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CMS Final Rule: What Does it Mean for ME?

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Advancing the
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CMS Final Rule: What Does it Mean for ME?

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SO WHAT?

What does all this mean for ME and MY RESPONSIBILITIES?

Learning Objectives

Attendees will be able to:

1. Discuss the current changes in the Requirements of Participation for LTC for Food, Nutrition and Dining
2. Implement the new requirements into daily operations for survey readiness.
3. Understand the pathways to certification for the Food Service Director position.

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The Regulatory Landscape

- The Final Rule
 - Revised requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. Federal Register on 10/04/2016
 - Available online at:
<https://federalregister.gov/d/2016-23503>
- Implementation Time Frames
 - Phase I: Nov 28, 2016 (New Regulatory Language)
 - Phase II: Nov 2017 (New F Tag Numbers, Interpretive Guidance (IG) to Surveyors, New survey process starts)
 - Phase III: November 2019

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The Regulatory Landscape

- Advance Copy of SOM Appendix PP
 - To Access: Go to <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html>
 - Then scroll down to - Advance Copy - Revisions to State Operations Manual (SOM), Appendix PP-Revised Regulations and Tags 17-07-NH 2016-11-09 2017 (SOM is 821 pages)



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The Regulatory Landscape

- Key Focus Areas
 - Person-Centered Care (Member of food and nutrition services staff participation)
 - Quality of Care and Quality of Life (Choice: Informed, Options, Best Practice)
 - Physician Services: Delegation dietary orders
 - 483.60 (Food and Nutrition Services)
 - Staffing: F360-F362
 - Menus: F363
 - Food and Drink: F364-F366
 - Therapeutic Diets: F 367
 - Frequency of Meals: F368
 - Food Safety Requirements: F371
 - Interdisciplinary Team
 - RD/CDM Team



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SO HOW?

How can we be successful from an operations view?

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Meal/Snack Times


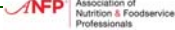
Alternative meals/snacks must be provided to residents eating outside of traditional/scheduled times.

F368
§483.60(f) Frequency of Meals

§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community *or in accordance with resident needs, preferences, requests, and plan of care.* ★

§483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is *served* at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

★ §483.60(f)(3) *Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.*

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Meal/Snack Times

Open dining hours


- Limited menu 24/7
- Extend meal hours with a "bar" concept

Personal refrigerators

Nursing Units stocked

Mobile carts

Collaborate with Activities



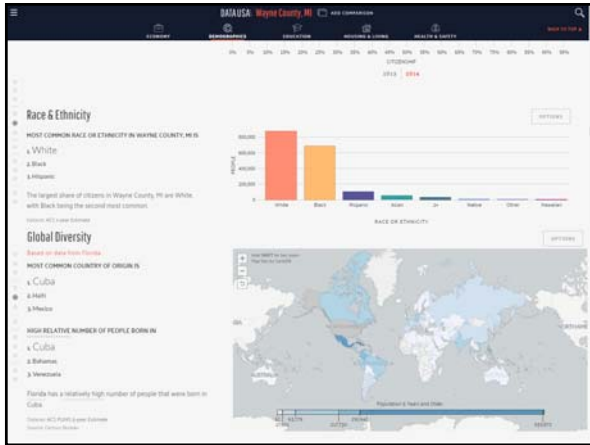
Cultural/Ethnic Preferences

F363 Menus

★ *§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups.*

- Know your local community
 - census.gov
 - Datausa.io







Cultural/Ethnic Preferences

F363 Menus


★ *§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups.*


- Community census
- Resident Survey
- Selective Menus
 - Recipes
- Celebrate holidays





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Cuban and Latin



 Cuban Roast Beef



 Chicken and Black Bean Burrito


 Jambon Moque Pasaouit



 Chicken Kinchea Fried Rice



German


 Chicken Jagerschnitzel


 Fasulet Papoten


 Stein Huedle Beef


 Thai Chicken and Citrus Salad

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Hydration

F364 Expanded to include meeting hydration needs and preferences regarding fluids.

