would be in compliance with these provisions by assisting resident access to the dental office within the facility. Finally, we propose to re-designate § 483.55(a)(4) as § 483.55(a)(5) and would require that referral for dental services occur in 3 business days or less from the time the loss or damage to dentures is identified unless the facility can provide documentation of extenuating circumstances that resulted in the delay. We believe that it is imperative that the loss or damage is addressed and corrected quickly to avoid adverse consequences such as weight loss. We propose to make the same changes at § 483.55(b)(2) and § 483.55(b)(3) to apply to nursing facilities and add a new § 483.55(b)(4) to require that facilities assist residents to apply for reimbursement of dental services as an incurred medical expense under the state plan as appropriate.

P. Food and Nutrition Services (§ 483.60)

Dietary standards for residents of LTC facilities are critical to both quality of care and quality of life. An August 2011 report by the Pioneer Network Food and Dining Clinical Standards Task Force notes research by Simmons and others (Simmons SF, Lim B & Schnelle JF. (2002). Accuracy of Minimum Data Set in identifying residents at risk for undernutrition: Oral intake and food complaints. Journal of the American Medical Directors’ Association, 3(May/June):140-145) that 50 to 70 percent of residents leave 25 percent or more of their food uneaten at most meals and that documentation by facility staff on food consumption is inaccurate. A 2005 position paper by the American Dietetic Association suggests that malnutrition is one of the most serious problems in LTC and is associated with poor outcomes (http://www.journals elsevierhealth.com/periodicals/yjda/article/S0002-8223(05)01742-6/fulltext). Malnutrition, protein-energy under nutrition (PEU), and dehydration can have a deleterious cascade effect on residents, resulting in a downward spiral of declining physical, mental and psychosocial well-being. An earlier (2000) report sponsored by the Commonwealth Fund stated that between 35 percent and 85 percent of nursing home residents are malnourished and between 3 percent and 50 percent are substandard in bodyweight (http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2000/Jul/Malnutrition%20and%20Dehydration%20in%20Nursing%20Homes%20%20&ton%20Prevention%20%20issues%20in%20Homes%20%20%20and%20%20-%20Report). Thus, in considering requirements for food and nutrition services in facilities, we seek to establish minimum health and safety standards that support the nutritional well-being of all nursing home residents while respecting each resident’s right to make informed choices about his or her care, including decisions about diet. Given the diversity of nursing home residents, it may be challenging for facilities to meet every resident’s individual preferences every time; however, we believe by incorporating a facility assessment, along with individual assessments, more can be done to ensure residents are offered meaningful choices in diets that are nutritionally adequate and satisfying to the individual. At the same time, we do not intend to require facilities to adopt an ongoing basis a diet that would be impractical or financially unreasonable. Therefore, we propose revisions described below consistent with our goals to provide flexibility for the facility while enhancing resident choice. We believe that this will lead to overall improvement in the nutritional status of nursing home residents.

It is not enough; however, to ensure that residents have choices in what they eat. Many nursing home residents have other barriers to eating, including dental issues, medical issues, medication-related issues, physical limitations and the need for proper positioning and assistance at mealtimes. With so many issues facing nursing home residents, adequate nutrition requires both an understanding of the facility’s population as a whole and an interdisciplinary approach for each resident. This includes ensuring that sufficient staff are available and have the appropriate skill sets, competencies, and training to assess and plan an overall facility dietary program as well as assist and assess individual residents at meals and with snacks. Some individual residents may require assistance to get to a dining area or to sit up in a comfortable position conducive to eating. Other residents may require the correct application and set up of assistive devices or may need an individual to sit with them and actively assist them throughout the meal. Thus, our proposed revisions include person-centered requirements that are outcome focused and intended to ensure each resident is provided, in a dignified manner, the nutritional and dietary care and services needed to meet the statutory goal of attaining or maintaining his or her highest practicable mental, physical and psychosocial well-being. We propose to revise this section as follows:

We propose to re-designate existing § 483.35 “Dietary Services” as new proposed § 483.60 “Food and Nutrition Services” and revise the introductory language to include taking resident preferences into consideration. We propose to revise § 483.60(a) to require that the facility employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population.

