

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Dear Colleague:

I am pleased to send you a draft for comment of revised Guidance to Surveyors of Long Term Care Facilities for the current tag, F325 Nutritional Status.

This draft product was developed as part of our contract with the American Institutes for Research to update the Guidance to Surveyors (also known as the interpretive guidelines) and to provide specific information to assist surveyors in making appropriate determinations of severity for deficiencies cited under this Tag. It includes interpretive guidelines, an investigative protocol, and severity guidance for deficiencies cited. This draft was developed with the assistance of a panel of expert clinicians and surveyors.

Attachment A provides biographical information about the members of the Nutritional Status panel. Attachment B is intended to replace all current text contained in the Guidance to Surveyors for current Tags F325. We are providing a 45-day comment period for review of the draft materials contained in Attachment B.

We have included a reference sheet entitled “Tips for Reviewers” which contains tips for your review, as well as a copy of the current scope and severity grid that includes the letters for each grid box and the definitions of each severity level. This enclosure directly follows this letter. Be sure to review this information prior to reviewing the draft guidance.

Please provide comment on these materials to the contractor **by May 15, 2006**. You may reply via regular mail addressed to:

Nancy Matheson, Ph.D.
Project Director
American Institutes for Research
1000 Thomas Jefferson Street, NW
Washington, DC 20007

You may also reply via email to CMSComment@air.org. Please organize your comments by attachment and page number in order to compare your comment to the text to which you are referring. If you have any questions about this mailout, please contact Dr. Matheson at 202-403-5050.

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We look forward to your comments on this mailout as well as future mailouts of revisions to other Tags, as we proceed with this project to improve our guidance to surveyors.

Sincerely,

/s/

Thomas E. Hamilton
Director

Attachments

TIPS FOR REVIEWERS

This mail-out package includes the following materials for your review:

- Nutritional Status (Attachment B)
 - Guidance to Surveyors
 - Investigative Protocol
 - Task 6: Determination of Compliance
 - V. Deficiency Categorization (i.e., Severity Guidance).

Note: V. Deficiency Categorization is considered part of Appendix P, Part V of the same title, but it will be stored in Appendix PP of the State Operations Manual (SOM) along with its tag.

We have included the Scope and Severity Grid for your reference when reviewing the severity guidance for the Accidents and Supervision tags. This is included to assist your review and is not for comment.

Tips for Commenting

When providing comments to the materials included in this mail-out package, please follow the referencing guidelines below. This will aid in our ability to sort comments by section, paragraph, and sentence.

For each comment, please reference the following information, whenever possible:

- **Section within Document** (i.e., Guidance to Surveyors; Investigative Protocol; Task 6; Deficiency Categorization)
- **Page Number**

When relevant, please also reference sub-heading within section, paragraph, and/or sentence to which the comment applies.

Severity Grid for Rating Nursing Home Deficiencies

Severity	Immediate Jeopardy to Resident Health or Safety	J	K	L
	Actual Harm That Is Not Immediate Jeopardy	G	H	I
	No Actual Harm with Potential for More than Minimal Harm That Is Not Immediate Jeopardy	D	E	F
	No Actual Harm with Potential for Minimal Harm	A	B	C
		Isolated	Pattern	Widespread

Level 4: Immediate Jeopardy to resident health or safety. (J, K, L)

Noncompliance that results in immediate jeopardy, a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.

Level 3: Actual Harm that is not Immediate Jeopardy. (G, H, I)

Noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and psychosocial well-being.

Level 2: No Actual Harm with potential for more than minimal harm that is not Immediate Jeopardy. (D, E, F)

Noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential, (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being.

Level 1: No Actual Harm with the potential for minimal harm. (A, B, C)

A deficiency that has the potential for causing no more than a minor negative impact on the resident(s).

NOTE: The Severity and Scope Grid is included to assist your review and is not for comment.

