

SURVEY INTERPRETATION OF REGULATIONS

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Preface: This author would like to express appreciation for those who contributed suggestions for this paper, especially Registered Dietitians (RD), Interdisciplinary team (IDT) “culture change” team members, and surveyors. Some of the quotes are confidential but many are available upon request, or if there are questions, please contact the author at linda@handydietaryconsulting.com

I. INTRODUCTION:

Let’s state the crux of the matter: Facilities want to be in regulatory compliance, but there is uncertainty if this will be the case when “culture changes” are made to support residents the right to make choices of self-determination. The facilities may be “allowing” residents the right of choice in dietary/nutrition areas that are in direct non-compliance with the stated regulation or the intent of the regulations as defined by the surveyor guidance. In order for facilities or homes to make progress in implementing “culture change”, these facilities must feel confident that they will not be cited. Many do not. Some are advocates that certain regulations should be eliminated. Most agree that regulations were established for “good care.” So if this “good care” is expected, how can there be clearly defined guidance for NOT citing facilities when facilities have “non-compliance” as a direct result of a resident choice? This clearly defined guidance is needed for both the provider and the surveyor.

The following is a summary of this problem. It is followed by an evaluation of barriers, a listing of specific regulations that are impacted with actual deficiencies that have been given, or perceived deficiencies that are anticipated to be given, and recommendations. Finally, there is a sharing of the California Culture Change Coalition’s Dining Pilot 2008.

A. Facility Determination: When a resident choice of self-determination conflicts with the facility’s ability to follow the dietary/nutrition regulation that says “must” and “should”, the facility makes a determination to NOT comply with the intent of the dietary/nutrition regulations. What are the specific requirements of the facility to defend this action?

1. What actions by the facility are required and need to be documented?
2. How can a facility have a “comfort level” that there are specific guidelines that ALLOW non-compliance with the intent of a dietary/nutrition regulation and it will clearly NOT receive a deficiency?

Recommendation for CMS guidance for facility providers: There is a need to guide facilities regarding the steps that need to be taken and documented when a resident’s choice of self-determination would result in the facility being non-compliant with the regulation or surveyor guidance for the intent. Example: What should be included in the facility’s policies and procedures? What should the Interdisciplinary Team (IDT) discuss with the resident (family, or decision makers), what are reasonable alternatives to be offered to the resident, what education should be provided to the resident on risk/benefit of non-compliance, what staff training should be provided for awareness of resident’s decisions and their role in supporting the resident, what continual monitoring of the resident’s outcomes should be provided (and reported back to the resident for review) when

these informed choices for non-compliance, including with physician orders, are made? This is particularly of concern when there is negative outcome.

B. Surveyor Determination: Dietary/nutrition regulations, as with all regulations, have a purpose to establish how a facility is to care for a resident. The regulations, in and of themselves, may or may not be the problem. Some stakeholders are adamant that if CMS eliminated some of the dietary/nutrition regulations, this problem of compliance would be solved as residents make choices of self-determination.

For example: Why should an attending physician order a diet when a resident is admitted or when there may be a nutritional need? And why should the facility ensure that this ordered diet is “received and consumed” by the resident as stated at SOM, Appendix PP, and Surveyor Interpretive Guidance for F 367?

If CMS were to eliminate regulations, who is to determine “good care”? This paper for the most part, will NOT be about whether the dietary/nutrition regulations are or are not “good care” regulations. Revision after revision has honed these regulations, their intent, and guidance to surveyors in establishing good care. This discussion will focus mainly on the determination of deficient practice when these “good care” dietary/nutrition regulations are not followed or are not in compliance as a direct result of resident choice of self-determination. This discussion is about facilities which have years of knowing and doing what the surveyors “expected” for compliance to these “good care” regulations. Some facilities will tell you that it has taken years to figure out what the expectations were for “good care.” Facilities base their policies and training upon these “good care” regulations. For the most part, it is a fair statement to say, that facilities have known how to be compliant when they were in charge of ensuring compliance (in the traditional, institutional model). In the past, facilities offered resident “choices” and “self-determination” to meet the intent of those regulations, as long as those “choices” could still fit within the structure of allowing the facility to ensure compliance with the “good care” or intent of the regulations. The revisions to surveyor guidance for the intent and surveyor’s procedures for “quality of life” regulations, implemented June 12, 2009, clarified what the expectations were for resident choice of self-determination, which was the original intent of OBRA “87. It stated, under F 242, “The intent has added language that directs that the home is responsible to create an environment respectful of the residents’ rights to make choices,” “If there are issues, has the home actively sought information about preferences and choices and attempted to accommodate them”, and “Surveyors should ... interview residents to note if needs and preferences are being accommodated to the extent reasonable.”

(See full document at: www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09_39.pdf)

This new emphasis and surveyor’s guidance promoting residents’ rights but at the same time, in order to accommodate these, facilities may be non compliant with the intent of the regulations...

For example: Registered Dietitians (RD) have a rather defined “personality trait” of obsessive desire for “good care,” if I may be so bold as to speculate on my breed. The defining of “good care” in dietary/nutrition areas in long term care (LTC) has changed over the years. RDs, often coming from a hospital model of dietetics, have had to change when coming to practice in LTC. Some have been forced to shift from their rigid clinical methods of assessing and recommending “heart healthy with dietary restriction to live longer” to incorporating resident preference and quality of life factors (which usually include a resident’s desire for no dietary restriction) in their LTC dietary assessments and care planning. Most LTC RDs have their focus on regulatory compliance of maintaining the residents’ nutritional status (and associated regulatory tags) while providing enjoyable, nourishing food offerings, one of the few and greatest comforts or pleasures of residents’ later

years. This focus is shared by doctors, nurses, and other LTC health professionals. The monkey wrench is when a resident's choices in self-determination jeopardize compliance with regulatory requirements. A resident is not held to compliance, regardless of his or her decisions, the facility is. Then the very thought of "non-compliance" and repercussions, brings sweat to the brow of administration as they view their license on the wall tilting a bit, have nightmares over federal certification funds being cut and admissions stopped, and star ratings plunging.

Now, when facilities are NOT compliant with the intent of the "good care" regulations, because of resident choice, this new ground seems like quick sand, with both the facilities and the surveyors becoming mired in uncertainty. FACILITIES ARE CONCERNED ABOUT the surveyor determinations which many stakeholders claim are currently unclear or inconsistent. Hence, the potential determination or even the "threat of a deficiency" may impede innovative culture change in dining and prevent resident right of choice and decrease quality of life. SURVEYORS ARE WORRIED ABOUT their role in providing appropriate citations when facilities are not in compliance to the stated regulations. So let's evaluate these surveyor determinations.

There are really two determinations:

1. How can surveyors determine that the facility did NOT need to be compliant with the intent of the regulation? If the facility honored the right of the resident to make choices (and the facility demonstrated appropriate efforts on behalf of the resident during decisions of not following the intent of the regulation,) does resident's right of choice SUPERSEDE the requirements or intent of the dietary/nutrition regulations, or some would say "TRUMPS" these requirements?
2. Or how can surveyors determine that the facility SHOULD have been compliant with the intent of the regulation. We are back to deciding when the right of resident choice of self-determination SUPERSEDE this dietary/nutrition regulation? Sometimes there are "BUT" statements that follow guidance statements. In other words, facilities are encouraged to allow residents to make choices of self-determinations... "BUT" sometimes a facility may not be able to "honor" that choice or decision. A facility has a right to know WHEN they are at risk for receiving a deficiency when the facility had "assumed" it was doing everything "expected" by NOT being compliant with the "good care" regulations. The facility must know when the resident's choice of self-determination superseding the requirement.

Sometimes the statement of deficiencies may be blamed on a surveyor who the facility claims may not "recognize" that resident's choice was the issue, not the facility practices. Surveyors are to determine if "good care" is given, even when, and especially when, there are resident's choices with the potential of negative outcome. The survey process is always about what care should have been provided to this resident.

For example: A deficiency was written by the surveyor who determined that the facility did not comply with the "good care" intended by the dietary/nutrition regulation Tag 325 Nutritional Parameters. The facility's defense was that the resident made choices that were not within compliance of the regulation, and they could not provide the "good care" intended by the regulation. The resident had negative outcome. The deficiency identified that there had been

limited efforts on the part of the facility except to document the resident's choices. There was little documentation for what attempts were made for the intended "good care" for this resident during this decision making and resident's choices to prevent the negative outcome. The surveyor's statement of deficient practice was about this lack of effort or documentation, as well as a lack of adequate policies and practice guidelines. The surveyor stated that staff had not received adequate training and was uncertain as to their role when the resident made these choices. The facility was upset about the deficiency and felt that the surveyor was unfair. The surveyor's point was that the facility could not just say, "Oh well, this was the resident's choice to(causing negative outcome), and it's not our fault." When the surveyor 'investigates further' regarding the deficient practice, this question will be evaluated, "Did the facility CAUSE the negative outcome or did the resident's CHOOSE to risk this negative outcome?" Even the CMS F 366 provides an example regarding substitutions and identifies 'residents who refuse food served.'

Recommendation for CMS guidance for state agency surveyors: When the surveyor becomes aware that the facility is NOT compliant with what has traditionally been considered "good care" intended by the dietary/nutrition regulation because of a resident's choice, there needs to be guidance for the surveyor to determine that there should NOT be a statement of deficient practice. When does the resident's choice SUPERSEDE the requirements or intent of the regulations? How does the surveyor determine that the facility provided adequate efforts and documentation when there is a lack of compliance as a direct result of honoring the right of the resident choice of self-determination? CMS needs to clarify what they expect from the facility when the resident's 'informed choice' is made.

II. BARRIERS:

While it was always the intent of OBRA '87, the emphasis of culture change to a more person centered or "resident right of choice" approach to care has just begun in recent years. There has been tremendous attention with co-sponsorship of video trainings and symposiums by CMS and provider groups such as Pioneer Network. Thomas Hamilton, Director of CMS, has supported these joint ventures with Karen Schoeneman, as the passionate CMS point person and facilitator.