In proposed § 483.60(a)(1) we would retain the requirement that a facility employ a qualified dietitian on a full-time, part-time or consultant basis and update the requirements to be considered a qualified dietitian. The role of the dietitian is critical in the delivery of food and nutrition services. Dietitians are part of the interdisciplinary team and play a significant role, working with other clinicians, to treat wounds, weight-gain or -loss, protein malnutrition, dehydration, and nutrition-related chronic diseases such as diabetes, congestive heart failure and chronic obstructive pulmonary disease. The dietitian is the subject-matter expert for making person-centered recommendations to ensure the nutritional well-being of each resident. In addition to individual evaluations, the dietitian plays a vital role in developing the nursing home’s overall menus. This means the dietitian must understand the general and individual needs of the population of the nursing home, encompassing not just minimum nutritional needs, but also diversity and cultural variety of the residents and work with the director of food service to craft menus to serve the facility population. Finally, the dietitian plays a role in managing and monitoring the dietary staff and food quality, including nutritional standards, food service standards, and infection control standards. In order to ensure the highest level of expertise to meet these requirements, we are proposing to require minimum qualifications for dietitians working in SNFs or NFs. We propose to require that a qualified dietitian must either be registered by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics, or be recognized (licensed or certified) by the state in which the SNF or NF operates as a dietitian or a clinically qualified nutrition professional.

Currently, five states (AZ, CA, CO, NJ, and VA) do not license or certify
diets. We note that the California State Personnel Board requires valid certificate of registration with the Commission on Dietetic Registration of the American Dietetic Association to qualify for state employment in various dietetic positions. We would allow for the retention of dietitians hired or contracted prior to the effective dates of the revised regulations, for a period of no longer than 5 years after the effective date of a finalized requirement. We propose to change the requirement for employment of a dietitian on a full-time, part-time or consultant basis to allow for employment of other clinically qualified nutrition professionals who are recognized (licensed or certified) by the state in which the SNF or NF operates. Retaining the option to employ a dietitian or other clinically qualified nutrition professional less than full-time would allow flexibility for small facilities and alternative care delivery models. We note that regardless of how the facility chooses to obtain the services of a dietitian or other clinically qualified nutrition professional, the facility must ensure it achieves the required outcomes for food and nutrition services, both in terms of providing a nourishing, palatable, balanced diet and in terms of ensuring that each resident is provided the necessary services, both assessment and care delivery, to achieve his or her highest practicable physical, mental, and psychosocial well-being.

In re-designated § 483.60(a)(2), we propose to continue to require that, if a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who receives periodic scheduled consultations from a qualified dietitian. We do not currently establish any standards for a director of food and nutrition services. However, we believe that this position is responsible for critical aspects of food and nutrition services and we believe this individual should have specialized training to manage menus, food purchasing, and food preparation; to be able to apply nutrition principles, document nutrition information, ensure food safety and sanitary procedures, and to manage staff and work teams. We propose to require that the director of food and nutrition services, if hired or designated after the effective date of these regulations, must be a certified dietary manager or certified food service manager as evidenced by meeting national certification standards for a certified dietary manager such as those by the Association of Nutrition and Foodservice Professionals (ANFP), or for a certified food manager such as those by the International Food Service Executives Association or the Food Management Professional certification through the National Restaurant Association. If already serving as a director of food and nutrition service on the effective date without one of these certifications, the individual must obtain a certification no later than 5 years after the effective date of the rule. Alternatively, the director of food and nutrition services may also meet the proposed requirement through specialized education or training in food service management and safety resulting in an associate's or higher degree in hospitality or food service management. Finally, the director of food and nutrition services would meet our proposed requirement if he or she meets applicable state requirements to be a food service manager or dietary manager. We do not suggest that the director of food and nutrition services replaces the specialized expertise of qualified dietitians or other clinically qualified nutrition professionals; however, with their expertise in managing dietary operations in a facility, they may provide needed expertise and assistance in combination with a qualified dietitian or other clinically qualified nutrition professional to achieve the necessary quality of food and nutrition services for residents.

In new § 483.60(a)(4), we propose to require that the facility provide sufficient support personnel with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessment, individual plans of care and a facility assessment that includes the number, acuity and diagnoses of the facility's resident population. The current regulations require that the facility employ sufficient support personnel to carry out the functions of the dietary service. Our proposed revisions would clarify that those support personnel must have the requisite skill sets that take into account an assessment of the facility and considering the individual needs of residents. We believe that most facilities already meet this requirement; however, because nutrition and dining safety are critical to the well-being of residents, we think it is important to be more explicit in our expectations. In particular, we think it is imperative that facilities consider not just the number of residents when making staffing decisions, but the acuity and diagnoses of residents in order to provide effective and appropriate food and nutrition services. SNF and NF residents have become sicker and more complex over time and this must be factored into staffing decisions, both in terms of how many staff are present and the skill sets and competencies the staff need to have.