ATTACHMENT A

REGULATORY TAG 325—NUTRITIONAL STATUS

EXPERT PANEL BIOGRAPHIES

- ***Captain Eloise Beechinor, RD, MPH***, has been a Federal Health Facility evaluator for the Centers for Medicare and Medicaid Services (CMS) since February 1985. Eloise has over 21 years surveying Nursing facilities, Immediate Care Facilities for the Mentally Retarded, and Hospitals. She is a retired U. S. Public Health Service Commissioned Officer with over 30 years of service. She has worked for CMS to assess the State Survey Agency's performance in the interpretation, application, and enforcement of the Federal Regulations and has conducted much training for surveyors and providers on the Survey Procedures, Interpretive Guidelines and Federal Regulations.
- ***Ronni Chernoff, PhD, RD, FADA***, currently serves as the Associate Director of the Geriatric Research Education and Clinical Center for Education and Evaluation at the Central Arkansas Veterans Healthcare System, as well as a Director at the Arkansas Geriatric Education Center. Dr. Chernoff is also a Professor of Geriatrics and a professor of Health Behavior and Health Education at the University of Arkansas for Medical Sciences. She has over 30 years experience in the field of nutrition.
- ***Ann Gallagher, RD, LD, CD, BS in Dietetics***, is a noted lecturer, author, and expert in the field of nutrition as it relates to long term care and has over 35 years experience in Geriatric Nutrition. Ms. Gallagher is President of Gallagher and Associates, a Nutrition and Food Management Company serving long term care facilities. She is a past-President of both the Indiana and American Dietetic Associations, has chaired the ADA Long Term Care Task Force, Health Care Reform Team, and served on the committee to develop the MDS and the Nutrition RAP. Ms. Gallagher is currently a member of the ADA Aging Task Force.
- ***Betty Leif, RD, CD***, currently serves as the Director of Nutrition and Dining Services at Sunrise Care Center, Inc. in Milwaukee, Wisconsin. In addition, she is a nutrition consultant to assisted living facilities and long term care, including St. John's on the Lake which was recently televised on PBS for the documentary, "Almost Home." Over the past year, Ms. Leif has been working with facilities to include person-centered dining services as part of the new culture change in long term care.

- **Emma Luten, RD, MS, LD**, is a former employee of the CMS and served as a captain of the U.S. Public Health Service. Ms. Luten was selected as Chief Professional Officer, Dietitian Category by two Surgeon Generals. She developed CMS' Guidance to Surveyors for nutrition and food-borne illness and led surveyor training in these areas. She participated in the President's Nursing Home Initiative to improve nursing home quality, developed the investigative protocols for unintended weight loss, hydration, and dining and food service, and was a principal advisor on the Investigative Protocol for pressure ulcers.
- **Connie Magnuson, MS**, currently serves as a Field Supervisor and Assistant Regional Supervisor with the Illinois Department of Public Health where she supervises dietitians who conduct surveys for the Division of Health Care Regulations, Bureau of Long Term Care. Ms. Magnuson is a member of the state faculty, training new surveyors in the Dietary aspects of the Long Term Care Survey process for the past 8 years. In addition, Ms. Magnuson has over 20 years of experience as a nutritionist with both the Illinois and Winnebago County Departments of Public Health.
- **Kathleen Niedert, MBA, RD, LD, FADA**, is presently a doctoral candidate in Health Care Administration and will graduate in December 2006. Ms. Niedert serves as the Director of Clinical Nutrition and Dining Services at Western Home Communities in addition to working as a nutrition consultant to health care providers, physicians, and private industry. Ms. Niedert has also been an adjunct professor at the University of Northern Iowa during her 30-year career in dietetics.
- **Patty Pasquarella, MS in Nutrition, RD**, is Chief Nutrition Consultant at the California Department for Health Services, Licensing and Certification. She has over 25 years of experience in various health care settings, including health care facilities, public health, private practice and clinical pediatrics.
- **George Taler, MD, CMD**, currently serves as Director of Long Term Care at the Washington Hospital Center and Medical Director at the Northwest Health Care Center, Washington, DC. Dr. Taler's research interests include geriatric medicine and health care delivery. He chaired the clinical practice guideline committee on "Altered Nutritional States" for the American Medical Directors Association, published Spring 2002.

ATTACHMENT B

F325 NUTRITIONAL STATUS GUIDANCE

INTENT: (F325) 483.25(i) Nutritional Status

The intent of this requirement is to ensure that the facility provided care and services to maintain acceptable parameters of nutritional status to the extent possible given the resident's clinical condition. Care and services include:

- Assessing the resident's nutritional status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status;
- Analyzing the assessment information to identify the medical conditions, causes and/or problems related to the resident's condition and needs;
- Defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice, or explaining adequately in the medical record why the facility could not or should not do so; and
- Monitoring and evaluating the resident's response or lack of response to the interventions; and revising or discontinuing the approaches as appropriate, or justifying the continuation of current approaches.