F364
§483.60(d) Food and drink
 Each resident receives and the facility provides—

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;
§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.

F366
§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;
§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and
§483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.

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Hydration

F364 Expanded to include meeting hydration needs and preferences regarding fluids.



- Document beverage preferences
- Make beverages visible
 - Create homelike beverage stations
 - Mobile carts
- Increase variety of beverages
 - Fruit infused water (TCS food)
 - Syrup flavorings

Hydration

- “Hand held” liquids
 - Jello, popsicles, ice cream sandwiches, watermelon, etc
- Attach cup holder to wheel chairs and walkers
- Engage all staff
 - Appropriate staff at meal time
 - Activities Department
 - Nursing team (Stock nursing stations)
- STAFF TRAINING




Assistance During Meals/Snacks

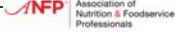


F369: Appropriate assistance is provided to the resident to use the assistive devices when consuming meals and snacks.

NOW WHAT?

So you want to be a CDM/CFPP
AND comply with the new Federal regs?







483.60 (Food and Nutrition Services)
Staffing: F360

(§483.60(a)(2)) state, "we proposed to continue to require that, if a qualified dietitian or other clinically qualified nutrition professional was not employed full-time, the facility would have to designate a person to **serve as the Director of Food and Nutrition Services** who would receive frequently scheduled consultation from a qualified dietitian.


We proposed to require that the director of food and nutrition services, if hired or designated after the effective date of these regulations, **would have to be a certified dietary manager such as those by the Association of Nutrition & Foodservice Professionals (ANFP)**

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Let this Resource be Your Guide!
www.CBDMonline.org




 The credentialing agency for
CFPP Certified Food Protection Professional


CDM Certified Dietary Manager
CFPP Certified Food Protection Professional

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www.CBDMonline.org



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Our History



The CDM®, CFPP® Credentialing Exam—offered since 1985—is part of the competency assurance program for dietary managers. A Certified Dietary Manager, Certified Food Protection Professional (CDM®, CFPP®) has the education and experience to **competently** perform the responsibilities of a dietary manager...

and has **proven this by passing a nationally recognized credentialing exam** and fulfilling the requirements needed to maintain certified status.

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The Pathways



CBDM created pathways to make it possible to meet the eligibility requirements to sit for the CDM/CFPP exam!



Reach out to them with any questions and the required paperwork needed to get you down the path.....also be sure and check with ANFP/or your State ANFP chapter for scholarship opportunities!



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Pathway I:

For candidates who have graduated from an ANFP-approved foodservice manager training program.



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Pathway II:
 for candidates who hold a **two-year or four-year college degree** in foodservice management or nutrition, two-year culinary arts degree, or two-year hotel-restaurant management degree. Candidates must have completed a **minimum of one course in nutrition and two courses in foodservice management.**



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Pathway III:
 For graduates of a **comprehensive 90-hour foodservice course curriculum**, who also have **two years of institutional foodservice management experience**. Transcripts must include a minimum of one course in nutrition and two courses in foodservice management. You must submit a copy of your transcript and certificate of course completion, as well as **employment information with your application.**

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Pathway IV:
 For current and former members of the U.S. military who have **graduated from an approved military dietary manager training program and have attained the grade of E-5**. You must submit your documentation of military training and pay grade when applying under Pathway IV to determine eligibility. Note that your exam fee may be reimbursable through the Montgomery GI Bill; visit www.gibill.va.gov for information.



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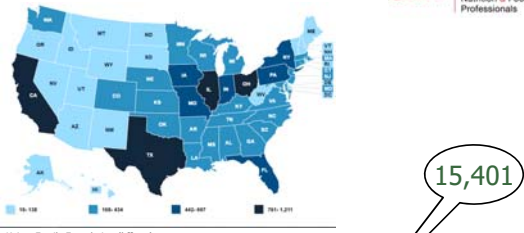


Pathway V:
 for candidates who hold an **alternate two-year, four-year or higher degree**. Candidates must have a **minimum of five years of institutional foodservice management experience**, and must also complete **one course in nutrition and two courses in foodservice management**.