We propose a new § 483.60(b) to specify that a member of food and nutrition services also participate in the IDT. The registered dietitian or other clinically qualified nutrition professional is a critical member of the IDT; however, in some cases another member of food and nutrition services with the appropriate skill sets and competencies may be an acceptable alternative. Nutrition is an integral aspect of a resident's well-being, thus it is critical an individual knowledgeable about the facility capabilities as well as the resident's needs and preferences participate in the interdisciplinary team in order to ensure that resident can achieve or maintain his or her maximum practicable well-being.

In proposed § 483.60(c)(1), we would change "Recommended Dietary Allowances" to "established national guidelines or industry standards." For example, United States Department of Agriculture provides an online, interactive tool for healthcare professionals to calculate daily nutrient recommendations for dietary planning based on the Dietary Reference Intakes (DRIs) at [http://fnic.nal.usda.gov/fnic/interactiveDRI/](http://fnic.nal.usda.gov/fnic/interactiveDRI/). The DRIs are the Food and Nutrition Board of the Institute of Medicine’s update to the Recommended Dietary Allowances, developed in partnership with Health Canada. Since 1998, the Institute of Medicine has issued a series of DRIs that offer quantitative estimates of nutrient intakes to be used for planning and assessing diets applicable to healthy individuals in the United States and Canada. Additional information on the DRIs, including access to 14 nutrient specific reports and several summary charts, are available in the USDA Food and Nutrition Information Center at [http://fnic.nal.usda.gov/](http://fnic.nal.usda.gov/). We also propose to add a new § 483.60(c)(4) to require that menus reflect the religious, cultural, and ethnic needs of the residents, as well as input received from residents or resident groups. While we do not require that every resident be afforded every possible choice at any time, we are cognizant of the importance of appropriate choice availability. Utilizing information from a facility assessment and from residents and resident groups should assist in ensuring that appropriate options are
available to residents under most circumstances.

In proposed § 483.60(d), we propose minor revisions to incorporate the addition of drinks, to clarify that "proper" means both safe and appetizing, to include consideration of allergies, intolerances, and preferences in preparing food, and to ensure that water and other dietary liquids are available to residents and provided, consistent with resident needs and preferences. We believe it is critical to specifically include dietary fluids in our regulations pertaining to food and nutrition services. Hydration is a critical aspect of nutrition and elderly people who do not receive adequate fluids are more susceptible to urinary tract infections, pneumonia, decubitus ulcers, and confusion and disorientation. Chidester, J.C., and Spangler, A.A., "Fluid Intake in the Institutionalized Elderly," Journal of the American Dietetic Association 97 (1997):23–30. Orthostasis, confusion and disorientation, function decline, recurrent falls, pressure sores, urinary tract infections, pneumonia, and skin infections are all common conditions associated with inadequate fluid intake in frail, elderly long-term care residents. Feinsod, F., Levenson, S., Rapp, K., Rapp, M., Beechiner, E., & Liebmann, L. (2004). "Dehydration in frail, older residents in long-term care facilities." Journal of The American Medical Directors Association, 5(2 Suppl), S35–S41. Available from: MEDLINE with Full Text, Ipswich, MA. A 1999 study by Caspar revealed that only 8 of 99 nursing home residents observed met their standard water requirement based on two 24 hour observation periods. (Gasper, P.M. “Water Intake of Nursing Home Residents.” Journal of Gerontologic Nursing. 1999;25(4):22–29.)

In new § 483.60(e) "Therapeutic diets," we propose to retain the requirement in current § 483.35(e) that therapeutic diets be prescribed by the attending physician. However, we propose to add a new § 483.60(e)(2) to allow the attending physician to delegate to a qualified dietitian or other clinically qualified nutrition professional the task of prescribing a resident’s diet, including a therapeutic diet, to the extent allowed by state law. While the statute requires physician supervision of each resident’s nursing home care, we believe that the physician can delegate authority to a dietitian or other clinically qualified nutrition professional to write dietary orders, so long as the authority is consistent with dietitian or other clinically qualified nutrition professional practice allowed under state law. In this instance, the physician is responsible for making the decision of whether or not to delegate this task and remains responsible for the resident’s care even if the task is delegated.