A. Provider Barriers: At this very same time, there has been an introduction to the public of a Nursing Home Compare or star rating system based in part upon deficiency findings. The 2567 statement of deficiencies has always been available and many states have posted them online for ready access by the public. Nursing homes are earnest about making every effort to NOT have deficiencies and NOT have deficiencies impact their star ratings. Here is a statement from a state agency's guide to the star rating system. See how the more common deficiencies are related to dietary and nutrition care: (Full report at www.ahcaxnet.fdhc.state.fl.us/nhcguide> "[Explanation of the Performance Measures \(Stars\)](#)" and "[Explanation of Inspection Scoring](#)")

"Some of the more common deficiencies in the Quality of Care category involve the unsanitary storage, preparation, and distribution of food; improper treatment to prevent and treat pressure ulcers; and failing to maintain a resident's nutritional status.

Some of the more common deficiencies in the Quality of Life category involve improper use of physical or chemical restraints, failing to treat the resident with dignity, and failing to accommodate resident needs and preferences.

Some of the more common deficiencies in the Administration category involve the inaccuracy of comprehensive assessments of the residents' health status and failing to develop adequate comprehensive care plans for the residents. "

Tremendous pressure is upon these nursing homes to demonstrate high standards and avoid deficiencies whenever possible.

When regulations are open ended and not specific or conditioned by a resident "right of choice", who determines compliance? The facility? The surveyors? How confusing is this? How does a nursing home provider's IDT "perceive" their risk when it considers any change that facilitates a resident's right of choice or person centered dining programs? Some nursing home providers have stated that there is simply a comfort level which resists change, i.e. "We know what the surveyors want, so leave well enough alone." Some have stated that there is a genuine fear of being cited, i.e. "We would try this culture change concept if there was guidance in order to comply with all the regulations." In other words, why risk getting "dinged"? See the very interesting responses to a survey of nursing homes in Florida who were polled regarding regulatory compliance in dietary/nutrition tags and barriers that prevented them from implementing culture change in dining (at the end of this paper.)

B. Surveyor Barriers: One huge barrier, in my opinion, is the difficulty that surveyors have as they wade through compliance decisions with all these "changes." One has to recognize the years of "training" and earnest intent. Surveyors after all are charged with "protecting" the nursing home residents and it is taken seriously. How often do surveyors feel that they are "advocates" for those who cannot advocate for themselves and the burden to ensure good care is upon their shoulders?

It is the nature of the survey process, there can be no punches pulled (not that this is an adversarial "fight"), punches are full on and surveyors are trained to enforce the specifics of the regulations. If it were not so, it would be very difficult to train a surveyor and to generate a 2567 statement of deficiencies. Surveyors are trained to thoroughly "investigate further" according to detailed specifics of the Investigative Protocols. Then they are trained to document according to detailed Principles of Documentation.

The local CMS regional office staff is charged with scrutinizing the state agency to determine if the survey process was correct (by means of federal observers) and if the 2567 provided detailed descriptions of WHAT the facility failed to do according to the regulations and WHY they failed to do this. Not that nursing homes would have much sympathy given their own experiences of constant scrutiny, but state agency surveyors receive detailed reports from the regional CMS staff similar to a 2567 statement of deficiencies in performing their tasks. State agency surveyors are directed in no uncertain terms by CMS, which in turn is also held accountable. I remember when California surveyors were scrutinized in a federal auditing report for not ensuring the nutritional status of residents in the surveys that had been audited. To address this problem, initiatives were developed to strengthen federal standards, oversight, and enforcement of nursing homes. (See full report: www.gao.gov/archive/1999/he99155t.pdf.) I have participated on many a "plan of correction" to improve surveyor performance. Simply stated, the state agency must ensure compliance by nursing homes in all regulatory requirements.

Up to two years ago, prior to an early disability retirement due to an injury, this author could very well have been the surveyor who wrote some of the deficiencies cited in this paper or been the state agency's dietitian consultant reviewer of an IDR. Now that I am on the "provider side" and networking with colleague dietitians

who are in the thick of encouraging their nursing homes to make “changes”, I am viewing challenges on BOTH sides: Nursing Homes and State Agency Surveyors. In my opinion, regulatory compliance in dietary/nutrition regulations lean more toward “institutional” compliance rather than the “person centered” compliance. The facility seems to be under the burden of competing regulatory requirements: First, F 242 Self-determination which must ensure that residents have right of choice and right of refusal. Second, the facility must meet the specific requirements of the dietary/nutrition regulations. Until the surveyor guidance and survey process becomes more clearly defined, there will be barriers to moving nursing homes along their journey of culture change or person centered dining programs.

III. REGULATORY COMPLIANCE AND DEFICIENCY AREAS

A sampling of deficiencies that have been cited will be given which are challenging regulatory compliance issues as shared by RDs and other IDT members in nursing homes across the nation. There will be an evaluation of the difficulty of moving from an institutional, traditional food service (trayline control with set times for three meals a day and evening snack) to a more person centered dining with right of choice as it relates to regulatory compliance. Regulations and surveyor interpretive guidance are from the 9/25/09 revision of State Operations Manual, Appendix PP (unless otherwise indicated).

Please note: *Italic* is usually a direct quote from CMS, a regulation, a state agency or 2567 statement of deficiency.

Let's start with the TWO therapeutic diet tags: F 325 Nutritional Parameters and F 367 which is under Dietary Services, with the intent that a resident will ‘receive and consume’ the physician’s ordered diet.

F 325 Nutritional Parameters

Based on a resident’s comprehensive assessment, the facility must ensure that a resident-- 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 Receives a therapeutic diet when there is a nutritional problem.

Right of Resident Preference for therapeutic diet: A very important change in the wording and intent addressing resident rights occurred with the revision of F 325 Surveyor Interpretive Guidance, implemented 9/1/08. This regulatory intent was changed to emphasis, as part of the assessment, not only the need but also the RESIDENT’S PREFERENCE. The new intent stated: *“Provides a therapeutic diet that takes into account the resident’s clinical condition, and preferences, when there is a nutritional indication.”*

Let's focus on two timely ‘positions’ taken by the American Dietetic Association. First, there was a recent ADA decision to establish a workgroup, which this author is currently participating on, to develop a “Standard of Practice/Standard of Professional Practice (SOP/SOPP)” for Registered Dietitians in Extended Care Facilities or Long Term Care (LTC.) The new SOP/SOPP is anticipated at the end of 2010. The workgroup is changing the traditional ‘model’ of the Nutrition Care Process to more clearly identify the Registered Dietitian’s role in identifying the LTC residents’ nutritional needs, based upon resident’s preferences/desires and quality of life, as goals and care planning are determined and implemented. From this author’s perspective, this workgroup has an exciting and challenging project that will no doubt impact on the way the entire Interdisciplinary Team in LTC is held accountable for honoring resident’s rights and improving their quality of life in all dietary related areas. The workgroup’s draft is a work in progress, but look at the areas

being developed: “Identify the resident’s nutrition care preference”, “Appropriateness of current diet prescription”, “Adjusts protocols, based on resident’s needs and desires”, “Educate the resident and/or responsible party on risk benefit of refusal to follow the nutrition prescription, give alternative choice”, and “Assesses resident’s developmental, functional, and mental status, and cultural, ethnic, and lifestyle factors using data from validated assessment/ tools, consults with other professionals as needed.” How timely to have the new MDS 3.0 launched with the new mental status and mood interviews as assessment tools.

Second, American Dietetic Association’s Position Paper entitled, “Liberalization of the Diet Prescription Improves Quality of Life for Older Adults in Long-Term Care” 2005 that set two goals for LTC: Maintenance of health and the promotion of quality of life through allowing residents’ their right of choice and desires. This is the abstract of ADA’s position:

“It is the position of the American Dietetic Association (ADA) that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by liberalization of the diet prescription. The Association advocates the use of qualified dietetics professionals to assess and evaluate the need for medical nutrition therapy according to each person's individual medical condition, needs, desires, and rights. In 2003, ADA designated aging as its second ‘emerging’ area. Nutrition care in long-term settings must meet two goals: maintenance of health and promotion of quality of life. The Nutrition Care Process includes assessment of nutritional status through development of an individualized nutrition intervention plan. Medical nutrition therapy must balance medical needs and individual desires and maintain quality of life. The recent paradigm shift from restrictive institutions to vibrant communities for older adults requires dietetics professionals to be open-minded when assessing risks versus benefits of therapeutic diets, especially for frail older adults. Food is an essential component of quality of life; an unacceptable or unpalatable diet can lead to poor food and fluid intake, resulting in weight loss and undernutrition and a spiral of negative health effects. Facilities are adopting new attitudes toward providing care. ‘Person-centered’ or ‘resident-centered care’ involves residents in decisions about schedules, menus, and dining locations. Allowing residents to participate in diet-related decisions can provide nutrient needs, allow alterations contingent on medical conditions, and simultaneously increase the desire to eat and enjoyment of food, thus decreasing the risks of weight loss, undernutrition, and other potential negative effects of poor nutrition and hydration.”

(Obtain full document at <http://www.eatright.org/About/Content.aspx?id=8373>)

In the CMS Individualized Care Video series, (Part III, 2007), a CMS Central Office dietitian from the Division of Nursing Homes, Alisa Overgaard, made the following profound statements:

“Liberalized diets should be the norm, restricted diets should be the exception”; “No research shows restricted diets have any benefit”; “Some homes have made liberalized diet the standard with monitoring of edema, high blood pressure, blood sugars and then make changes as necessary”; “Research shows that quality of life may be enhanced by a liberalized diet”; “Facilities should review existing diets to minimize unnecessary restrictions”; “There is broad consensus that dietary restrictions, the so-called therapeutic diets such as low fat, sodium restricted and modified textured diets are only sometimes helpful and may actually inhibit adequate nutrition especially in undernourished or at risk individuals”; “Generally weight stabilization and adequate nutrition are promoted by serving residents regular or minimally restricted diets”

The CMS revision of F 325 Surveyor Interpretive Guidance references the ADA’s position paper and went on to discuss the need to liberalize diets and often beneficial result of less restriction:

“Research suggests that a liberalized diet can enhance the quality of life and nutritional status of older adults in long-term care facilities. Thus, it is often beneficial to minimize restrictions, consistent with a resident’s condition, prognosis, and choices before using supplementation. It may also be helpful to provide the

residents their food preferences, before using supplementation. This pertains to newly developed meal plans as well as to the review of existing diets.