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Number of Nursing Facilities



Kaiser Family Foundation (kff.org)

CDMs in LTC are in DEMAND. MAKE it Your Career Choice & Get Certified!



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Closing Comments

by
 Dana Fillmore, RDN and Barbara Thomsen, CDM, CFPP, RAC-CT, UCAC

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Dietetics in Health Care Connections
 www.dieteticsinhealthcare.org
 #DieteticsinHealthCare

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Questions?

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PRACTICE TIPS: Reform Requirements for the RDN in Long Term Care Facilities

STEPS to prepare for implementation of revised Regulations

1. Assess the Practice Act, Certification, or Title Protection laws for Dietitian Nutritionist for the State in which you provide care and services.
 - The State law will review specifics on how to proceed with ordering privileges and/or delegated orders.
 - Find your State via the **State Licensure Agency Contact List** link:
<http://www.eatrightpro.org/resource/advocacy/quality-health-care/consumer-protection-and-licensure/state-licensure-agency-contact-list>
 - Outcome of review will determine how the RDN practitioner who is license or certified in the State will proceed.
 - Contact your **State Affiliate Academy of Nutrition and Dietetics** to work with the RDN members of their Public Policy Panel for latest update. Use the **Affiliate** link to select your State: <http://www.eatrightpro.org/resource/membership/academy-groups/affiliates/state-affiliates>

2. Review the FINAL RULE by the Centers for Medicare & Medicaid Services (CMS) - Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. CMS released revised Requirements for Participation for Medicare and Medicaid-certified nursing facilities on September 28, 2016.
 - Use the **CMS Final Rule** link to review:
<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaidprograms-reform-of-requirements-for-long-term-care-facilities>
 - Most regulatory sections have been revised and re-designated per the final rule.
 - Table 1: Title 42 Cross-Reference to Part 483 Subpart B in the final rule lists the previous and new regulation
 - Most regulations groups were re-designated and have new numbers.
 - Advance Copy - Revisions to SOM Appendix PP: CMS has incorporated revised regulation text into the SOM Appendix PP. The regulation text is effective November 28, 2016.
 - Revised F-Tags: The current F-Tags have been revised to include the requirements and regulation text as is presented in the final rule.
 - The final rule also stipulated that regulations will be effective through three different phases from November 28, 2016 through November 28, 2019. The phases and their effective dates are as follows:

- 1) Phase 1 – November 28, 2016 = upon the effective date of the final rule.
 - 2) Phase 2 – November 28, 2017 = 1 year following the effective date of the final rule.
 - 3) Phase 3 – November 29, 2019 = 3 years following the effective date of the final rule.
3. Read the revised sections in the “advanced copy” of the Centers for Medicare & Medicaid Services (CMS) **State Operations Manual (SOM)** released on November 14, 2016 - 821 pages. Based on services, responsibilities and job functions provided in Long Term Care facilities, note the changes in regulations pertaining to food service, dietitian and other nutrition professionals as well as technical, support and administrative staff.
- Revisions in the **State Operations Manual (SOM), Appendix PP Revised Regulations and Tags** are *italicized* and in **red color**.
 - Read the CMS Memo from the Center for Clinical Standards and Quality/Survey & Certification Group dated November 9, 2016 that precedes the SOM – Pages 1-3 of 821.
 - **State Operations Manual (SOM) link:** <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf>
4. Note the following Sections in the **State Operations Manual (SOM)**:
- 1) §483.21 Comprehensive Person-Centered Care Planning – *Implementation in Phase 1*
 - Except for: (a) – Baseline care plan - *Implementation in Phase 2*
 - Except for: (b)(3)(iii) – Trauma informed care - *Implementation in Phase 3*
 - See Pages 168-178 of 821
 - 2) §483.30 Physician Services – *Implementation in Phase 1*
 - Note: A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. *A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident’s immediate care and needs.*
 - **Definitions** - Pages 537-538 of 821:
 - **“Nurse practitioner”** is a registered professional nurse now licensed to practice in the State and who meets the State’s requirements governing the qualification of nurse practitioners
 - **“Clinical nurse specialist”** is a registered professional nurse currently in practice in the State and who meets the State’s requirements governing the qualifications of clinical nurse specialists.
 - **“Physician assistant”** is a person who meets the applicable State requirements governing the qualifications for assistants to physician.