Further, if necessary, the physician would be able to modify a diet order with a subsequent physician order. We believe this is consistent with other tasks that the physician may delegate and may allow for more efficient use of physician time and effort and more frequent assessment and updating of diet orders by an on-site dietitian or other clinically qualified nutrition professional. We believe qualified dietitians and other clinically qualified nutrition professional are well qualified to assess a resident’s nutritional status and design and implement a nutritional treatment plan in consultation with the resident’s interdisciplinary team. In order for residents to receive timely nutritional care, the qualified dietitian or other clinically qualified nutrition professional must be viewed as an integral member of the IDT who, as the team’s clinical nutrition expert, is responsible for a resident’s nutritional evaluation and treatment in light of the resident’s medical diagnosis. Without allowing for the delegation for writing diet orders to qualified dietitians or other clinically qualified nutrition professionals, nursing homes will not be able to effectively realize the improved resident outcomes and overall cost savings that we believe would be possible with these changes. However, we note that because a few states elect not to use the regulatory term “licensed” (or use no modifying term at all), we are proposing to use the term “qualified dietitian.”

Our intention is to include all qualified dietitians, regardless of the modifying term (or lack thereof), as long as each qualified dietitian meets the requirements of his or her respective state laws. We also recognize that there are other nutrition professionals who are equally qualified to provide required services and we are expressly including these or other clinically qualified nutrition professionals to the extent they are authorized under state law.

We propose to modify § 483.35(f) in re-designated § 483.60(f) regarding frequency of meals. Specifically, we propose to modify the requirement that facilities provide and residents receive 3 meals per day at regular times by adding language to clarify that meals should be served at times in accordance with resident needs, preferences, requests and the plan of care. We further propose to eliminate the requirement that there be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a substantial bedtime snack is provided, and focus instead on when residents prefer to eat and on ensuring that meal service is provided to meet residents’ clinical and nutritional needs. Rather, we propose to require instead that the facility provide suitable, nourishing alternative meals and snacks for each resident who want to eat at non-traditional times or outside of the facility’s scheduled meal service times, in accordance with their respective plan of care. By suitable, nourishing alternative meals, we mean that when a resident misses a meal or snack, an alternative of comparable nutritive value to the missed meal or snack should be provided. We do not intend to require a 24-hour-a-day full service food operation or an on-site chef. Suitable alternatives may be meals prepared in advance that can be appropriately served by appropriately trained facility staff at non-traditional times. For example, staff may be trained to safely re-heat soup and serve a sandwich as a reasonable alternative for a resident who prefers to eat a late supper, so long as it meets the resident’s nutritional needs, takes into consideration the resident’s preferences, and is prepared using safe food handling techniques.

We propose to re-designate existing § 483.35(g) as new § 483.60(g) and revise it to require that the facility provide not only adaptive eating equipment and utensils for residents who need these devices but also provide the appropriate staff assistance to ensure that these residents can use the assistive devices when consuming meals and snacks. We propose to re-designate existing § 483.35(h) as new § 483.60(h) and retain, with some revisions, provisions for paid feeding assistants, as set out in the 2003 final rule (68 FR 55528). We believe the use of paid feeding assistants provides a valuable flexibility to nursing facilities and can serve to ensure that residents requiring dining assistance are able to receive it. In § 483.60(h)(2)(ii), we propose to eliminate the reference to the resident call system. Section 483.35(h)(2)(ii) currently requires that, in an emergency, a paid feeding assistant must call a supervisory nurse for help “on the resident call system.” Paid feeding assistants should be able to call for assistance in whatever manner is most efficient rather than be limited to a specific call system. We focus on the outcome of getting assistance rather than on the mechanism used to request it. We also propose to have the IDT
make the determination if a resident is appropriate for assistance by a paid feeding assistant which would be separate from a charge nurse’s ability and responsibility to make work assignments on a more immediate basis reflecting the current situation.