Dietary restrictions, therapeutic (e.g., low fat or sodium restricted) diets, and mechanically altered diets may help in select situations. At other times, they may impair adequate nutrition and lead to further decline in nutritional status, especially in already undernourished or at-risk individuals. When a resident is not eating well or is losing weight, the interdisciplinary team may temporarily abate dietary restrictions and liberalize the diet to improve the resident's food intake to try to stabilize their weight. Sometimes, a resident or resident's representative decides to decline medically relevant dietary restrictions. In such circumstances, the resident, facility and practitioner collaborate to identify pertinent alternatives."

Read those last two lines. If the surveyor is to evaluate "such circumstances" of a resident declining medically relevant dietary restrictions, the guidance is that surveyors should expect the resident, facility and practitioner (prescriber of the restrictive diet) to "collaborate to identify pertinent alternatives." Do surveyors hold facilities accountable for this collaboration? Both the ADA position and the CMS position for liberalizing diets in LTC are relatively new and a "culture change" from the past traditional approaches (and regulatory requirement) of what was perceived to be "good care" by providing the needed therapeutic diets. Then you throw in the change to emphasize resident decision making based upon preference, with the need for pertinent alternatives. All this "changing" is challenging and often resisted, by both the providers and the surveyors.

Let's ask these questions: Are nursing homes liberalizing residents' diets according to the clearly stated guidance from CMS? Are nursing homes addressing the desires and preferences of a resident as a determining factor in the ordering and provision of a therapeutic diet? If not, why? And if not, are surveyors addressing the lack of a nursing home's liberalizing of diets, determining a resident's preference, and offering pertinent alternatives? Many current deficiency citations focus on why the nursing home did not provide the ordered therapeutic diet or ensure that the resident 'received and consumed' the ordered diet (See deficiency example under F 367.) Perhaps a more insightful question would be regarding the decision making of the surveyor. Did the surveyor determine WHY the therapeutic diet was ordered in the first place, especially if it was clearly documented that this was not the resident's preference? Did the surveyor determine if the nursing home had addressed resident's choice in their Interdisciplinary committees and established appropriate policies and procedures?

Let's look at more guidance given by CMS. The following excerpts from the revised F 325 Surveyor Interpretive Guidance emphasize consideration of a resident's desires and preferences for a nutrition care decision and therapeutic diet or if declined, the facility must address the resident's concerns and offer relevant alternatives:

Qualified dietitians help identify nutritional risk factors and recommend nutritional interventions, based on each resident's medical condition, needs, desires, and goals.

A resident or resident representative has the right to make informed choices about accepting or declining care and treatment. The facility can help the resident exercise those rights effectively by discussing with the resident (or the resident's representative) the resident's condition, treatment options (including related risks and benefits, and expected outcomes), personal preferences, and any potential consequences of accepting or refusing treatment. If the resident declines specific interventions, the facility must address the resident's concerns and offer relevant alternatives.

The Surveyor Interpretive Guidance under Environmental Factors for F 325 states:

“Appetite is often enhanced by the appealing aroma, flavor, form and appearance of food. Resident specific facility practices that may help improve intake include providing a pleasant dining experience (e.g., flexible dining environments, styles and schedules), providing meals that are palatable, attractive and nutritious (e.g., prepare food with seasonings, serve food at proper temperatures, etc.), and making sure that the environment where residents eat (e.g., dining room and/or resident’s room) is conducive to dining.”

What does this guidance really say? Flexible dining environments, styles and schedules help improve dining intake. In other words, open hours, 24 hour access to food choices, buffets, restaurant and family style dining, are culture change dining practices designed to honor self-directed living which have resulted in weight gain instead of weight loss and have contributed to both quality of care and quality of life.

The F 325 Definitions for Avoidable/Unavoidable identify “resident goals” as a determining factor.

“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.*

Read that last part of “unavoidable” again. Surveyors are to investigate whether it was avoidable in light of “poor care” practice or unavoidable in light of “good care” practices. Only the avoidable weight loss will become a deficiency. According to this definition, when the resident’s needs or goals, such as to eating whatever foods they want, lead to some unacceptable parameter of nutritional status, it is considered unavoidable. Are surveyors investigating whether the facility identified the “resident’s needs and goals” and considering “recognized standards of practice?” And are surveyors investigating whether the home was determining and honoring food preferences? That is part of providing “good care” and now a part of the new guidance for Tag F242 Self-determination and Participation. Are most facilities, most physicians and most surveyors continuing to treat restricted diets as the norm?

Under the Surveyor Investigative Protocol for F 325 it states:

“Review of Facility Practices, If the interventions defined, or the care provided, appear to be inconsistent with recognized standards of practice, interview one or more health care

practitioners as necessary (e.g., physician, hospice nurse, dietitian, charge nurse, director of nursing or medical director)."

Surveyors are expected to interview and determine the knowledge level of staff related to recognized standards of practice. Do surveyors ask about liberalizing diets, honoring resident's choice, and related recognized standards of practice? Is staff prepared to discuss recognized standards of practice and how they are implemented in their facilities? Surveyors could inquire as to why there is still a physician's order for a restricted diet when the resident won't follow it and cite deficient practice when the resident's choices and the standard of practice to liberalized diets is *not* being followed.

The Surveyor Investigative Protocol for Tag F325 gives this guidance under Observations:

"During observations, surveyors may see non-traditional or alternate approaches to dining services such as buffet, restaurant style of or family style dining. These alternate dining approaches may include more choices in meal options, preparations, dining areas and meal times. Such alternate dining approaches are acceptable and encouraged."

In the revised section on Severity Levels for F 325, CMS has stated and implied the importance of resident choice and preferences:

Example under Severity Level 4 - Immediate Jeopardy:

"Substantial and ongoing decline in food intake resulting in significant unplanned weight loss due to dietary restrictions or downgraded diet textures (e.g., mechanic soft, preferences. pureed) provided by the facility against the resident's expressed preferences."

Examples under Severity Level 3 - Actual Harm:

"Unplanned weight change and declining food and/or fluid intake due to the facility's failure to assess the relative benefits and risks of restricting or downgrading diet and food consistency or to obtain or accommodate resident preferences in accepting related risks;

Decline in function related to poor food/fluid intake due to the facility's failure to accommodate documented resident food dislikes and provide appropriate substitutes."

This author has never seen F 325 cited at either level when there was unplanned weight loss or declining intakes as stated here or *"Against the resident's expressed preference."* What takes place commonly are citations for *"Failure to accommodate resident preferences"* and/or not providing *"appropriate substitutes."* If surveyors really held facilities accountable and wrote deficiencies at this severity level, would there not be a rush to establish effective systems to accommodate resident preferences? Providers would undoubtedly NOT want more potential for higher severity level citations. The focus here is on this CMS example where the surveyor is to make a determination based upon the facility's demonstration that it is accommodating resident preferences with accompanying guidance for accepting related risks.

Under the section Potential Tags for Additional Investigation, the very first tag mentioned is Tag 150 Resident Rights that states:

“Determine if the resident’s preferences related to nutrition and food intake were considered.”

Let’s shift to the attending physicians and the facility’s Medical Director’s role. It is this author’s opinion the American Medical Director’s Association (AMDA) supports resident centered care and advocates for resident’s choice; however, there is a disconnect between what is offered in their professional organization’s guidance and what is often demonstrated by Medical Directors.

From their new 2009 publication entitled, Synopsis of Federal Regulations in the Nursing Home: Implication for Attending Physicians and Medical Directors, here are excerpts emphasizing liberalizing diets and addressing resident’s choice:

Under F 325, this AMDA document states:

AMDA Recommendation for Attending Physicians: “Review pertinent diet orders. Consider liberalizing dietary restrictions (e.g., calorie limitation, salt restrictions) that are not essential to the resident’s well being, and that may impair quality of life or acceptance of diet...” (It goes on to make recommendations for identifying risk factors, treatable causes of anorexia or refusal of food such as medication side effects, poor oral status, and depression.)

AMDA Recommendations for Medical Director: “Help the facility implement appropriate evidence-based approaches to evaluate and address nutrition and hydration issues. Review whether physicians see and address medical causes of anorexia and weight loss, and document responses to interventions.”

(Obtain full document is available for purchase at www.amda.com/publications.)

Facilities ultimately are responsible for ensuring that the Medical Director fulfills this role according to the regulatory requirements (F 501) ensuring appropriate resident care. One facility, who had started their journey for culture changes in dining, reported that they had changed Medical Directors three times until they finally found one who understood the role and its importance in what they were trying to accomplish. What does that say about the facility? This facility grasped the concept that “status quo” of what used to be acceptable for mediocre performance by physicians and Medical Directors is no longer tolerable and needs to be addressed head on. Isn’t it a basic principle that the bar is always raised when expectations and even job opportunities demand a higher level of performance? Our proud Olympians often give credit to competing colleagues who raise the bar on performance and exact their better performance. Facility staff might ask themselves if they are receiving exceptional performance and support from their Medical Director, especially as they move more into culture changes in dining. More and more citations are being written for F 501 when the Medical Director is not providing the services according to the intent of this regulation.

Many AMDA articles on related nutrition care are archived and available to the public. An interesting recent article in their publication: Caring for the Ages by Dr. Jeffrey Nichols (January 2010) answers a question of the Medical Director’s role in “How to Prepare for an Annual State Survey”

<http://download.journals.elsevierhealth.com/pdfs/journals/1526-4114/PIIS1526411410600042.pdf>

Dr Nichols references the revision of the Surveyor Interpretive Guidance for Medical Director. F 501 Medical Director states:

“The intent of this regulation is that:

The medical director collaborates with the facility leadership, staff, and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice; and

- *The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that:*

- o Affect resident care, medical care or quality of life”*

The revised Surveyor Interpretive Guidance states:

“The medical director’s input promotes the attainment of optimal resident outcomes which may also be influenced by many other factors, such as resident characteristics and preferences... the medical director can help ensure that appropriate systems exist to facilitate good medical care, establish and apply good monitoring systems and effective documentation and follow up of findings, and help improve physician compliance with regulations...The medical director’s role involves collaborating with the facility regarding the policies and protocols that guide clinical decision making (for example, interpretation of clinical information, treatment selection, and monitoring of risks and benefits of interventions)...The medical director has a key role in helping the facility to incorporate current standards of practice into resident care policies and procedures/guidelines to help assure that they address the needs of the residents...Nationally accepted statements concerning the roles, responsibilities and functions of a medical director can be found at the American Medical Directors Association Web site at www.ama.com.”