DEFINITIONS

Definitions are provided to clarify clinical terms related to nutritional status.

- "Acceptable Parameters of Nutritional Status" refers to factors that reflect adequate nutrition (e.g., weight, food/fluid intake, and pertinent laboratory values).
- "Anorexia" refers to loss of appetite, including loss of interest in seeking and consuming food.
- "Avoidable/Unavoidable Failure to Maintain Acceptable Parameters of Nutritional Status"
 - "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.
 - "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 nutrition 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.

- “Body Mass Index (BMI)” refers to estimates of total body mass. It provides important information about body composition, making it a useful indicator of nutritional status. To calculate BMI:
 - $BMI = \frac{\text{weight (lbs.)}}{\text{height (inches}^2)} \times 705$ or $BMI = \frac{\text{weight (Kg)}}{\text{height (M}^2)}$
- “Cachexia” refers to a state of loss of body fat, muscle atrophy, malnutrition, and poor health that may be caused by inflammatory mediators, chronic conditions (e.g., advanced cancer, advanced dementia), serious acute medical illness, and age.
- “Current standards of practice” refers to approaches to care, procedures, techniques, treatments, etc., that are validated and accepted, adopted or promulgated by recognized professional organizations, State licensing authorities, national accrediting bodies, current manuals or textbooks, or publications including current clinical guidelines of recognized organizations.
- “In-depth nutritional assessment” refers to an evaluation by the interdisciplinary team, including qualified dietetics professionals, of key components related to nutritional status and weight, including anthropometric, dietary, and biochemical information; oral health; functional ability; medications; specific clinical circumstances; and goals and prognosis.
- “Insidious weight loss” refers to a gradual, unintended, progressive weight loss over an extended time.
- “Sarcopenia” refers to the loss of muscle mass due to diverse causes including decreased physical activity, atherosclerosis, age-related decline in motor unit activity, and increased pro-inflammatory cytokines.
- “Usual body weight” refers to a stable weight over a period of at least 6 months (e.g., usual weight through adult life) and is the preferred standard for older adults.

OVERVIEW

To comply with F325, the facility provides care and services to maintain acceptable parameters of nutritional status for each resident or demonstrates why maintaining or improving nutritional status was not attainable. This includes identifying and assessing each resident’s nutritional risk factors; evaluating/analyzing the assessment information; implementing appropriate interventions; and monitoring the response to those

interventions and revising them as necessary. Providing clinical justification for each resident that fails to maintain acceptable parameters of nutritional status helps support why it was not attainable.

An in-depth nutritional assessment includes an evaluation of nutritional status, nutritional need, and factors that may influence nutrition and weight. Analyzing the information generated by the nutritional assessment allows the facility to try to identify the causes of the conditions or problems to develop an individualized nutrition care plan. Resident-specific interventions include thorough, consistent interventions by all appropriate staff. The outcomes of those interventions are monitored, and the care plan reevaluated and revised promptly, based on the resident's responses, outcomes, and needs.

Research has identified several key factors that influence body weight, including starvation, anorexia, sarcopenia, and cachexia.¹ While weight can be a useful indicator of nutritional status, only some of these influential factors are linked to nutrition. Wasting and extremely low body weight (cachexia) or loss of skeletal muscle mass (sarcopenia) may reflect a primary underlying cause other than malnutrition.

Once nutrients are consumed or infused and absorbed, utilization by organs and cells is determined by many factors including aging, illness, and inflammation. Inflammatory mediators are increasingly identified as causing diverse complications related to acute and chronic diseases, including much of the decline associated with later life.² Factors that affect nutritional needs may be present simultaneously in a given individual, making it challenging to identify the specific cause of weight loss.

Nutritional deficits and imbalances often take time to correct, or they may not be fully correctable, especially when they are longstanding or due to a serious acute or chronic illness. It is appropriate for the facility to take a step-wise approach to address impaired nutrition and to adjust the approach based on results.

