Objectives

Participants will be able to:
• Understand the basic components of F325 and F371,
• Describe one operational strategy for F325 and F371 and
• Describe an audit system that will evaluate the key components of each F-tag.

Proposed Changes to SOM

• Add a nurse aide, food and nutrition services and a social worker to the IDT that develops the comprehensive care plan
• Require MD, NP, PA or CNS in-person evaluation before hospitalization
• Allow physicians to delegate dietary orders to registered dietitians
• Remove the 14 hour rule
• Clarify procurement of food items from local producers and produce grown in facility gardens
• Require policy regarding use and storage of foods brought to residents by family and other visitors.
• QAPI

Proposed Rules

Summary of Costs and Benefits

• We (CMS) estimate the total projected cost of this rule would be $729,495,614 in the first year. This results in an estimated first-year cost of approximately $46,491 per facility and a subsequent-year cost of $40,685 per facility on 15,691 LTC facilities.
CMS recognizes the U.S. Food and Drug Administration’s (FDA) Food Code and the Centers for Disease Control and Prevention’s (CDC) food safety guidance as national standards to procure, store, prepare, distribute and serve food in long term care facilities in a safe and sanitary manner.

Unpasteurized eggs when cooked to order in response to resident request and to be eaten promptly after cooking must be cooked until all parts of the egg are completely firm;

Pooled Eggs - Pooled eggs are raw eggs that have been cracked and combined together. The facility should crack only enough eggs for immediate service in response to a resident’s requests or as an ingredient immediately before baking. Salmonella infections associated with unpasteurized eggs can be prevented by using pasteurized shell eggs or be substituted for raw eggs in the preparation of foods that will not be thoroughly cooked, such as but not limited to Caesar dressing, Hollandaise or Béarnaise sauce, egg fortified beverages, ice cream and French toast.

Is the facility aware of current CDC and FDA nursing home egg handling and preparation polices and does the facility have written egg storage and preparation policies that honor resident preferences safely.

Nursing Home Gardens – Nursing homes with gardens are compliant with the food procurement requirements as long as the facility has and follows policies and procedures for maintaining the gardens. The facility should immediately report any outbreaks of food borne illnesses, for any cause, to their local health department. NOTE: If there are local or State requirements related to food grown on the facility grounds for resident consumption, facilities are to be in compliance with the specific State requirement.
The policies and procedures for maintaining nursing home gardens should be reviewed, if there is an outbreak of food borne illness and the facility’s primary food service has been ruled out as the cause of the outbreak.

Glove Use

- Gloves are not a replacement for handwashing
- Use of hand sanitizers*

Safe Food Preparation - Nourishments and Snacks

- Assure foods in refrigerators (units) are labeled, dated and appropriately covered
- Refrigerator temps on units are at proper temperatures
- Medication pass items

Food Service and Distribution

Transported foods – bag lunches for dialysis, sporting events

Ice – used to cool food items is not to be used for consumption
- no bare hand contact
- what’s your policy on draining, cleaning, and sanitizing your ice machine?

Surveyors will look for:
- Documentation of internal and external temperature gauges
- Measure the temp of a PHF/TCS that has a prolonged cooling time
- Check for potential cross-contamination
- Check the firmness of frozen food and inspect the wrapper to determine if it is intact enough to protect the food
- Interview food service personnel
Wiping Cloths

- Placed in chemical sanitizing solution when in not in use
- Test strips

### F371 Food Service Audit

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Procurement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frozen foods stored appropriately</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Frozen food stored immediately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food purchased from approved vendors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand washing appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves worn appropriately</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hair restrained, use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No bare-hand food contact with ready-to-eat foods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food contact surfaces washed/food sanitized properly to prevent cross contamination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final cost temperatures of HPS correct</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified consistency food maintained outside of Danger Zone (41°F – 135°F) or reheated to 160°F quickly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thermometers calibrated</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wiping cloths stored in chemical solution, monitored with test strips</td>
<td></td>
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</tbody>
</table>

### SOM

**F325**

(Rev. 36, Issued: 08-01-08, Effective: 08-01-08 Implementation: 08-01-08)

§483.25(i) Nutrition

Based on a resident’s comprehensive assessment, the facility must ensure that a resident—

§483.25(i)(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible; and

§483.25(i)(2) Receives a therapeutic diet when there is a nutritional problem.

