program. A dedicated, organized restorative nurse will make restorative nursing happen every day. In some facilities the restorative nurse helps in creating or reviewing policies, procedures, and budgets. The restorative nurse makes sure that the restorative nursing program is interdisciplinary, coordinating with therapy, activities, dietary, and other services as needed.

The restorative nurse writes the orders for restorative nursing programs for residents. This means she has identified the need and assessed the resident. This usually involves chart review and discussion of the resident with the nursing assistants involved in his care. The restorative nurse is also often the person providing the training to new and seasoned restorative staff.



The RAI manual requires a "licensed nurse" to supervise restorative nursing programs. RN or LPN is not noted. In many facilities the restorative nurse is a registered nurse due to state requirements that a RN assess, evaluate, and validate resident assessments and then establish the plan of care. There are facilities that use LPNs for restorative nurses, but have an RN that coordinates the total assessment. This does not mean that the RN simply co-signs an assessment performed by the LPN, as many states will not accept this as adequate. Check your state regulations and state survey office regarding LPNs in Restorative Nurse positions.

Restorative nursing is a 6-day per week service. This means more than one full-time equivalent (FTE) is required. It is easy to pull RNA staff to cover absentees or staff in educational sessions. But the restorative nursing program should be a high priority for staffing, with RNAs being pulled only for real emergencies, such as a snowstorm.

Restorative Nursing: Eating

The need for a restorative focus on eating is based on studies that show the extent of the problem in healthcare today. The risk of malnutrition across care settings is high: 43% in homecare, 45% in hospitals, and **48%** in nursing homes (Guigoz, 2009).

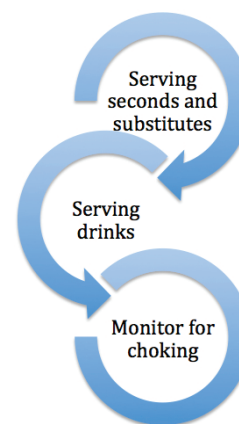
Loss of weight is the single best indicator of nutritional problems in a resident.

Any unintended weight loss of 5% of body weight or more in a year is a red flag for nutritional issues. Be sure to check the resident's weight after a hospital stay. A 2010 study showed that **between 20% and 30%** of all patients in hospitals are at risk of under-nutrition (Rasmussen, 2010).

Most restorative nursing programs for eating happen in a quiet area near or in the dining room. Residents with dysphagia and those progressing from feeding tubes to solid food need a special restorative feeding program in a separate area to reduce distraction. One-to-one staffing can be required for these residents.

A dining strategy that is very effective is "the circulator". This is a staff member who circulates among all the tables, offering substitutes and seconds, pouring extra water, encouraging residents to eat, and monitoring for swallowing problems. Simple, practical approaches are often the best to help residents be more independent at mealtime. Ask nursing assistants to share success stories and tips for programs with others during inservices. This "group wisdom" helps spread positive practices throughout the facility, and gives the nursing assistants a chance to shine in front of their peers.

the "Circulator"



Restorative Nursing: Bowel & Bladder

The area of toileting is a minefield of dignity and residents' rights issues. You never want a resident to say in a survey interview, "They make me wear a diaper here, and won't let me go to the bathroom when I need to. They tell me to just go in my diaper." The restorative mindset is the polar opposite of the "check and change" mentality. Briefs should be the last option for residents. The medical record should include documentation of assessment, resident involvement in planning (if able), and a plan of care addressing incontinence.

A thorough resident assessment is needed before establishing a restorative elimination plan. The type of incontinence, elimination history, physical issues, and cognitive factors must be taken into account. Take two weeks to assess the resident. Get a good idea of the resident's elimination schedule in order to develop an effective plan.

It is not enough to write "toilet q2h" in the care plan. Surveyors know that this cookie-cutter approach is not effective. Writing "toilet q2h" invites further investigation and deficiencies. Few people void every two hours. However, you may find that staff balk at a toileting plan with erratic times. It is a common misperception that "toileting q2h" is the easiest way to accomplish resident toileting. It can actually take more time to toilet every two hours. The resident's assessment-based schedule may look like this:

AM: 3:30, 6, 9

PM: 1:45, 5, 8:30, 11:30

This customized schedule is only 7 episodes per day, versus 12 if the resident is indeed toileted every two hours. Also note the time intervals, which range from 2 ½ hours to more than three hours. As long as staff keep track of the schedules, customized programs are less work and more effective.