- §483.30(e) Physician delegation of tasks in SNFs – Page 537 of 821
 1. *§483.30(e)(2) A resident’s attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who—*
 - (i) *Is acting within the scope of practice as defined by State law; and*
 - (ii) *Is under the supervision of the physician.*
 2. *§483.30(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility’s own policies.*

- §483.70(h) Medical Director - Pages 660 - 666 of 821
 1. See Medical Direction and Implementation of Resident Care Policies and Procedures – Pages 663 – 666

- Page 669 - If concerns are identified for any of the following physician services, determine how the facility obtained the medical director’s input in evaluating and coordinating the provision of medical care:
 1. Assuring that other practitioners who may perform physician delegated tasks, act within the regulatory requirements and within their scope of practice as defined by State law - §483.45

- 3) §483.60 Food and Nutrition Services - *Implementation in Phase 1* – Pages 484-530
 - Except 483.70 - *Implementation in Phase 2*
 1. (a)(1)(iv) – Dietitians hired or contracted prior to effective rule date
 2. (a)(2)(i) – Director of Food and Nutrition Services designated to serve prior to effective – 5 years from the final rule date
 3. (a)(2)(i) –Dietitians designated to serve after the effective date – 1 year from the final rule effective date

- 4) §483.75 Quality Assurance and Performance Improvement – *Implementation in Phase 3*
 - Except – initiate QAPI plan must be provided too State Surveyor at annual survey – *Implementation in Phase 2*
 - QAA Committee - *Implementation in Phase 1*
 - Disclosure information and sanctions - *Implementation in Phase 1*

5) DEFINITIONS – Pages 379-381

- Definitions are provided to clarify clinical terms related to nutritional status.
 - **“Acceptable parameters of nutritional status”** refers to factors that reflect that an individual’s nutritional status is adequate, relative to his/her overall condition and prognosis.
 - **“Albumin”** is the body’s major plasma protein, essential for maintaining osmotic pressure and also serving as a transport protein.
 - **“Anemia”** refers to a condition of low hemoglobin concentration caused by decreased production, increased loss, or destruction of red blood cells.
 - **“Anorexia”** refers to loss of appetite, including loss of interest in seeking and consuming food.
 - **“Artificial nutrition”** refers to nutrition that is provided through routes other than the usual oral route, typically by placing a tube directly into the stomach, the intestine or a vein.
 - **“Avoidable/Unavoidable”** failure to maintain acceptable parameters of nutritional status:
 - o **“Avoidable”** means that the resident did not maintain acceptable parameters of nutritional status and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and nutritional risk factors; define and implement interventions that are consistent with resident needs, resident goals and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
 - o **“Unavoidable”** means that the resident did not maintain acceptable parameters of nutritional status even though the facility had evaluated the resident’s clinical condition and nutritional risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
 - **“Clinically significant”** refers to effects, results, or consequences that materially affect or are likely to affect an individual’s physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
 - **“Current standards of practice”** refers to approaches to care, procedures, techniques, treatments, etc., that are based on research or expert consensus and that are contained in current manuals, textbooks, or publications, or that are

accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies.

- **“Dietary supplements”** refers to nutrients (e.g., vitamins, minerals, amino acids, and herbs) that are added to a person’s diet when they are missing or not consumed in enough quantity.
- **“Insidious weight loss”** refers to a gradual, unintended, progressive weight loss over time.
- **“Nutritional Supplements”** refers to products that are used to complement a resident’s dietary needs (e.g., total parenteral products, enteral products, and meal replacement products).
- **“Parameters of nutritional status”** refers to factors (e.g., weight, food/fluid intake, and pertinent laboratory values) that reflect the resident’s nutritional status.
- **“Qualified dietitian”** refers to one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association or as permitted by State law, on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.
- **“Therapeutic diet”** refers to a diet ordered by a health care practitioner as part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.
- **“Usual body weight”** refers to the resident’s usual weight through adult life or a stable weight over time.