(See full document at www.cms.hhs.gov/SurveyCertification-GenInfo/downloads/SCLetter06-05.pdf

or if this page is unavailable: Go to main website at www.cms.hhs.gov/transmittals> Select Year 2005, check box for “Show only item containing the following word”: Medical Director)

Recommendation for F 325 Nutritional Parameters:

First, the regulation requirement is for: *“Receives a therapeutic diet when there is a nutritional problem.”* There is a need to evaluate supportive research that indicates there may NOT be a need for “therapeutic diet” when a “nutritional problem” with the elderly and the psycho/social ‘harm’ of demanding therapeutic dietary restrictions or loss of resident choice in this area. Consider changing this wording to ‘offer’ or language indicating a support of the resident’s therapeutic needs while not mandating a therapeutic diet.

Second, the new intent and surveyor interpretive guidance of the revision of 9/1/08 has some excellent wording, such as: *“Provides a therapeutic diet that takes into account the resident’s clinical condition, and **preferences**, when there is a nutritional indication.”*

If indeed, resident “preference” is a criterion for ordering a therapeutic diet, why are therapeutic diets still being ordered, regardless of a resident’s “preference” and desires? There is a need to further clarify this intent for both providers and surveyors. A person’s preferences are not problems. Additionally CMS has added to its new guidance at Tag 325 a focus on resident’s goals. Clarify that the facilities are to ask residents what their goals are and change the focus to the person and personal goals (also a preference) instead of the facility’s goals for the resident. That is institutional care and not individualized care.

Third, there is a need to clarify deficient practice when the IDT, physicians, and Medical Director have not established clear policies and procedures to address resident’s right of self-determination and choice for therapeutic diets and restrictions.

Fourth, there is a need to define ‘unavoidable’ decline in the nutritional parameters in the context of resident’s choice of self determination. There is a need to review and expand the severity examples of Immediate Jeopardy and harm.

F 367 This is the second Therapeutic Diets regulation, found under Dietary Services: ***“Therapeutic Diets: Therapeutic diets must be prescribed by the attending physician. The intent of this regulation is to assure that the resident receives and consumes foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the treatment and plan of care.”***

Actual deficiency example for F 367: *“It was observed that the resident (on a carbohydrate consistent, diabetic diet) chose barbeque beef sandwich, steamed rice, French Fries, and an egg roll. Each of these items was high in carbohydrate. During a discussion with the dietary manager, she stated currently their system allowed residents to pick the foods they wanted. This system did not account for physician ordered diets and ensuring residents were offered items within the scope of those diets.”*

Actual deficiency for F 367, with IDR, and deficiency was upheld: In this example, the nursing home created what they considered to be a “homelike” dining environment with person centered dining approaches, including having condiments on the tables, much as any home would have. In their first survey after the change, there was a surveyor’s 2567 statement of deficiency practice which identified four residents who did not want to “follow their ordered diet” (No Added Salt or No Sugar Packets), and consumed the salt and sugar condiments placed on the dining room tables. In the past, this would have been a very appropriate 2567 deficiency citation, or “the norm.” What would be more basic than an assessment for a therapeutic diet that the resident needed, followed by a physician’s order, and then the expectation that the nursing home would ensure that this therapeutic diet be provided to the resident? This has been the expected, “appropriate care” in the past.

In an Informal Dispute Resolution statement, the nursing home offered detailed documentation of their efforts with each of the four residents, who also had no negative outcome from their choices. The deficiency was upheld and supported by the state agency. This appears to be the crux of the problem.

One has to ask tough questions. How does the nursing home maneuver to meet the intent of a regulation when the resident refuses to comply? What exactly are the rules now? We often hear that “change” and perhaps “more resident rights sensitivity” is difficult for the staff at nursing homes. We hear that the great “barrier” for embracing “culture change” or more person centered approaches by a nursing home is quite frankly a fear of 2567 deficiency citations by the state agency. It’s new territory when a nursing home makes changes, even as simple as this. It is understandable that when a nursing home finally manages to nail down an understanding of regulatory compliance (from years of a traditional, institutional approach of control), change is often seen as putting the nursing home in jeopardy of the unknown. Throw in the fear of any deficient practice that may impact the Nursing Home Compare Star Rating, and a nursing home will understandably be concerned for any probability of putting its status in jeopardy.

In the past, good surveys, in other words “no dietary deficiencies,” were given to a nursing home with a well informed staff and a well run trayline. This would be a typical trayline where resident trays had food items that were measured and evaluated for meeting the requirements of the ordered therapeutic diet. No salt packet would ever be allowed on the tray of a resident on the “No Added Salt” Diet. And no sugar packet would ever be allowed on a tray of a “No Concentrated Sweets” or “Consistent Carbohydrate” Diet. It did not matter if the resident wanted salt or sugar, if these were not part of the physician’s ordered diet, they could not be “received or consumed.” For years, these two limited dietary restrictions (No Added Salt, and No Added Sugar, or a variation on liberalized carbohydrate control) were considered “liberalizing” the diets. These two diets were more liberal when compared to many very restrictive diets. Today, some consulting dietitians and IDT members in nursing homes would tell you that they define “liberalizing” diets as “eliminating” all physician ordered dietary restrictions unless the resident or surrogate decision makers desired these restrictions. Some facilities will bargain with the physician to have the ordered therapeutic diet set aside or “liberalized” to allow resident choice during buffets and special events.

When you read the IDR response of the state agency for upholding this deficiency, try to view the statements from the surveyor’s perspective of enforcing a regulatory requirement that the residents should “be provided and consume” the ordered therapeutic diet. Isn’t this what the regulation and its surveyor interpretive guidance states? Was the surveyor wrong? Was the state agency wrong to support this?

When you read this state agency’s response to the IDR, try to see the nursing home’s point of view. If the nursing home had refused to respect the residents’ stated desires for not following their ordered diet and insisted that these residents not have the salt and sugar condiments even

removing them from access would there have been a deficiency under F 242 for not ensuring the right of self-determination? If the nursing home had separated or banished the residents to dining room tables without salt and sugar condiments, would there have been a deficiency under F 241 for not ensuring the right of dignity? The last question on the table is where does the nursing home go from here? The plan of correction (POC) must “correct” the deficiency areas. How would this administrator write a POC? The nursing home provided details of their efforts and pointed out how they were respecting resident rights **AS THEY ARE ALSO REQUIRED TO DO** in the Informal Dispute Resolution, but the state agency did not accept this and the deficiency stood.

Actual state agency responses to the facility’s IDR (6/17/09) along with this author’s evaluation:

- a. *The facility admits that the physician’s orders were not followed. The facility admits that the dining tables, in an attempt to promote ‘homelike’ environment are set up with condiments which include salt and sugar. The facility was aware, not unaware, of these residents’ preferences and choices and were honoring them (something like this?) admits that the resident did not following the ordered therapeutic diet (even when the facility was very aware that this was the resident’s informed choice of not following an ordered therapeutic diet), Linda, they were cited for 367 so can you better explain the point you are trying to make? You already made some points above.*
- b. *Therefore these residents were able to use condiments not allowed on their therapeutic diets...The facility admits that all the tables are set up the same and that they anticipated that in some instances residents on therapeutic diets will exercise their right to make choices to eat types and/or amounts of food that are not in keeping with the physician ordered therapeutic diet. Is there an expectation that a resident be removed or denied access to all food items that are not on the ordered diet or seated at a table without restricted condiments? Would this be a dignity issue? You already made this point above.*
- c. *In the IDR document the facility admitted that the dietary tray cards instructed staff to ‘encourage’ residents to use Mrs. Dash/Sweet N Low vs. regular salt/sugar. There are no instructions on the tray cards that instruct staff to remove restricted items from the tables or out to reach of the residents. IDR documentation provided confirms that the facility knew the residents were non-compliant with the diet orders. When dietary/nursing staff provides “encouragement” to follow the therapeutic diet, and still the resident refuses, are they to remove restricted items from the resident? Now, there is a good question. Taking control OVER a resident, wouldn’t that be coercion? And wouldn’t that fall under abuse? Is this what CMS and survey agencies want staff to do?*
- d. *The facility provided with the IDR documents a form titled, ‘Benefits vs. Risks’ as evidence that risk vs. benefits of dietary non-compliance was discussed with the resident. There were no details on this form of what was actually discussed with the resident. The form lists ‘noncompliance with current diet’ as an area of concern, but does not contain specifically what part (s) of this form ...was of concern. What do state agencies and CMS expect for risk versus benefit education and documentation of it?*

Recommendation for F 367 (a): Deficiencies are being given under this tag, because it is a very “black and white” compliance tag. There is a need to clarify the facility’s responsibility to assure the resident “receives and consumes foods” as prescribed by the physician when the resident’s preference is NOT to follow the diet as ordered. There is a conflict here. The facility is required to honor resident preference per F325 and to honor resident’s choice per F242.

CMS or state agency guidance that has a “BUT” statement: Any time CMS or the state agency provides detailed guidance, it should be applauded. However, if this guidance has an exception or “BUT” statement, it causes confusion and lack of clarity. This is what happened with the answer from CMS Region IX and the CA Department of Public Health (CMS Q and A for California) during the 2008 Dining Project of the California Culture Change Coalition (CCCC).