Restorative Nursing: Mobility

The Borun Gerontological Center suggests that the restorative nurse make rounds daily at 10 a.m. and 4 p.m., noting which residents are in bed at both times. There is a strong correlation with excessive time in bed (over 16 hours) and these check times. Consider these residents for an ambulation or exercise program (Borun, 2009). The Borun Center's research on ambulation programs had only one criterion for inclusion in the study: the ability to follow a one-step command. Do not rule out residents with dementia when assessing for mobility programs. Sometimes even those with severe cognitive impairments will literally "step up" to this program.

Creativity can help make ambulation part of many activities. A "Walk to Dine" program not only gets the resident time in ambulation, but it is ambulation with a purpose. "Let's walk to lunch" is much more appealing than, "Let's walk down the corridor and back". Some facilities create walking trails and walking clubs. The distance along halls can be marked with discreet signage for accurate documentation.

Safety is an issue in mobility programs. Nursing assistants should always use a gait belt with residents unless medically contraindicated. Body mechanics inservices should be held on a regular basis. Residents and family members should also be trained in safe transfers, use of adaptive equipment, and how to safely walk with the resident. A fall can wipe out any progress the resident has made with an injury or fracture.



Restorative Nursing: Range of Motion

The resident is particularly at risk for decreased range of motion if bedfast. It is estimated that up to 8% of nursing home residents are bedfast (NHQI, 2004). A bedfast resident is defined in the RAI Manual as any resident who is in a bed or recliner chair (not a wheelchair) 22 hours or more per day. The MDS further classifies as bedfast the resident who is in the bed/recliner chair for 22 hours or more per day 4 days out of a 7-day period.

Restorative nursing range of motion (ROM) programs are paid for by Medicare when the activity is performed 15 minutes per day, 6 days per week, and is not incidental to an ADL activity such as bathing or dressing. This does not mean that range of motion during ADLs should not happen. Range of motion during ADLs is a vital part of keeping residents from losing range of motion. However, for Medicare restorative nursing programs, nursing assistants must be trained to count only those minutes working with residents on active or passive range of motion in planned, scheduled ROM exercise.

Active range of motion (AROM) and passive range of motion (PROM) are considered one restorative program. However, 15 minutes of AROM or PROM must be given to receive credit. AROM and PROM minutes may not be added together. Minutes of treatment in one or the other category (AROM or PROM) counted throughout the day can be added together, however, as with any restorative nursing program.

Acceptable: 10 minutes PROM + 5 minutes PROM = 15 minutes

Not acceptable: 10 minutes AROM + 5 minutes PROM

A resident using a continuous passive motion (CPM) device or pedaler (sometimes called a restorator) can qualify for a restorative range of motion program. A physician must order the CPM device. Documentation must show that staff have been trained in use of the device. Qualified time is limited to the time spent setting up, applying, monitoring, removing the unit, and documenting on the resident's activity and progress. Time the resident spends using the unit is not counted.

Restorative Nursing: Activities of Daily Living

Nursing assistants may tell you there are just not enough hours in the day to assist residents in activities of daily living programs. The reality is, residents are slow and nursing assistants have a need for speed due to their workload. Many times the issue is the paradigm of care – caring for one resident from start to finish and then moving on to the next resident. This is not efficient care. Teach the nursing assistants to divide their time between several residents. One resident may be set up to brush her hair and teeth; while the resident completes her grooming the nursing assistant sets up the next resident to shave. Organizing the work in this way is much more effective.

Restorative bathing programs can include a full-body tub bath, whirlpool, shower, or sponge bath. The MDS adds **the resident's ability to transfer as part of the definition for bathing**. The MDS specifically states that bathing “does not include the ability to wash the back or hair”.

State laws vary on the number of baths required for nursing home residents each week. It is generally one to two per week. A partial bath is needed daily for residents who are incontinent.

Often the key to increased independence is adaptive equipment. Most adaptive equipment is fairly standard, but you may want to consult the occupational therapist about creative ways to help residents become more independent. Use of mirrors on stands as part of a grooming kit can make care more efficient as well as allowing flexibility in care for the resident in a wheelchair, who may not be able to reach the sink well or see herself in the mirror.

Survey

Thinking like a surveyor can help in identifying risk factors, decline as it starts, and possible restorative nursing programs for the resident. When a surveyor evaluates a resident, she will first look for baseline status. Then she will check for diagnoses, and consider the normal progression of these diagnoses. Is the resident worse or better than would be expected of a person with these medical problems or injuries? Have risk factors been identified and documented? Are thorough, complete assessments in the resident's record?