- **OVERVIEW**

- Nutrients are essential for many critical metabolic processes, the maintenance and repair of cells and organs, and energy to support daily functioning. Therefore, it is important to maintain adequate nutritional status, to the extent possible.
- Other key factors in addition to intake can influence weight and nutritional status. For example, the body may not absorb or use nutrients effectively. Low weight may also pertain to: age-related loss of muscle mass, strength, and function (sarcopenia), wasting (cachexia) that occurs as a consequence of illness and inflammatory processes, or disease causing changes in mental status. Changes in the ability to taste food may accompany later life. Impaired nutritional status is not an expected part of normal aging. It may be associated with an increased risk of mortality and other negative outcomes such as impairment of anticipated wound

healing, decline in function, fluid and electrolyte imbalance/dehydration, and unplanned weight change. The early identification of residents with, or at risk for, impaired nutrition, may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before additional complications arise. However, since intake is not the only factor that affects nutritional status, nutrition-related interventions only sometimes improve markers of nutritional status such as body weight and laboratory results. While they can often be stabilized or improved, nutritional deficits and imbalances may take time to improve or they may not be fully correctable in some individuals.

- A systematic approach can help staff's efforts to optimize a resident's nutritional status. This process includes identifying and assessing each resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing pertinent approaches, and monitoring the effectiveness of interventions and revising them as necessary.

6) Summary of FTags and Regulatory Text for 483.60 – Food and Nutrition Services –
• Pages 770-775

7) TextFTag Job Aide — See Crosswalk of the current FTags, their corresponding regulatory section(s), and subparts.

- Pages 811-821
- The intent of the job aide is to inform surveyors of what has been added into the Automated Survey Processing Environment (ASPEN) system used during surveys.
- For example, the advance copy of Appendix PP includes regulation text for Phases 1-3, whereas ASPEN will include regulation text only for Phase 1.

The Reform of Requirements for Long-Term Care Facilities Final Rule was recently released. The following links will provide up to date information on the implementation of these new rules.

Academy of Nutrition and Dietetics

"Practice Tips: Reform Requirements for the RDN in Long Term Care Facilities,"

<http://www.eatrightpro.org/resource/news-center/in-practice/quality-and-coverage/practice-tip-released-in-preparation-for-cms-regulations>

Federal Register – Reform of Requirements for Long-Term Care Facilities Final Rule

<http://cirrus.mail-list.com/dhcc-board/22535547.html>

Advance Copy Appendix PP* *(including FTAG job aid)

<http://cirrus.mail-list.com/dhcc-board/53205334.html>

CMS Surveyor Training

Phase 1 Implementation of New Nursing Home Regulations for Providers

<<http://surveyortraining.cms.hhs.gov/pubs/ProviderTraining.aspx>>

DHCC Connections Newsletter coming soon

Leading Age

<http://cirrus.mail-list.com/dhcc-board/18475034.html>

ANFP

<http://cirrus.mail-list.com/dhcc-board/61619959.html>

American Healthcare Association

<https://www.ahcancal.org/Pages/Default.aspx>

CMS Final Rule: Highlights for Food and Nutrition Services

Dana Fillmore, RD

CMS recently released the Federal Register – Reform of Requirements for Long-Term Care Facilities Final Rule. Phase one of implementation was effective starting November 28th 2016. The State Operations Manual Appendix PP has been updated to highlight the new language for phase one. It is important to note that for this phase the F-tag numbering system will not change. The new regulatory language was incorporated into the existing numbering system.

The following is a summary of CHANGES in the regulations as they relates to Food and Nutrition Services.