Question from the CCCC in the CMS Q and A to California SA and CMS Regional Office:
QUESTION 1: Linda, when a quote is in italics you do not also put quotation marks around it

*“OBRA regulations support ‘self-determination’ and a resident’s right to make choices about aspects of their lives that are important to them. Person-directed dining practices such as buffet and restaurant – style menus, and snack centers where residents have an array of food items from which to choose, expand the choices that residents have about **what** (types and kinds of food and fluids) **when**, (various times during a 24 hour day), **where**, (selected physical location such as choice of which dining room, activity room, outside such as on patio, bedroom, corridor, in front of the nurses’ station, **who** (**alone** or choice of which other residents, families, visitors, and/or staff), **how much** they want to be served (small or double portions, and/or seconds of some favorite food/s) and **how much** they want to eat (actual intake.)*

We anticipate that this may result in some instances where residents with clinically appropriate therapeutic diet orders will exercise their choice to eat types and/or amounts of food (more or less) that is not in keeping with those daily physician ordered diets. The CCCC recognizes that it is the responsibility of the facility to assess, monitor, plan, educate the residents about their risks, and work with the resident to provide care that is consistent with both their needs and their wishes.

• What other actions would the facility be expected to take in this kind of situation in order to have met their regulatory responsibilities to provide care and services to meet that individual’s needs?”

The 2/12/08 response from CMS and CDPH offers exceptional information. It provides detailed guidance of what surveyors would expect to find in nursing home compliance. Please note that the full, detailed answer from CMS/CDPH is a “landmark” document in this author’s opinion. It can become a basis for the IDT to develop effective policies, clinical practice guidelines for risk/benefit, education, IDT roles and monitoring systems for liberalizing the diets and for decision making when a resident refuses to follow an ordered therapeutic diet.

Answer from CMS/ CDPH:

*The question acknowledges the need for staff training and provision of individual assistance, however since culture changes includes changes for staff, it may be of benefit to identify that the training **should include staff's recognition when to act.** Perhaps in addition to individualized care, there are also benefits to create and establish systemic methods for staff to implement these nutrition approaches. **This would require the facility dietitian's coordination and involvement to ensure policies and procedures are created, are feasible to carry out and are implemented via trained and competent staff within the operational constraints of the facility.***

However, within that document, here is the exception or "BUT" statement:

*Staff participants may need to be flexible in allowing certain foods prohibited on any resident's dietary restrictions and focus on the role of nutrition in maintaining health in the nursing home's residents. While the facility is required to follow the doctor's orders for a resident's diet, staff participants may need to clarify information to the doctor regarding the resident rights and the role of nutrition in maintaining the resident's health and quality of life... A health professional's expertise is utilized to incorporate favorite foods; **however, there may be the rare instance when resident's choices cannot be integrated** (bolded as in the document.)*

Read that last sentence again. When are the rare instances? When can resident's choices NOT be integrated or honored? When is the professional's expertise and role of nutrition in maintaining the resident's health to supersede the resident's quality of life or right to refuse or right of choice? Who is to make that determination? (For the full document: www.calculturechange.org >our services> Dining Project 2008, CMS Q and A for California.)

Recommendation for F 367 (b): With the CMS guidance (Memo to CCCC Q and A 2/9/08) that has stated, "*While the facility is required to follow the doctor's orders for a resident's diet, staff participants may need to clarify information to the doctor regarding the resident rights and the role of nutrition in maintaining the resident's health and quality of life... A health professional's expertise is utilized to incorporate favorite foods; **however, there may be the rare instance when resident's choices cannot be integrated.***" (bolded as in the document)

There needs to be clarification on any exceptions where the facility CANNOT honor the resident's preference to not follow the physician's therapeutic diet order. Would this be in direct conflict with CMS requirements to honor choice and the right to refuse treatment as in Tag F155?

F 241 Dignity

Is it a "dignity" issue to have residents arrive and be served at different times at the same table?

Concern for dignity and timely dining: "Our dining areas are open for an hour and a half - come anytime. The surveyor was not happy someone would not be served but be sitting with

someone who was eating. Serving everyone at one time at a table works against their freedom to come and go and choose their table. If you wait until the table is full to serve then people are waiting unnecessarily.”

A perspective on culture change and surveyor concern for dignity, assigned seating: “We have not received any citations for our culture change dining program but we have had to argue our point with a surveyor. In 2008 during our annual survey (our first QIS survey) a surveyor on the team who was a dietitian by trade was very aggressive that we must have assigned resident seating in our dining areas. The Administrator and I spent a long period of time (up to 2 hours) explaining why this is not necessary and why it goes against culture change. We explained that the dining areas are open for periods of 2 hours at each meal and our residents are encouraged to come at any time during those 2 hours. Due to this schedule assigned seating would eliminate the socialization factor we were trying to instill. We try to encourage our members to sit with new individuals and increase friendships and build self esteem. After explaining this to her and showing her multiple resources as to why this type of dining program is beneficial we did not hear anymore about it and there were no dining or dietary citations that year. This has been our only ‘bump in the road’ with a surveyor in regards to all the culture change programs we have instilled. Overall, the surveyors are very supportive of culture change and are seeing the positive aspects of what is being done. We must remember, just as we have done a great job institutionalizing our residents over the years, we have also done a great job institutionalizing LTC leaders and surveyors. Thank you for taking the time to let us be heard!”

Recommendation for F 241: There is a need to clarify when there is a “dignity” issue or not when seating residents at different times at the same table. Obviously, early diners will be dining as a late diner is seated and waiting. In the past, surveyors cited this as a dignity issue.

F 363 Menus and Nutritional Adequacy
Planned in advance; be followed.

Actual deficiency for F 363, when liquid supplements were offered per resident preference, and no “meal” tray was send to resident room.

The Surveyor Interpretive Guidance for F 363 states:

“For sampled residents...observe if meals served are consistent with the planned menu and care plan in the amounts, types and consistency of foods served. If the survey team observes deviation from the planned menu, review appropriate documentation from diet card, record review, and interviews with food service manager or dietician to support reason(s) for deviation from the written menu.”

When there are deviations from the menu, the last sentence directs the survey team to “investigate further” by interview and record review, to determine if there are supportive reasons for the deviation from the written menu.

The RD reported that the surveyor cited the nursing home for not serving a tray with a nutritionally balanced meal, but sent just what the resident requested which was 2 health shakes per meal. The resident was not nutritionally compromised nor had any recent weight loss. The RD stated: “These are the kinds of citations that worry me, especially in light of ‘culture change’, which is going to be all about what the resident wants. If this wasn’t emphasized before, it sure will be now! But, different states are at different levels when it comes to surveyor training and knowledge; it will take a while before they’re all on the same page.”

Actual deficiency for F 363, when 7 residents in restaurant style dining did not choose and were not served the 2 oz. protein listed planned menu. The RD stated: “We were cited for not giving residents 2 oz. of meat when they requested small portions of the entrée through our restaurant-style dining system. We didn’t have documentation that this was what they chose routinely, but in almost all of the 7 residents which the surveyors referred to the findings, they could choose the quantity they wanted on a daily basis. Chicken legs were the example and residents stated that they were overwhelmed by getting 2 oz. rather than 1 oz. even though that is the menu requirement (2 oz of meat.) There was no negative outcome.”

When a resident disregards the menu as planned and chooses NOT to have a balanced diet or the resident’s choices do not include certain food groups or nutrients or has smaller portions, what is the nursing home’s responsible to ensure a nutritionally adequate diet for that resident? The facility OFFERED a balanced diet and it was reflected on the menu. This regulation should be changed to reflect that a balanced meal “is available” instead of “be followed” which is causing confusion for surveyors.

Recommendations for F 363: There is a need to consider changing this wording for a requirement to have this adequate or balanced menu plan as available or offer instead of “be followed.” This is causing confusion to providers and surveyors. A consideration to give guidance that a planned menu is “not intended to restrict resident choice” similar to the new guidance for F 371 regarding the facility’s responsibilities for providing safe food but does not restrict resident choice to consume visitor foods brought into their home. There is also a need to clarify the resident’s right to have “arbitrary scoop sizes” versus the planned menu or traditional “large and small” portion sizes.

F 364 Food: Resident receives and the facility provides:

- (1) Food prepared by methods that conserve nutritive value, flavor, and appearance;**
- (2) Food that is palatable, attractive, and at the proper temperature**

One RD comment on F 364: “Palatability is so very subjective. Please help establish more guidelines for the surveyors to address this. We have many examples of the surveyor thinking the

vegetables were ‘too soft’ or the ‘fluffy rice was bland’, when these are not resident comments, but rather surveyor preference.”

An example of an actual deficiency for unpalatable hot food temperatures during family style dining and a facility’s concern for burns and spills:

The nursing home reported: “Family Style dining was encouraged within a Memory Care unit for individuals with Alzheimer’s Dementia. Residents were encouraged to participate in the home-like environment by setting the table, pouring their own drinks and serving foods from multi-portion family style bowls. Staff assists as needed and then joins residents for the meal to encourage companionship, consistency and socialization. Courses were encouraged where practical: beverages, appetizer (hot/cold cereal, soup, and salad), entrée and desserts. During the training process, it became apparent the biggest hurdle was staff fear and prejudice about residents handling the serving bowls. Infection control, burns, spills and other negatives were preventing staff from allowing the time and patience for residents to participate fully. During survey, surveyors acknowledged that family style dining was a new concept. Hot food temperatures dropped as bowls of food were removed from the heat source and delivered to the dining area. Surveyors maintained that regardless of the service style, the delivery temperature must be ‘palatable’ when served to residents.”

Here are some concerns by RDs for hot beverages (coffee) being too hot (cited under Tag, F323 Accidents) and its impact on the right of residents to have hot beverages which they consider palatable:

“I question the need or desirability of having coffee served to all residents at 120 degrees F or below because the facility water cannot be above this. This makes no sense when the hot food from the steam table must be above 135 degrees F.”

“We were cited for the hot temperature of the coffee putting the residents at risk. It was found to be above 155 degrees F in the self service area of the dining room. The surveyor said the residents were at risk for third degree burns according to F 323. We felt we were ‘on top of it’ and showed the surveyors that we had developed guidelines and staff training to ensure residents were protected. Some of our residents wanted their coffee very hot. Our facility wanted to do whatever would be accepted quickly to clear the deficiency and did not want to deal with an IDR. Our plan of correction was to limit the temperature of hot beverages. Some of our residents are very unhappy.”