The surveyor will then turn to the care plan to assess if appropriate plans with measurable objectives are present, and if the resident and responsible parties, as well as nursing assistants, have been involved in giving input for the care plan. Reassessment and revision of the care plan should be well documented. Any resident or family teaching, counseling, or alternatives for care should also be documented.

F-tags that address restorative nursing include F-309 (highest practical quality of life) and F-297 (development of a comprehensive care plan). F-309 could be described as the essence of restorative nursing: the **highest practical quality of life for the resident**. Highest: because nurses always aspire for the best. Practical: because we work within the limitations of the person's physical and emotional resources.

Other F-tags that impact restorative nursing are:

F241: dignity

F272: comprehensive assessments

F279: comprehensive care plans

F310: ensuring ADLs do not decline unless the decline is unavoidable

F311: providing appropriate care and services to maintain or improve resident abilities

F312: dependent resident receiving necessary/appropriate services

F315: incontinence programs – resident not catheterized unless unavoidable

F317: maintain range of motion unless unavoidable

F318: range of motion treatment

F325: nutritional status maintained

F155, refusal of care, can be called into play with a resident who has many documented instances of refusing restorative nursing treatments. The surveyor will look for documentation that staff attempted to determine the reason for ongoing refusal, as well as attempts to assist the resident with pain medication, adaptive equipment, seeking the family's assistance, or other creative problem-solving activities.

With the advent of extensive resident interviewing, the issue of resident (and family) understanding of restorative nursing programs has become very important. Some surveyors have found during interviews that the resident had no idea he was in a restorative nursing program. Even when prompted with the care plan goals, the resident denied working with staff on those goals. Some auditors even found that staff had no idea there was a restorative nursing program for particular residents. A few staff told surveyors that restorative nursing services were only given "when I have time". This would trigger F282 – failure to follow the care plan. Good documentation and communication with the resident, family, and staff is important to assure that the surveyor hears the same information from all concerned.

Conclusion

Successful restorative nursing programs provide residents with activities that can slow or stop a decline in function. The restorative team can improve quality of life for residents as well as generate Medicare reimbursement for the facility to underwrite further care.

"Lack of activity destroys the good condition of every human being, while movement and methodical physical exercise save it and preserve it". Plato

About the Author

Barbara Acello is an independent nurse consultant and educator in Denton, Texas. She is a member of the Texas Nurses Association, NANDA International, and American College of Healthcare Administrators (ACHCA). She is the recipient of the 2006 ACHCA education award and 2008 ACHCA journalism award. She has assisted in writing and developing mandatory state curricula for nurse aides and EMTs, and has written and contributed to numerous textbooks, instructor guides, quick reference guides, and supplemental instructional material for healthcare personnel. Geriatrics is her preferred area of clinical practice, and she is committed to improving working conditions, education, and professionalism for personnel in the long-term care industry. Resident safety, pain assessment and management, restraints, pressure ulcers, and infection control are subspecialty areas of her practice.

Barbara has over 25 books, workbooks, examination preparation guides, and desktop references published.



Graphics

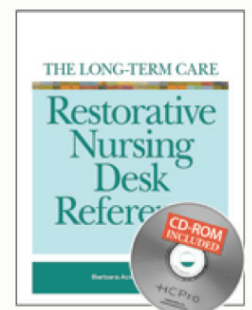
Photos by Fotolia, <http://www.Fotolia.com>. Illustrations and editing by Laura More.

Resources

This paper is based on material from two books written by Barbara Acello:

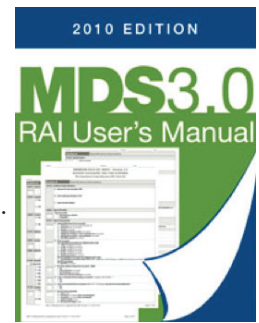
The Long-Term Care Nursing Assistant's Guide to Advanced Restorative Skills

The Long-Term Care Restorative Nursing Desk Reference



If you have not already done so, you may want to download the Resident Assessment Instrument (RAI) Manual. Chapter 3, Section O, "Restorative Nursing", will be especially helpful. It can be accessed online here: https://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

Look for the link to "MDS 3.0 RAI Manual" and click to download. Note: it is a very large zipped file, and may take some time to download. Click and plan to do something else while the file downloads. Save it to your computer for future use.



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