Resources are available that recommend interventions to improve nutritional status, assess nutritional risk, and prevent malnutrition.³ Website resources include www.amda.com and www.eatright.org.

NOTE: References to non-CMS sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

IN-DEPTH NUTRITIONAL ASSESSMENT

Although the RAI is the only required assessment tool, a more in-depth nutritional evaluation may be necessary to help the interdisciplinary team determine the causative factors and plan individualized care. Some factors that existed prior to admission, such

as poor intake and weight loss, CVA, or recent surgery may have increased the resident's subsequent nutritional risk. The 2005 Scope of Dietetics Practice Framework published by the American Dietetics Association states, "Nutrition assessment is a systematic process of obtaining, verifying and interpreting data in order to make decisions about the nature and cause of nutrition-related problems."⁴

An in-depth nutritional assessment by the interdisciplinary team helps identify the nature and causes of impaired nutrition and nutrition-related risks. It also permits subsequent interventions to be consistent with the resident's goals, wishes, and prognosis (e.g., resident with multi-systems failure or an end-of-life condition). This assessment includes evaluation of general physical appearance and condition, anthropometrics, and dietary, clinical (e.g., oral health, functional ability, and medications), and lab/diagnostic factors.

The in-depth nutritional assessment includes information from any discipline that has a role in:

- Identifying current physical condition and functional, psychosocial, and nutritional status; resident goals, objectives, and wishes; and environmental and social factors associated with eating and food intake;
- Analyzing information obtained as part of the nutritional evaluation and drawing conclusions about the nature, category, causes, management, and prognosis of weight loss, impaired nutrition, or nutrition-related risks;
- Identifying and implementing general and cause-specific interventions; and
- Monitoring progress towards nutrition-related goals or identifying why the goals have not or cannot be attained.

Qualified dietetics professionals, as part of the interdisciplinary team, help identify risk factors and causes of impaired nutrition and nutritional risk, and evaluate and recommend medical nutrition therapy and options for nutrition interventions, based on each resident's medical condition, needs, desires, and goals. In addition to dietitians, other disciplines (including nurses and physicians) are involved in the assessment process to help identify causes of anorexia and weight change and to clarify a resident's nutritional issues and needs in the context of his/her overall condition.

NOTE: A resident's designation as "high risk" does not necessarily indicate that failure to maintain acceptable parameters of nutritional status is unavoidable and does not release the facility from the responsibilities outlined under the Intent.

General Appearance

General appearance includes a broad description of the resident in relation to nutritional status (e.g., robust, thin, obese, or cachectic) and other findings that may affect aspects of

nutrition (e.g., level of consciousness, responsiveness, and affect). An example of a standardized approach to identifying malnutrition is the Subjective Global Assessment, which systematically looks at muscle and fat mass, hydration status and pertinent recent history or weight loss and poor appetite.⁵

Anthropometric Evaluation

The anthropometric evaluation includes height, weight, and the calculation of body mass index (BMI).

Height. A protocol for measuring or estimating the height of each resident on admission, including those who are unable to stand, helps ensure that height will be measured accurately. The literature describes various ways of estimating height if standing height cannot be measured.

Weight. Weight can be a useful indicator of nutritional status. Significant or severe changes in weight, or a continuing weight loss trend, may indicate a nutritional problem. Weight loss of 5% in one month, 7.5% in three months, or 10% in six months is significant. Weight loss exceeding these levels is considered severe.

Nutrition management begins with weighing the resident at admission. Reweighing within 48 hours is a good verification practice. Thereafter, weighing occurs at least monthly on a regular schedule and is documented in the medical record. Persistent unintended changes in weight (insidious weight loss) are identified and documented. A resident is also weighed if there is a persistent condition change, food intake has declined and persisted (e.g., for more than a week), or signs and symptoms of altered nutritional status appear. If weight monitoring is not indicated (e.g., because the individual is terminally ill or has declined to be weighed), the reason is documented in the resident's care plan and alternative strategies for assessing nutritional status are identified (e.g., monitoring food and fluid intake).

Accurate weights for each resident (including those who are bed or chair-bound) depend on using the facility's protocol, and an appropriately calibrated scale (e.g., wheel chair scale or bed scale). Since weight varies throughout the day, a consistent process and technique (e.g., weighing the resident at approximately the same part of the day, using the same scale, and verifying scale accuracy) can help increase the reliability of weights.