- F284 The interdisciplinary team (IDT) must begin discharge planning on admission, including assessment of the resident's goals.
- F322 (Assisted Nutrition and Hydration) The updated information requires that a resident who has been able to eat enough is not fed by enteral methods unless the clinically indicated and consented to by the resident. A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding.
- F325 (Assisted Nutrition and Hydration) Identifies acceptable parameters of nutrition status as usual or desirable body weight and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Highlights that therapeutic diet is offered when a health care provider orders it.
- F327 (Assisted Nutrition and Hydration) The change is the addition of the word "offered" in the term "offered sufficient fluid intake." The intent is to assure that the resident is offered sufficient amount of fluids to prevent dehydration.
- F360 This section has been renamed from "Dietary" to "Food and nutrition services". The change is a focus on meeting preferences of each resident.
- F361 Explicit qualifications and timelines are listed for the Director of Food and Nutrition Services if a dietitian or "*other clinically qualified nutrition professional* " is not employed full-time. State requirements for food service or dietary managers must be followed. See the ANFP resources below for further information.
- F362 A member of the Food and nutrition services staff must participate on the interdisciplinary team. The words "safely and effectively" were added preceding "carry out the functions of the food and nutrition service." (Also reference F280)
- F363 Menus and Nutritional Adequacy - The updates to this section bring a few points to our attention.

- Clarifies that established national guidelines shall be used to assure menus meet nutritional needs. The previous version stated that the menus must be in accordance with the RDA of Food and Nutrition Board of the National Research Council, National Academy of Sciences
- Requires that you take reasonable efforts to assure menus meet the residents religious, cultural and ethnic needs. It also specifies that input must be received from residents.
- Mandates that menus should be updated periodically, and reviewed by approved staff.
- Highlights the residents right to make personal choices

- F364 This section was expanded to include meeting hydration needs and preferences regarding beverages. The language includes a new mention of “a safe and appetizing temperature for food and drink.
- F366 Explicit requirements are listed for accommodating allergies, intolerance and preferences to food and drink. A key word added here is that options for those that request of different meal choice must be “appealing”. This section also stresses beverages, including water, to maintain hydration.
- F367 The attending physician may delegate the task of prescribing a resident’s diet to a registered or licensed dietitian to the extent allowed by State law, and must be under supervision of the physician. (Also see F390)
- F368 The main change highlighted here is that alternative meals/snacks must be provided to residents that request to eat outside of traditional/scheduled times. These options should be meet preferences and be consistent with the care plan.
- F369 Appropriate assistance should be provided to those using assistive devices at meals and snacks.
- F371 This section clarifies three key points:
- Foods from local producers must meet applicable state/local rules.
 - Produce from own gardens must be handled safely.
 - Residents are able to have foods from outside. A policy is required regarding the use and storage of these foods.
- F373 The interdisciplinary team is responsible for assessing the need for a feeding assistant, and the rationale for use of feeding assistant program should be reflected in the care plan.
- F520 A quality assurance and performance improvement (QAPI) program must be in place by phase 3. Discussion in this section includes whether the facility has trained staff (including food and nutrition services) in how to communicate with and address behaviors in residents with dementia. (See F495, F497, F498)

Resources:

Federal Register – Reform of Requirements for Long-Term Care Facilities Final Rule

<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

Advance Copy Appendix PP (including FTAG job aid)

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-17-07.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

CMS Surveyor Training Phase 1 Implementation of New Nursing Home Regulations for Providers

<http://surveyortraining.cms.hhs.gov/pubs/ProviderTraining.aspx>

Academy of Nutrition and Dietetics "Practice Tips: Reform Requirements for the RDN in Long Term Care Facilities," <http://www.eatrightpro.org/resource/news-center/in-practice/quality-and-coverage/practice-tip-released-in-preparation-for-cms-regulations>

Dietetics in Healthcare Communities www.dhccdpg.org

Association for Nutrition and Food Professionals

<http://www.anfponline.org/news-resources/anfp-news/news-details/2016/09/30/cms-finalizes-new-ltc-regulations>