There are maximum water temperature ranges for “safe bathing” in F 323 and in many state regulations, but there are no maximum hot food temperatures, for safety or palatability, stated in surveyor interpretive guidance. Table 1 in surveyor interpretive guidance in F 323, entitled “Time and Temperature Relationship to Serious Burns Water Temperature”, lists the first temperature as 155 degrees F for 3rd degree burns to occur in one second. Then this guidance succinctly states the following, “*The responsibility to respect a resident’s choices is balanced by*

considering the potential impact of these choices on other individuals and on the facility's obligation to protect the residents from harm. The facility has a responsibility to educate a resident, family, and staff regarding significant risks related to a resident's choices. Incorporating a resident's choices into the plan of care can help the facility balance interventions to reduce the risk of an accident, while honoring the resident's autonomy. Consent by resident or responsible party alone does not relieve the provider of its responsibility to assure the health, safety, and welfare of its residents, including protecting them from avoidable accidents."

Recommendation for F 364 and F365 Accidents: The need to clarify reasonable temperatures of hot beverages as facilities offer increased choice of self service and allow residents to safely enjoy very hot beverages to be served at their palatability preference as Tag 325 clearly recommends for resident preferences.

F 365 Food prepared in a form designed to meet individual needs

Actual deficiency example: *"Resident 6's Therapy Treatment Progress Note: "Presents with severe oral and pharyngeal dysphagia. Power of Attorney (POA) has requested feeding in spite of risk for pleasure." Review of Resident 6's Physician's Orders revealed, "Pureed and mechanical soft moistened items for pleasure". Observation revealed Resident 6 had a slice of ham that the Nursing Assistant A had cut up into (small) pieces." The RD stated that the nursing home was told during the exit interview by the state agency team that they could not provide foods that would put the resident at risk. Other examples where IDT and RDs have expressed concern is when residents who have dysphagia do not want to follow an order for "thickened liquids." There is hesitancy to "allow a resident the right of choice" if the result might be a choking incident, aspiration, or worse case scenario, death. They ask, "Would the nursing home receive a deficiency finding?"*

Recommendation for F 365: There is a need to clarify the reasonable expectations for the facility's responsibility when a resident, who has been assessed at risk for choking and has been identified to need a texture modification or thickened liquid diet order, does NOT want to follow the order or have a restriction.

F 368 Frequency of Meals

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.

(3) The facility must offer snacks at bedtime daily.

(4) When a nourishing snack is provided 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, and a nourishing snack is served.

Actual deficiency example for F 368: *On 5/8/09 at 4:35 PM, an interview was conducted with the food service supervisor (FSS). The FSS revealed that the full dietary cart came out and went around each night with bedtime snacks. A person was hired to take the cart and serve night snacks. The FSS was informed the residents had stated there was no night time snacks passed. The FSS stated when the snack cart made rounds, if the residents were in bed asleep, they were not awakened.*

In this deficiency, HS snacks were made available through an enhanced snack system: mobile cart, variety of foods and beverages for ad lib enjoyment for all textures and diets and, physician ordered snacks (labeled for specific residents). Residents observed to be sleeping during the HS snack rounds were not awakened. Surveyors stated concern that physician ordered snacks for RCS (Diabetic) diets were not served to this population group. RD emphasized to survey team that residents were not awakened according to a schedule – either during the p.m. snack pass or early in the morning; but were instead encouraged to sleep until well-rested and that the clinical care team took this practice into account during assessment of nutritional health. The nursing home still received this deficiency.

CMS has addressed F 368 (Frequency of Meals)

(See CMS Memo at

www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07_07.pdf

and www.calculturechange.org under CMS Regulatory Compliance Q and A.)

Question 1: Tag F368 (Frequency of Meals): You request a clarification that the regulation language at this Tag that “each resident receives and the facility provides at least three meals daily” does not require the resident to actually eat the food for the facility to be in compliance. You also ask for clarification about the regulatory language specifying that there must be no more than 14 hours between supper and breakfast (or 16 hours if a resident group agrees and a nourishing snack is provided). You state that some believe this language means all of the residents must actually eat promptly by the 14th hour, which makes it difficult for the facility to honor a specific resident’s request to refuse a night snack and then sleep late.

(CMS) Response 1: *The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at Tag F242, Self-determination and Participation. You are correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complains about the food items provided. If a resident is sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident*

to eat when they awaken (such as continental breakfast items) if they desire any food before lunch time begins.

Recommendation for F 368: While this was addressed in the CMS memo on Frequency of Meals (and evening snack), deficiencies have been cited and there needs to be further clarification of the facility's responsibilities when residents make choices. Do state agencies and CMS want residents to be woken up from sleep in order to receive snacks?

F 371 Sanitary Conditions

The facility must –

- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and*
- (2) -Store, prepare, distribute and serve food under sanitary conditions*

This author had the privilege of being loaned from CDPH to participate on the CMS expert panel workgroup to revise F 371, which took over two years (implemented 9/1/08.) When the first draft was released and all stakeholders were invited to make comments, suggestions, and offer changes, there were 850 for our workgroup to review (with the American Dietetic considered “one” stakeholder, though it had a dozen pages.) The final revision had a great deal more detail and guidance than the previous surveyor guidance of 1995. The basis of surveyor interpretive guidance is HOW a facility can demonstrate that it is preventing food borne illness and this guidance is cross referenced to the current FDA Food Code which is an authoritative model, best practice, and established standards for food safety. Facility food should be safe.

One section of the F 371 revision, in which our workgroup tried to address the right of “a resident to have visitor food brought in by family” was not clearly defined and caused tremendous discussion and disagreement after it was implemented. A CMS memo was issued to address this and provided a “rewording” of the surveyor interpretive guidance.

(See full document at:

www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09_39.pdf.)

Rewording or the revision of F 371 (implemented 6/12/09) Food Procurement under Sanitary Conditions memo SC09-39 states: *Residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices at F 242, Self-determination and Participation. The CMS regulation at F242 protects the resident(s) right to choose to accept food from visitors, family, friends, or other guests (e.g., facility-sponsored activities such as a community pot luck). This regulation states, ‘The resident has the right to make choices about his or her life in the facility that are significant to the resident.’ When the survey team determines that a facility has not allowed a resident or residents to choose to accept food from any friends, family, visitors or other guests, the team should consult the regulation and guidance at F 242 to determine if the resident(s) rights have been violated.* Many providers appreciated this clarification provided by CMS.

However, facilities in one state were concerned when they were told that they would receive deficiencies if they allowed residents to accept food that was determined to be “unsafe” or not prepared safely by the facility. Several RDs were confused about the resident’s right and the mixed messages being given. They asked for written guidance from this state agency. This state agency’s memo may have been well intended to help facilities in their state not “run afoul of the FDA”, but the message was in direct conflict with the CMS memo that had just been issued on resident rights and visitor food. The following is an excerpt from this state agency dated July 20, 2009:

Please remember that facilities are functioning under FDA and (this state licensure requirements), not just CMS certification requirements. According to FDA and (this state’s) Food Code, food items prepared in home kitchens are not allowed for general service to residents in substitution of a meal that is prepared in an approved kitchen. This means that, even if the facility is assured that foods are handled properly, a facility cannot utilize a ‘family potluck’ as a substitute for a meal. It is important to realize that, if foods are prepared by people not trained in the food code and in kitchens that are not food code compliant, the facility cannot really say for certain that the foods have been handled properly.

Potato salad is a potentially hazardous food and should never be utilized unless it comes from an approved source. Facilities may serve non-potentially hazardous food, like cake and other baked goods, from “unapproved” sources under certain conditions:

- Residents must be made aware that the item(s) is from an “unapproved” source so they can consume or not consume at their choice.*
- The item is served as an option that residents may select. This means that the facility must have prepared something that can be served if the resident chooses not to consume the item from the “unapproved” source.*
- Someone that participated in the preparation of the item must be present to answer questions about the ingredients and preparation method should questions arise.*
- As an infection control practice, the facility should track who consumed or did not consume the item from the “unapproved” source.*

Vegetables can be utilized from any source as long as they have not been processed in any way – i.e. tomatoes only washed, not cut up or slices, corn can be husked but not cut off the cob.

(The state agency) feels that these ‘rules’ regarding foods from ‘unapproved’ sources still allows the residents the freedom of choice, in compliance with CMS’s guidance, but also comply with the FDA requirements. Following these ‘rules’ should prevent a facility from “running afoul” of the FDA inspectors should one choose to inspect a nursing home’s kitchen (which they are allowed to do and have done so in (this state.) FDA inspectors do not inspect based on resident rights but inspect on the prevention of food borne illness. It is important to a facility to understand that the FDA inspectors have the authority to immediately shut down a non-compliant facility kitchen and prevent food processing from that kitchen until they deem it compliant.

These are the questions from nursing homes to this state agency and to CMS: Didn’t the CMS memo address the right of residents to partake of all visitor foods and “community” potlucks?

While the facility food must meet the sanitary conditions (all FDA Food Code and state requirements), isn't the intent of CMS to honor residents the right of informed choice in a homelike environment (regardless of whether the food is a potentially hazardous food or not)? Does this state agency's perception that a FDA survey could come at any time, prevent the nursing home from honoring resident right of choice for visitor foods, if these foods cannot be demonstrated as being compliance with FDA standards? And wouldn't then the facility be out of compliance with CMS' requirement at Tag F242 to honor resident choice?

It is understandable that the RDs and dietary managers, who had received the CMS memo on visitor food and revision to F 371, wanted this author to ask CMS to clarify these issues and have consistency from their state agency guidance. They say, given the climate of enforcement of this state's survey agency, it is unlikely that it will honor resident right of choice for "visitor food" as intended by the CMS memo.

A state agency surveyor's comment of food safety and resident' right of choice: "As a surveyor, I am informing the homes that there is no regulatory barrier to the personalization of the dining experience in particular and in promoting personal choice in general. We are encouraging the homes to be creative and to call us if they have concerns regarding the regulations. We in turn will check with Food Safety to determine that we are all in sync. We had an issue regarding a facility which would not allow a family member to bring in food from a health department approved source (a supermarket or bakery), while allowing an activities volunteer to bake cakes from her home kitchen for residents to celebrate birthdays as a group with other residents. Despite the intention of the facility to 'protect' the residents, the facility failed to honor the choice of the resident for food brought in by the family. As a surveyor, I want to see the process by which decisions were made and the education of staff, family and residents regarding safety. Otherwise, our position here is that individual preferences need to be honored and there is no regulatory barrier to doing so."