A system for verifying weights will help provide accurate information. Sometimes, apparent weight change is due to procedural variations and is not confirmed on reweighing. There may be significant differences between weights obtained in different settings. For example, the last weight obtained in the hospital may be very different from the initial weight upon admission to the facility, and is not to be used in lieu of actually weighing the resident. If weight changes are believed to be invalid, documentation can help to show how the facility monitored and tried to standardize the weighing process, and why an apparent weight change was not considered valid.

Reweighting a resident within a week of initiating or substantially revising nutritional interventions to address anorexia or weight loss helps monitor responses to these interventions. This is done at least until weight is stable or increasing (or there is documentation in the medical record that the facility has determined that the weight cannot be stabilized or increased), and then routinely thereafter.

Body Mass Index (BMI). Body mass index is a useful indicator of nutritional status. A BMI of less than 21 is associated with increased mortality.⁶ A BMI under 19 is considered to indicate severe underweight and a high likelihood of undernutrition, or may indicate sarcopenia or cachexia due to other causes.⁷ Using a BMI of less than 21 to help identify a resident at nutritional risk may result in earlier intervention and prevent the BMI from declining further.

Dietary Evaluation

The dietary component of the nutritional assessment estimates calories, nutrient, and fluid needs, and whether intake is adequate to meet those needs. The documented evaluation includes the route of intake (oral, enteral or parenteral feeding); any special formulation; food allergies, intolerances, dislikes, and preferences (including ethnic foods); meal/snack patterns; and preferred portion sizes. The facility's policies and procedures specify which members of the health care team are responsible for documenting food and fluid intake; how food and fluid intake is determined; and how it is monitored over time.

Impaired Nutritional Intake and Utilization. Commonly, multiple causes of weight loss or impaired nutrition coexist in the same individual. Evaluation includes situations or symptoms related to appetite, food intake, digestion, excretion, and conditions associated with weight loss. These may include: significant change in mood, behavior, or level of consciousness affecting food intake; presence of physical/medical factors contributing to recent or current weight loss or risk of subsequent weight loss (e.g., cancer, medications, diuretics, or recent changes in edema); level of activity; and environmental factors affecting food intake or appetite. Anorexia may indicate a significant problem and be related to an underlying medical condition, regardless of whether weight loss is present. Whether or not the individual is nutritionally impaired at present, early identification of factors known to increase the risk of anorexia and weight loss can help the facility develop effective interventions.⁸

In order to develop effective interventions, the facility determines if inadequate intake is due to the resident not wanting to eat/drink (e.g., anorexia); not being able to consume what is provided (e.g., due to form or consistency of food/fluid, functional decline, or lack of assistance); or insufficient availability of food and fluid (e.g., inadequate portion sizes or inadequate tube feedings).

Additional Clinical Evaluation

Symptom Management. The clinical evaluation includes assessment of symptoms that may affect appetite. Inadequately treated pain from arthritis, wounds, fractures, or

neuropathy is a common cause of anorexia. Breathlessness from advanced or uncontrolled heart or lung disease makes eating and breathing difficult.

Conditions Affecting Oral Function. The condition of the mouth, teeth, and gums will affect the resident's ability to chew and swallow foods. For example, chronic oral conditions such as dry or sore mouth, oropharyngeal infection (e.g., candidiasis/thrush), gingivitis, periodontal disease, ill-fitting dentures, and broken, decayed or missing teeth can reduce a resident's oral intake.

Other conditions affecting oral intake include swallowing and chewing dysfunction such as dysphagia. Some of these situations constitute clinically significant swallowing risks that require dietary restrictions or modification. Swallowing is a dynamic event that may vary from day to day. Therefore, results from a single swallowing study may not accurately reflect average daily oral function.⁹ When conditions affecting eating, chewing, and swallowing are identified, necessary referrals may help optimize the resident's comfort and enjoyment of meals.

Functional Ability. The resident's ability to eat and drink may be affected by factors including upper extremity motor coordination and strength, range of motion, cognition, level of consciousness (e.g., lethargy), and sensory limitations (e.g., blindness). The facility can optimize the resident's ability to feed him/herself by addressing factors that impair functional ability or by providing the appropriate food texture and necessary assistance, supervision and dining environment.