### Potential Tags related to Unintended Weight Loss

- **F157** Notification of changes
- **F272** Comprehensive assessment
- **F278** Resident assessment accuracy
- **F279** Comprehensive care plan
- **F280** Revision of care plan
- **F282** Implementation of care plan
- **F309** ADL diminished capacity
- **F312** Activities of daily living
- **F325** Nutrition
- **F365** Food proper form
- **F366** Food substitutes
- **F367** Food intake/snacks
- **F368** Frequency of meals
- **F369** Assistive devices
Fact or Fiction 7/2015

Clinical Conditions

- Cancer
- Infection
- Renal disease
- Polypharmacy
- Depression
- Parkinson’s
- Dysphagia
- COPD

- Edentulous
- Med changes
- Behavior changes
- Decrease in self feeding
- Increased activity pattern
- Drug/food interaction

Other Considerations:

If the results of the test can make a difference in assessment & care, consider check of:
- Pre-albumin (vs. Albumin)
- C-reactive Protein
- CBC
- Complete Metabolic Panel
- TSH

If the test results will make no difference, avoid extra cost and resident discomfort

Unintended Weight Loss

Assess clinical conditions, any new Dx?

• Abnormal labs?

• Assess resident’s nutritive and fluid requirements
Assessment to include

- Sensory limitations - vision, smell, taste, hearing.
- Oral cavity - cleanliness, dentition including caries at root and surface, fit of denture or other oral appliances, lesions, condition of gums and tongue.

Medications Associated with Unintended Weight Loss

Because virtually any medication can affect food intake, a review of the resident’s medication program for medications on this list is the beginning rather than the end of the medication review process.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Side Effect(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selective serotonin uptake inhibitors</td>
<td>Decreased appetite</td>
</tr>
<tr>
<td>(antidepressant), decongestants</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics, antidepressants, benzodiazepines</td>
<td>Increased confusion or sedation</td>
</tr>
<tr>
<td>Clarithromycin, ACE inhibitors, lithium, captopril, antihistamines</td>
<td>Change in taste</td>
</tr>
<tr>
<td>NSAIDs, digoxin, antibiotics, chemotherapy</td>
<td>Nausea and vomiting</td>
</tr>
</tbody>
</table>

Ferrous sulfate, opiates                   Constipation

Sources:

Action If Unplanned Weight Loss

- Request reweigh
- Identify cause
- Calorie count – detailed
- High calorie foods/fluids
- Supplements
- Nutrition risk list
- Contact physician
- Liberalize diet
- Depression?
- Review preferences
- Document why
- Behavior change?
- Adaptive devices
- Comfort foods
- Appetite stimulant
- Depression?
- Review preferences
- Document why
- Behavior change?
- Adaptive devices
- Comfort foods
- Appetite stimulant

Environment/Ambience

- Noise level: environmental noise from music, care givers, television is minimal; personal conversation between patient and care giver is encouraged.
- Light: adequate and no glare-producing versus dark, shadowy, or glaring.
- Aroma: familiar smells of food prepared versus all food prepared away from residents, or medicinal smells and waste.
- Adaptive equipment: available, appropriate, and clean; caregivers and/or resident is knowledgeable in use. Occupational therapist assists in evaluation.
- Dinining or patient room: personal trappings versus institutional; no treatments or other activities occurring during meals; no distractions.
- Tableware: use of standard dinnerware, e.g., china, glasses, cup and saucer, flatware, tablecloth, napkin versus disposable tableware and "bibs".
- Furniture: resident seated in armed chair, table appropriate height versus eating in wheelchair or in bed.

Mealtime Rituals

- Rituals used before meals (e.g., hand washing and toilet use), dressing for dinner.
- Blessings of food or grace, if appropriate.
- Religious rites or prohibitions observed in preparation of food or before meal begins, e.g., Moslem, Jewish, Seventh Day Adventist. Consult with Pastoral counselor, if available.
- Cultural or special cues of family history, especially rituals surrounding meals.
Relationship with Caregiver

- Social atmosphere: meal sharing versus accomplishment of task.
- Position of caregiver relative to resident: eye contact, seating so faces are in same plane (en face).
- Pacing and choice: caregiver allows resident to choose food and determine tempo of meal; relies on elder’s preference whenever known, voiced, or expressed through gestures and/or sounds.

Restorative Dining Approaches

- Restorative dining programs, which feature separate dining areas and assistants trained specifically to help patients eat
- Cross-training staff to help with mealtimes has become essential. "Get your management team assigned to a dining room every day." "What says they should go out to lunch when the residents are eating? This should be a time for all hands on deck. We have got to get our residents fed, as best we can, until they just quit eating. And eventually, if they have dementia, they will [quit eating]."