In proposed §483.60(i), we clarify in new §483.60(i)(1)(i) that facilities may procure food directly from local producers—farmers or growers, in accordance with state and local laws or regulations. We further propose to clarify in new §483.60(i)(1)(ii) that this provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and handling practices, such as using pesticides in accordance with manufacturers’ instructions. We note that facilities are required under proposed §483.70(b) and (c) to be in compliance with applicable federal, state and local laws, regulations and codes and professional standards as well as other HHS regulations. We believe this includes food service requirements applicable to facilities and note that most states and territories have adopted some version of the FDA model food code (http://www.fda.gov/Food/FoodSafety/ RetailFoodProtection/ FederalStateCooperativePrograms/ ucm108156.htm). We expect that facilities comply with these requirements as required by state law. Consistent with §483.70(b), we propose to specify in §483.60(i)(2) that facilities would be required to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. We considered requiring a Hazard Analysis and Critical Control Points (HACCP) program in facilities; however, we are concerned about the application of this requirement in innovative, small and small health care delivery models. We understand this may be a requirement under some state or local laws and solicit comment on whether or not a HACCP program should be required in all SNFs and NFs. We propose to add a new §483.60(i)(3) to require a facility to have a policy in place regarding use and storage of foods brought to residents by visitors to ensure safe and sanitary handling. A resident has the right to make choices, including the right to decide whether or not to accept food from family, friends, or other visitors and guests. However, the facility has a responsibility to help family, visitors, and residents understand safe food handling practices. If facility staff is assisting with reheating or other preparation activities for food brought by visitors, the facility staff must use safe food handling practices and encourage visitors and residents who are contributing to food preparation to also use these safe practices. We believe having a policy in place to address use and storage of foods brought to residents will help ensure consistent application of safe and sanitary food handling practices by staff when these foods are present in the facility.

Q. Specialized Rehabilitative Services (§483.65)

Current regulations at §483.45 set forth the services that a facility must provide if a resident needs specialized rehabilitative services including, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness. Following our proposed reorganization of part 483 subpart B, we propose to relocate these existing provisions to proposed §483.65 with minor revisions. Consistent with specialized rehabilitative services, the need for respiratory therapy and respiratory illnesses are very common among older adults; however, the current regulations do not discuss respiratory therapy. According to data collected by the Centers for Disease Control and Prevention (CDC), 6.7 percent of nursing home residents have some form of disease of the respiratory system at the time of their admission into a nursing home (The National Nursing Home Survey, 2004 overview: National Center for health Statistics [on-line]. http:// www.cdc.gov/nchs/about/major/nhisd/nhisd.htm. Accessed January 10, 2013). In addition to the occurrence of respiratory illnesses at admission, outbreaks of respiratory tract infections are also common in LTC facilities among older adults. In LTC facilities, rates of pneumonia as high as 42 percent and case-fatality rates exceeding 70 percent have been reported in outbreaks due to the influenza virus (Loeb M, McGeer A, McArthur, Peeling R, Petric M, Simor A. Surveillance for outbreaks of respiratory tract infections in nursing homes (cover story). CMAJ; Canadian Medical Association Journal [serial online]. April 18, 2000;162(8):1133–1137. Available from: Health Policy Reference Center, Ipswich, MA. Accessed January 23, 2013). Given these statistics and our prior knowledge about the need for respiratory related treatment and therapy in facilities, we propose to re-designate §483.65(a) to specifically add respiratory therapy to the list of specialized rehabilitative services. Adding this service to the regulations would reflect the more current needs of facility residents. The addition of this service would also explicitly require facilities to provide or obtain these services when necessary and meet the needs of residents facing respiratory issues. However, this would not change coverage policy regarding respiratory therapy. At §483.65(a)(2), we propose to clarify that when it is necessary for facilities to obtain these services from an outside source, the provider should be a certified Medicare and/or Medicaid provider.

Secondly, we propose to clarify the meaning of specialized rehabilitative services in relation to PASARR. Current requirements do not clarify what specialized rehabilitative services for mental illness are and this has led to confusion among providers, states, and others. Therefore, to eliminate confusion and provide clarification, we propose to add in §483.65 a cross reference to the PASARR regulations at §483.120(c) which define the mental health or intellectual disability services a nursing facility must provide to all residents who need these services. In addition, we would correct a typographical error deleting the redundant “‘mental health’ before ‘rehabilitative services for mental illness and intellectual disability’.

R. Outpatient Rehabilitative Services (§483.67)

We propose to add a new §483.67 “Outpatient Rehabilitative Services” to address facilities that choose to provide outpatient rehabilitative therapy to patients who reside in the facility. We understand that some, and possible many, facilities provide rehabilitative services on an outpatient basis and that these services may be paid for under Medicare Part B (see section 1861(p) of the Act, implementing regulations at 42 CFR 410.60(b), and the Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, §220.1.4.) Therefore, we believe it is necessary to ensure that services meet health and safety standards. We propose to require facilities that provide outpatient rehabilitative therapy services to meet requirements similar to those already established for hospitals. Specifically, we propose to require in