Medications. Medications and nutritional supplements (prescribed and over-the-counter) may affect, or be affected by, eating or the intake or utilization of nutrients (e.g., Warfarin/Vitamin K, liquid Dilantin/tube feedings, etc.). Medications from almost every drug category may affect nutritional status by causing or exacerbating lethargy, confusion, nausea, constipation, or anorexia. Information about how specific drug/nutrient interactions or side effects may adversely affect an individual resident's nutritional status are more meaningful than just listing precautions that apply to the general population in the in-depth nutritional assessment.

(For additional Guidance related to medications, refer to 42 CFR 483.25(l)(1), F329, Unnecessary Drugs.)

Hypermetabolic States. A hypermetabolic state results from an increased demand for energy and protein and may increase the risk of weight loss/undernutrition. Examples include pressure ulcers and other chronic wounds, advanced COPD, pneumonia and other infections, cancer, hepatic disease, and fever. Residents with repetitive movement disorders can expend considerable energy (e.g. a resident who wanders, paces, or simply rocks in his/her chair all day). In these situations, additional calories may be indicated to try to stabilize weight, unless there is documentation why the underlying disorder precluded weight stabilization.

Conditions That May Affect Digestion or Gastrointestinal Function. Various

gastrointestinal disorders such as pancreatitis, gastritis, and liver dysfunction may affect digestion or absorption of food. Prolonged diarrhea or vomiting may increase nutritional requirements due to nutrient and fluid losses. Without effective interventions, dehydration or fluid/electrolyte imbalance could result. Constipation or fecal impaction may affect appetite and excretion. These conditions may also be related to the same conditions or situations that are simultaneously causing anorexia (e.g., adverse drug reactions).

Neuromuscular Disorders. Neuromuscular disorders may affect a resident's ability to feed him/herself or swallow. Examples include CVA with hemiparesis or other complications, Parkinson's disease, multiple sclerosis, cerebral palsy, tardive dyskinesia, and myasthenia gravis.

End of Life. Not maintaining acceptable parameters of nutritional status may be an expected outcome, and may constitute compliance with the requirement if:

- The resident is at the end of life and either has an advance directive according to State law, or a decision has been made by the resident's surrogate or representative in accordance with State law; or the resident has reached an end of life stage and is consuming minimal amounts of nutrients or intake has ceased; and
- Appropriate efforts, based on an in-depth nutritional assessment and resident wishes have been made to encourage and provide intake, and all of this information is clearly documented in the resident's medical record.

Goals and Prognosis. Goals and prognosis refer to the projected personal and clinical outcomes for a resident. These are influenced by the anticipated course of a resident's overall condition, the natural history of specific diagnoses (e.g., end-stage, terminal, or other irreversible conditions affecting a resident's food intake, nutritional status, and weight goals), and by the resident's willingness to permit additional diagnostic testing, monitoring and treatment. The facility is expected to explain in the medical record when potential interventions are not considered to be consistent with the resident's goals and prognosis.

NOTE: There should be a documented clinical basis for any conclusion that nutritional status or weight are unlikely to stabilize or improve.

Lab / Diagnostic Evaluation

Laboratory tests may indicate the body's balance or utilization of the nutrients consumed (e.g., cholesterol, hemoglobin, lymphocytes, and albumin), and diagnostic tests may help identify and categorize risks and causes of impaired nutrition. Frequently, nutritional status is clear (from either clinical observation or if the resident is already eating adequate amounts of calories, protein and other nutrients). In these situations, additional lab tests and other measurements may not add clinically meaningful information.

The decision to order lab or diagnostic tests, and the interpretation of subsequent results, is best done in light of a resident's condition and prognosis.¹⁰ Before ordering lab and diagnostic tests, it is appropriate for the interdisciplinary team and the physician to discuss whether the tests would potentially change the resident's diagnosis, management, outcome or quality of life or otherwise add materially to what is already known.