Potential deficiency on visitor food (fruit) brought in from local farms as stated by an RD:

"One issue that has come up is the sharing of fresh fruits and vegetables from the local farmers.

As a farming community, it is important for the residents and the local farmers to be able to share their produce with us. During a recent survey (11/09), plums were brought in and the surveyor said that the items were not from an approved vendor; therefore, these could not to be shared with the residents. We considered these visitor foods and offered as such. We do not serve these items as a planned facility food or menu choice. Is this an OK practice? Can we be cited?"

Personal, resident refrigerators and Sanitary Conditions: Comments from a state provider group representative: "I would like to mention the problem that has surfaced relative to residents and their personal refrigerators. It would be great to get some guidance from CMS on this issue. We have attempted to get the state agency to provide a memo or surveyor guidance on personal refrigerators as surveyors are not consistent in their approaches to this. We have seen facilities remove refrigerators from resident rooms and create 'no personal refrigerator' policies when it has become a survey issue. I would like to get some assistance from CMS so that there is an

ordered process for evaluating safety and sanitation around personal refrigerator use. I believe it really promotes resident directed services related to food and dining.”

Some of the questions from nursing homes regarding their responsibilities for resident refrigerators include: Monitoring temperatures, for cleaning, and for labeling and dating food items for discard. Some feel that it is not the nursing home’s responsibility, as it is the resident’s right to have visitor foods brought in and available. Some feel that nursing home staff should ensure that resident refrigerators and these visitor foods are maintained according to “best practice” guidelines, current Food Code, and the policies and procedures of the facility’s refrigerators.

Handling of visitor foods, once they are in the facility: When “hot foods” are provided by a visitor, then leftovers are held in cold hold storage (refrigerators), and reheated in a microwave for consumption, is it the facility’s responsibility to ensure that thermometers are used and the appropriate temperature of a safe reheat is reached (165 degrees F for 15 seconds) according to the Food Code?

There is a concern by RDs on maintaining sanitary conditions when staff is encouraged to eat with residents: “What are the regulatory issues that providers should be concerned about when a nursing home promotes staff eating with residents? Can a nurse aide or staff who has completed a state approved feeding assistance program “assist with feeding” a resident while also being a diner at the table?”

CMS Answer on staff eating with residents from Memorandum. (See full document at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07_07.pdf or access it through www.calculturechange.org under CMS Regulatory Compliance Q and A.)

Here is a RD’s statement on F 371 related to lack of state agency training, which has been expressed by numerous providers. CMS has made great efforts to provide state agency training and this author can speak from experience, having attended many, many CMS trainings. In recent years, with internet access, the posting of upcoming revisions to regulations, and CMS memorandums for clarification, there has never been a time when providers have benefitted from so much access to the same timely information as the state agency. It is still a challenge.

“Why are the surveyors not trained on revised regulations or new surveyor interpretative guidance or changes ‘before’ they become effective? We have surveyors come to our Health Care Association meetings to get the latest information about the regulations. Surveyors have actually acknowledged that they ‘didn’t know that’ before they came to our training. A recent example: On the revision of F 371 to allow residents to accept food from visitors (CMS State Agency SCMemo 09_39 dated 5/29/09, implemented 6/12/09), I did training to our association in July 2009 and the surveyors in the front of the room had never heard of this memo or change in surveyor guidance for F 371. I work with some consultants - nursing and otherwise - that state that they don’t even want me to do trainings where I talk about regulations and interpretative guidance or changes and possible examples of issues - because the next week, that is what the surveyors are out looking for..... Yikes! Can there be more of a ‘work together’ relationship between the provider and the survey agency? Why not? I think some states do this and it is so

much nicer to work in this environment. The impression is that the surveyors are often out to get the provider, or so it seems. Can CMS encourage joint education sessions or allow the providers to be trained alongside the surveyors, so everyone is hearing the same thing? This could only be beneficial to the resident, right? Would not this be a real CULTURE CHANGE in our industry?"

Recommendation for F 371: There is a need for further clarification on the facility's responsibilities for visitor food and in the following areas: Local produce brought into the facility, resident refrigerators, and staff eating with residents. Some providers have received conflicting direction from their state agencies which differs from what CMS guidance has been, especially with not allowing visitor foods that cannot be determined to be safe.

F 441(revised and implemented 9/25/09) Infection Control

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:

Before and after assisting a resident with meals (hand washing with soap and water)

Recommendation for F 441: Many nursing homes have used hand sanitizer throughout their facility and in the dining rooms. With the new revision on infection control, there is a need to clarify the reasonable expectation for hand washing (with soap and water) for safety when a staff member is providing assistance to more than one resident at the same time. Is it just required when there is visible soiling or cross contamination, or is it required between assisting each resident no matter? This is a hard line for some surveyors but it needs to be clarified and clearly identified.

We all want positive versus negative outcome or resident decline. We all know that the federal annual recertification survey by the state agency team is to determine regulatory compliance which is based upon determining negative resident outcomes. There can be many types of "negative outcomes" for residents. This author predicts that psychosocial negative outcome, lack of well being, and diminished quality of life as a direct result of not allowing resident's choices, including choices in dining, will be citations of the future. As providers and surveyors move away from traditional, institutional type of views, the revolution will happen. If you are reading this paper, you are probably already on your way toward person centered care. I applaud you and your facility's efforts to improve the quality of life of your honored residents.

IV. SHORT SUMMARY OF THE CALIFORNIA CULTURE CHANGE COALITION (CCCC) DINING PILOT 2008

SHORT SUMMARY OF THE CALIFORNIA CULTURE CHANGE COALITION (CCCC) DINING PILOT 2008.

This was a tremendous collaborative effort to jumpstart “culture change in dining” in nursing homes in California. This author was honored to be a part of this pilot and a liaison resource.

In 2007, California Association of Health Facilities (CAHF) embarked on a pilot project with the California Culture Change Coalition (CCCC) and CMS Region IX to test out several dining innovations in skilled nursing facilities. Eleven nursing homes volunteered to try out a new practice that expanded the dining choices for people living in their facilities. Three practices were piloted: restaurant style, buffet style, and an expanded snack program. The experiences of these providers and the “lessons learned” are described in the excerpts on the CCCC website. Documents were posted online that record the mission, the innovative culture change concepts, and the sharing of their journeys. All are encouraged to download these for resources they offer.

The CCCC introduction begins with the following:

“Many providers are interested in making changes that expand the choices their residents have for what and when they eat, but they are not sure where to start. Common barriers to implementing change include concerns about expense, staff resources and how to make those changes without breaking regulatory ‘rules.’ In an effort to address some of these concerns and promote the implementation of person-directed innovations in California nursing homes, the California Culture Change Coalition, in conjunction with the Center for Medicare and Medi-caid Services (CMS) Region IX and California Department of Public Health, Licensing and Certification (L&C), embarked on the Person-Directed Dining Pilot Project.”

This author considers the CMS Region IX and CDPH Questions and Answers (Q and A) for California, which has been referenced earlier in this paper, to be a “landmark” document for guidance to nursing homes. This and other documents may be obtained at www.calculturechange.org> our services>Person Centered Dining Pilot 2008.

The Sections posted include an Introduction & Overview, Culture Change Concepts or Practices implemented, Participant Practices and Summaries, Sample Policies and Forms, Resources, and Regulatory References. This author had the opportunity to provide guidance to the CCCC Dining Pilot participants and my own document entitled “Regulatory Compliance: Thinking Points” is posted on the site.

When you look at the Participant Practices and Summaries of what was accomplished and what was learned by each nursing home, you may be surprised. This author was a CCCC “liaison” for a very enthusiastic nursing home, Victoria Special Care, which is near my home in San Diego County. (I might point out that I had “surveyed” this nursing home several times with CDPH teams, and it was a pleasure to be in a more positive, supportive role during the Dining Pilot! Actually, they INVITED me and WANTED me to visit.)

I asked the monthly pilot questions and recorded their answers and hence, their journey. The original culture change “team” of decision makers at the nursing home was made up of leaders in nursing and dietary departments. All was established to implement the new concept, with a wonderful old fashion cart and “continental” late breakfast. Residents were to be allowed to have their “gentle awakening” with this late breakfast offering. In a nutshell, the first attempt was met with disaster and some very disgruntled CNAs (Certified Nurse Aides). Residents lined the halls, wanting to sample a “second” breakfast. I heard that the CNAs were upset because these “two” breakfasts had upset their whole schedule for showers, for rehab, and normal routines. The nursing home had to regroup. Who do you think was put on the next culture change “team”? You probably guessed. CNAs began to brainstormed, rearranged schedules, and came up with suggestions. They then took baby steps, with one floor and one day of the week being offered the late breakfast, and then expanded. They listened to what the residents wanted.

May I compliment the Administrator Ed Dove, Chef Ryan Krebs, and the rest of the IDT team at Victoria Special Care, for their persistence and dedication? Their summary (available on the website) states: “Be persistent, continue to implement in spite of barriers such as staff resistance, don’t let go of the intent to make change, and have better interdepartmental communication to get early buy in from all.” Here is what they recorded as accomplishments: “Improved quality of life and choices for residents (who could stay in bed if desired), family appreciation of new environment, residents are being more catered to with more snacking, and weights have stabilized by offering food throughout the day when resident are hungry.” Let’s also point out that these facilities who participated in the Dining Pilot are willing to discuss their experiences.

Comment from a CCCC committee member/leader: “What would I say about our Dining Pilot? It is the challenge of change. Many of our dining participants stayed in a ‘safety zone’ of practices such as a snack cart. This added choice to residents lives, but not control, as staff pushed it around and basically owned it. They offered it to residents, but it was not the residents’ choice. Why did so many facilities stay with such a safe choice? Part of it was fear of CDPH (deficiencies from state agency), but most of it, in my opinion, was fear of the teamwork and commitment that they would have to have with their own staff. A cart could be done with one or two staff people involved, and that was safer (not to mention easier) than taking on a practice that involved multiple depts. and multiple shifts. I think this is a huge hold up to culture change, this reluctance to declare a paradigm shift where staff silos are broken down, and communication, consistency, and commitment become the focus in a facility.”