Possible Referrals

- Dentist as needed
- Speech therapy to evaluate swallowing/coughing
- Occupational therapy for seating, adaptive equipment, therapy as appropriate
- Consult with dietitian
- Have the consulting pharmacist assess each medication regimen to identify medications that increase the risk for dehydration or weight loss.
- Psych

Diet Liberalization

- Despite the success of medical nutritional therapy for community-dwelling people with heart disease, kidney disease, or diabetes, many long-term care providers now question the efficacy of restricted diets for elderly people who live in institutional settings.

Diet Approaches – Food First

- Fortified Meals
  - High Calorie Low Volume
  - Ex: Fortified Oatmeal
- Small Portions to avoid overwhelming resident
- Non-traditional meals and timing of food offering
- High calorie, high protein fluids vs. water or juice

Nutrition Critical Element Pathway

Review the following to guide your observations and interventions

- Does the resident have a quiet place to eat or rest?
- Does the resident appear comfortable, content, and engaged?
- Are the resident’s needs met in a timely manner?
- Does the resident have access to water and food?
- Are the resident’s physical appearance indicates the potential for unmet nutritional needs (e.g., weight loss, dehydration)
- Are the resident’s mental status and mood appropriate?
- Are the resident’s cognitive and physical abilities consistent with their diet restriction?
- Are the resident’s dietary habits consistent with their cognitive and physical abilities?
- Are the resident’s dietary habits consistent with their cognitive and physical abilities?
Checklist for Unintentional Weight Loss

Resident Name___________________ Med Rec__________

Purpose: If unintentional weight loss occurs, the resident receives immediate
evaluation of weight loss, and actions are taken to correct the process within the
boundaries of the resident's wishes and/or health care
directive.

YES NO
1. Does the resident have a weight loss of 5% in one month or 10% in 6 months?
2. Is there a physician progress note for the diagnosis?
3. Has the dietitian been notified?
4. Has the oral cavity been assessed?
5. Has pain been assessed?
6. Has the resident's medication been reviewed and adjusted, i.e. pain, appetite stimulants?
7. Has the resident been eating as evidenced by meal % sheets?
8. Has acute illness been ruled out, i.e. N&V, diarrhea, UTI, pneumonia, etc.?
9. Has the resident's medications been reviewed and acted upon, i.e. digoxin toxicity, dilantin, diuretics, etc.?
10. Has Rehab evaluated the resident for swallowing or positioning while eating?
11. Has Psych been consulted for possible reason i.e. depression, agitation, anxiety?
12. Has the resident's eating routine been reviewed by the nurse, dietitian, etc.?
13. Has the resident needed assistance with feeding?
14. Has appetite stimulants been explored?
15. Has blood work been ordered and obtained, i.e. Alb, CBC, lytes?
16. Has tube placement been discussed/documented?
17. Is the resident in a “screwy” mood?
18. Have system failures identified & corrected?
19. Is the resident discussed “at risk” meeting?
20. Were system failures identified & corrected?

F325 Nutrition Audit

Assessment Includes

Item Yes No NA

Assessment Includes
General Appearance
Height/ Weights
Resident’s desirable/usual weight
Food and Fluid Intake
Chewing abnormalities
Swallowing abnormalities
Functional ability
Medication Changes
Laboratory/Diagnostic Evaluation
Resident's projected personal and clinical outcomes
Analysis
Weight changes
Calculated nutritional needs (i.e., calories, protein and fluid requirements) are compared with current intake
Underlying medical conditions are identified that prevent maintaining nutritional status
A clear statement of the nature of the nutritional concern provides the basis for interventions
Care Planning
Care Plan is based on the comprehensive assessment
Resident choice is identified
Resident or resident’s representative can be seen through documentation having involvement in the care plan
Resident specific interventions to meet needs are identified
Causes and interventions for unplanned weight gain are identified
Feeding tubes are used as an intervention only after documented discussion with resident/resident family and physician
Care Planning Interventions in Place (if Identified as Needed)

Weight related interventions
Diet liberalization
Environmental factors
Treatable causes of anorexia
Impaired skin
Functional status
Chewing and swallowing abnormalities
Medication changes
Food fortification and supplementation
Potential for hydration deficits
Comfort measures are provided based on the resident’s choices and pertinent nutritional assessment

Thank you!

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