Abnormal lab values do not necessarily imply that treatable clinical problems exist or that intervention is needed unless confirmed by additional clinical observation or evidence such as food intake, a resident's overall condition, etc.¹¹ For example, serum albumin may help establish prognosis but is only sometimes helpful in identifying impaired nutrition or guiding interventions. Because serum albumin may drop significantly during an acute illness due to non-nutritional causes (e.g., inflammatory mediators and protein leakage out of the circulation), albumin may not improve, or may fall further, despite consumption of adequate amounts of calories and protein.

NOTE: If lab tests were done prior to or after admission to the facility and the test results are abnormal, the physician and interdisciplinary team reviews the information and documents the decision to intervene or not intervene and the rationale for that decision.

ANALYSIS

Analysis refers to using the information from the in-depth nutritional assessment, Minimum Data Set (MDS), and/or review of the Resident Assessment Protocols (RAPs) to develop an individualized care plan.

The analysis can yield conclusions including (but not limited to): 1) approximate calorie and protein needs, based on actual or usual body weight; 2) whether any other clinically significant nutritional deficits exist; 3) a target range for weight, based on the individual's overall condition, goals, prognosis, etc.; 4) whether weight stabilization or improvement can be anticipated; 5) whether altered nutritional status could be secondary to an underlying medical condition (e.g., possible fluid and electrolyte imbalance, medication-related anorexia, or an infection).

Specification of the Nutritional Problem

A clear statement of the nature of the nutritional concern provides the basis for resident-specific interventions.¹² In many residents, multiple categories of issues coexist. For example:

- Food and fluid intake: Resident has poor oral intake, is not consuming specific food groups, and has increased nutritional needs due to specific clinical conditions, weight loss has been rapid over a few days, and review has identified that resident is taking medications that may affect appetite or cause lethargy.

NOTE: Fluid loss or imbalance can cause rapidly progressive or short-term weight loss or gain. Management of fluid-related problems may need the involvement of a health care practitioner. (For additional Guidance on fluid loss, refer to CFR 483.25(j), F327, Hydration.)

- Specific clinical conditions: Resident is in a hypermetabolic state associated with an increased demand for energy and protein. The resident also has a neuromuscular disorder affecting the ability to eat or swallow, and has an altered level of cognition or consciousness that impairs attention and enjoyment of food.

CARE PLANNING

The management of nutritional status in nursing homes involves medical, ethical, and functional considerations and typically requires an interdisciplinary team approach to identify residents with, or at risk for, impaired nutrition and to address related risks and causes. Failure to maintain acceptable parameters of nutritional status may be associated with negative outcomes, which include: undesired weight change; inadequate food and fluid intake; impaired wound healing; decline in performance of activities of daily living; and fluid and electrolyte imbalance (e.g., intravascular volume depletion, high or low sodium, or profound loss of total body water [i.e., dehydration]).

A care plan developed by the health care team (including a physician and the resident or the resident's surrogate decision maker) with pertinent approaches for correcting problems and minimizing risks of future complications, facilitates adequate nutritional support. Based on information generated by the in-depth nutritional assessment, the individualized care plan addresses the identified causes of impaired nutritional status and reflects the resident's goals and choices. It should include resident-specific interventions and a time frame for monitoring. The care plan should be:

- Individualized and consistently implemented;
- Developed in the context of the resident's overall condition and prognosis and related causes and risks;
- Updated in a timely fashion as conditions change or interventions are determined to be ineffective; and
- Modified as needed (i.e., if nutritional parameters are still not optimal, then another or additional pertinent approach should be considered or it should be documented as to why the current approach is continued) and as specific treatable causes of nutrition-related problems (anorexia, impaired chewing, etc.) are identified.

Facility documentation helps the survey team identify how the facility established goals for nutrition interventions based on information that is relevant to that individual (e.g., condition, prognosis, causes, co-morbid conditions, etc.).

Resident Choice

Discussion of the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment with the resident (or the resident's legal representative) facilitates informed choices about care and treatment and supports the right to refuse treatment.¹³ (See Resident's Rights 483.10(b)(3) and (4) (F154 and F155).

Meeting Nutritional Needs

A resident's basic energy and nutrient needs can generally be met by providing a diet that includes sufficient calories to try to stabilize body weight or attain a BMI in the acceptable range. Adjustments may be necessary according to clinical needs, including other comorbid conditions and risks. For example, limits on protein intake may be desirable in liver or kidney failure. If the facility provides less than basic amounts of calories and nutrients, the medical record documentation explains why providing more was not possible or desirable. In hypermetabolic states (e.g., fever, hyperthyroidism, end-stage heart or lung disease, or pressure ulcers) additional amounts of nutrients and calories may be indicated, so that the body will not use lean body mass for energy and wound repair.