There were questions about the responsibilities for infection control when nursing homes implement innovative culture change concepts. The CCCC question to CMS Region IX and CDPH was as follows:

QUESTION 3.

OBRA and state regulations require that food be stored, prepared and served in a manner that prevents contamination and the spread of food-borne illness. In supporting the practice of moving towards a 'home-like' environment, facilities plan to offer residents a chance to serve themselves food in a 'family – style' from communal bowls, or from a buffet or salad bar, and/or from a refrigerator where they will have free access to snacks. We recognize that it is the facility's responsibility to ensure that supervision is provided to protect that food from contamination, and/or to replace contaminated food before it is served. We also recognize that staff must ensure that food is not allowed to cool or warm to an unpalatable state during the meal or snack service. Additionally we know it is the facility's responsibility to ensure that the residents do not touch food that is available to other residents with their bare hands and so proper serving utensils, training, and/or individual packaging must be in place in these situations.

• What other actions would the facility is expected to take in this kind of situation in order to have met their regulatory responsibilities to provide safe and palatable food?

See the excellent guidance offered in the CMS Region IX and CDPH Q and A to California providers.

(Full document available at www.calculturechange.org >our services>Dining Pilot 2008> CMS Q and A for California)

It is interesting to note that collaborative meetings throughout the state are continuing the innovative “jump start” of the Dining Pilot, with sharing of experiences and support among a growing number of nursing homes who attend and participate.

V. SUMMARY OF RECOMMENDATIONS:

1. **Recommendation for CMS guidance for facility providers:** There is a need to guide facilities regarding the steps that need to be taken and documented when a resident's choice of self-determination would result in the facility being non-compliant with the regulation or surveyor guidance for the intent. Example: What should be included in the facility's policies and procedures? What should the Interdisciplinary Team (IDT) discuss with the resident (family, or decision makers), what are reasonable alternatives to be offered to the resident, what education should be provided to the resident on risk/benefit of non-compliance, what staff training should be provided for awareness of resident's decisions and their role in supporting the resident, what continual monitoring of the resident's outcomes should be provided (and reported back to the resident for review) when these informed choices for non-compliance, including with

physician orders, are made? This is particularly of concern when there is negative outcome.

2. **Recommendation for CMS guidance for state agency surveyors:** When the surveyor becomes aware that the facility is NOT compliant with what has traditionally been considered “good care” intended by the dietary/nutrition regulation because of a resident’s choice, there needs to be guidance for the surveyor to determine that there should NOT be a statement of deficient practice. When does the resident’s choice SUPERSEDE the requirements or intent of the regulations? How does the surveyor determine that the facility provided adequate efforts and documentation when there is a lack of compliance as a direct result of honoring the right of the resident choice of self-determination? CMS needs to clarify what they expect from the facility when the resident’s ‘informed choice’ is made.

3. **Recommendation for F 325 Nutritional Parameters:**

First, the regulation requirement is for: *“Receives a therapeutic diet when there is a nutritional problem.”* There is a need to evaluate supportive research that indicates there may NOT be a need for “therapeutic diet” when a “nutritional problem” with the elderly and the psycho/social ‘harm’ of demanding therapeutic dietary restrictions or loss of resident choice in this area. Consider changing this wording to ‘offer’ or language indicating a support of the resident’s therapeutic needs while not mandating a therapeutic diet.

Second, the new intent and surveyor interpretive guidance of the revision of 9/1/08 has some excellent wording, such as: *“Provides a therapeutic diet that takes into account the resident’s clinical condition, and **preferences**, when there is a nutritional indication.”*

If indeed, resident “preference” is a criterion for ordering a therapeutic diet, why are therapeutic diets still being ordered, regardless of a resident’s “preference” and desires? There is a need to further clarify this intent for both providers and surveyors. A person’s preferences are not problems. Additionally CMS has added to its new guidance at Tag 325 a focus on resident’s goals. Clarify that the facilities are to ask residents what their goals are and change the focus to the person and personal goals (also a preference) instead of the facility’s goals for the resident. That is institutional care and not individualized care.

Third, there is a need to clarify deficient practice when the IDT, physicians, and Medical Director have not established clear policies and procedures to address resident’s right of self-determination and choice for therapeutic diets and restrictions.

Fourth, there is a need to define ‘unavoidable’ decline in the nutritional parameters in the context of resident’s choice of self determination. There is a need to review and expand the severity examples of Immediate Jeopardy and harm.

4. **Recommendation for F 367 (a):** Deficiencies are being given under this tag, because it is a very “black and white” compliance tag. There is a need to clarify the facility’s responsibility to assure the resident “receives and consumes foods” as prescribed by the physician when the resident’s preference is NOT to follow the diet as ordered. There is a conflict here. The facility is required to honor resident preference per F325 and to honor resident’s choice per F242.
5. **Recommendation for F 367 (b):** With the CMS guidance (Memo to CCCC Q and A 2/9/08) that has stated, “***While the facility is required to follow the doctor’s orders for a resident’s diet, staff participants may need to clarify information to the doctor regarding the resident rights and the role of nutrition in maintaining the resident’s health and quality of life... A health professional’s expertise is utilized to incorporate favorite foods; however, there may be the rare instance when resident’s choices cannot be integrated.***” (bolded as in the document)
6. There needs to be clarification on any exceptions where the facility CANNOT honor the resident’s preference to not follow the physician’s therapeutic diet order. Would this be in direct conflict with CMS requirements to honor choice and the right to refuse treatment as in Tag F155?

Recommendation for F 241: There is a need to clarify when there is a “dignity” issue or not when seating residents at different times at the same table. Obviously, early diners will be dining as a late diner is seated and waiting. In the past, surveyors cited this as a dignity issue.

7. **Recommendations for F 363:** There is a need to consider changing this wording for a requirement to have this adequate or balanced menu plan as available or offer instead of “be followed.” This is causing confusion to providers and surveyors. A consideration to give guidance that a planned menu is “not intended to restrict resident choice” similar to the new guidance for F 371 regarding the facility’s responsibilities for providing safe food but does not restrict resident choice to consume visitor foods brought into their home. There is also a need to clarify the resident’s right to have “arbitrary scoop sizes” versus the planned menu or traditional “large and small” portion sizes.
8. **Recommendation for F 364 and F365 Accidents:** The need to clarify reasonable temperatures of hot beverages as facilities offer increased choice of self service and allow residents to safely enjoy very hot beverages to be served at their palatability preference as Tag 325 clearly recommends for resident preferences.
9. **Recommendation for F 365:** There needs to be clarification on reasonable expectations for the facility’s responsibility when a resident, who has been assessed at risk and has been identified to need a texture modification or thickened liquid diet order, does NOT want to follow the order or have a restriction.


10. **Recommendation for F 368:** While this was addressed in the CMS memo on Frequency of Meals (and evening snack), deficiencies have been cited and there needs to be further clarification of the facility's responsibilities when residents make choices. Do state agencies and CMS want residents to be woken up from sleep in order to receive snacks?
11. **Recommendation for F 371:** There is a need for further clarification on the facility's responsibilities for visitor food and in the following areas: Local produce brought into the facility, resident refrigerators, and staff eating with residents. Some providers have received conflicting direction from their state agencies which differs from what CMS guidance has been, especially with not allowing visitor foods that cannot be determined to be safe.
12. **Recommendations for F 441:** Many nursing homes have used hand sanitizer throughout their facility and in the dining rooms. With the new revision on infection control, there is a need to clarify the reasonable expectation for hand washing (with soap and water) for safety when a staff member is providing assistance to more than one resident at the same time. Is it just required when there is visible soiling or cross contamination, or is it required between assisting each resident no matter? This is a hard line for some surveyors but it needs to be clarified and clearly identified.
13. **Recommendation for increased communication and reduced barriers:** Consideration for each state agency and CMS Regional Office to have a point person to answer provider questions and clarification on compliance as culture change ideas not only in dining but in all areas.
14. **Recommendation for evidence based research** in this area, including a consideration for funding research on HOW allowing residents to make choices and have their preferences in dining impacts their well-being, quality of life, and increased nutritional status.

Finally, may we all enjoy our preferences in dining, and may our dining always, even if we become the elderly needing care giving, be according to our preferences.

Please note: The following is a Dining Survey from a Florida AHCA Culture Change Round Table, as referenced earlier.

Dining Survey Response Summary:

During May 2008 nursing homes in Florida were invited to respond to this survey in preparation for the June 17th AHCA Culture Change Round Table. The following table summarizes the responses. Fifty-three homes responded to the survey; not all homes answered every question as indicated by the fraction: number of respondents in a category/total number of respondents.

 <u>DINING PRACTICES</u>	We do it!	Would not do because of potential risks with regulations	Would not do because of labor and/ or costs	Would do if guidance was provided in order to comply with all regulations.
Steam table service in the dining room /or in “neighborhoods”	46% 24/52	14% 7/52	15% 8/52	25% 13/52
Family-style dining, restaurant or buffet dining in any location	47% 24/51	10% 5/51	20% 10/51	23% 12/51
Are there open dining times available (in addition to the scheduled, traditional times)	35% 18/52	8% 4/52	23% 12/52	35% 18/52
Wine or beer with meal	22% 10/45	24% 11/45	13% 6/45	40% 18/45
Small neighborhood kitchen meal prep & dining	24% 12/51	12% 6/51	39% 20/51	25% 13/51
Residents participate in menu planning or food preparation; or recipes	63% 32/51	6% 3/51	12% 6/51	20% 10/51
	24% 11/46	17%	20%	39%

Staff eat with residents		8/46	9/46	18/46
Outdoor barbecue meal	90% 47/52	2% 1/52	4% 2/52	4% 2/52
Food activities between meals in residents' living areas; e.g. baked cookies, popcorn, making ice cream sundaes	96% 50/52	0	2% 1/52	2% 1/52
Use domestic appliances for cooking or baking in living areas; e.g. toaster, coffee-maker, grill for eggs & pancakes	54% 28/52	17% 9/52	8% 3/52	21% 11/52