The scope of interventions to meet residents' nutritional needs depends on many factors, including a resident's food intake, degree of nutritional impairment or risk, response to initial interventions, and feasibility of addressing related conditions and causes. It may be appropriate to liberalize the diet or give the resident more of what he/she likes to eat before using supplementation.

Diet Liberalization

Research indicates that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by a liberalized diet. Reviewing existing diets is a way to minimize unnecessary restrictions to the extent possible. Pertinent documentation can provide a clear medical justification for not doing so (i.e., why the benefits of the restriction justify any nutritional risks). There is a broad consensus that dietary restrictions, "therapeutic" diets (low fat, markedly sodium restricted, modified texture, etc.), are only sometimes helpful and may inhibit adequate nutrition, especially in undernourished or at risk individuals.¹⁴

Generally, weight stabilization and adequate nutrition are promoted by serving residents a regular or minimally restricted meal plan (diet) with appropriate texture modifications. When a resident is not eating well or is losing weight, the problems for which dietary restrictions were originally instituted may be of secondary importance in the short term to the more urgent issue of stabilizing weight and improving appetite.

Weight-Related Interventions

For all residents (including overweight individuals), the resident's usual body weight prior to decline or admission is the most relevant basis for weight-related interventions. Using ideal body weight as the basis is usually not appropriate, because ideal body weight has not been definitively established for the frail elderly and those with chronic illnesses and disabilities.

Many risk factors and some causes of weight loss can be addressed, at least partially, while others may not be modifiable. A plan for nutritional interventions addresses underlying risks and causes for weight loss (e.g., the need for eating assistance, reduction of medication side effects, and additional portions of food that the resident will eat) or unplanned weight gain.

Weight stability is a key objective in maintaining nutritional status in the underweight or nutritionally at-risk elderly and chronically ill individual. After an acute illness or as part of an advanced or end-stage medical condition, weight and other nutritional parameters may not return to their previous levels, and may stabilize at a lower level.

Weight Gain. Unplanned weight gain in a resident with an elevated BMI (over 27) that has significant health implications may be a negative outcome. Rapid or abrupt increases in weight may also identify significant fluid and electrolyte imbalance. After assessing the resident for the cause of the weight gain (e.g., conditions related to fluid retention), care plan interventions may include dietary alterations according to the resident's medical condition, desires, rights, and accommodation of his/her needs. If the resident declines dietary restrictions, documentation reflects the resident's choices; the facility's attempts to educate the resident about the benefits of maintaining a healthy weight and consequences of his/her refusal; and the facility's additional efforts to try to get the resident to accept the recommended plan of care.

Weight Loss. Significant weight loss (i.e., 5% in one month, 7.5% in three months, and/or 10% in six months), as well as unplanned weight loss that occurs over time that does not meet the guidelines for significant weight loss and does not trigger review of the Nutritional Status Resident Assessment Protocol (RAP), should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss, unless the facility determined that the cause is known or the search for the cause has been exhausted or should be limited. Documentation reflects the reason why the search for the cause(s) was limited or discontinued. Once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed.

Environmental and Functional Factors

Ability to taste food declines with age, and appetite is often enhanced by the appealing aroma, flavor, and appearance of food. Facility practices that may help improve intake and provide a pleasant dining experience include 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. (See Dining and Food Service Investigative Protocol). Resident-specific interventions to ensure eyeglasses, dentures, and/or hearing aids are in place, provide personal hygiene prior to meals, properly position residents, provide assistive devices/utensils identified in the care plan (and seeing that they are used as planned) help to improve intake and should be included in the care plan as appropriate.

Anorexia

The facility, in consultation with the practitioner, identifies and addresses treatable causes of anorexia, or documents a clinically pertinent rationale for not doing so. For example, it is often beneficial to adjust or stop medications that may directly cause anorexia or indirectly lead to it by causing lethargy or confusion, and then to reevaluate whether appetite and weight have stabilized or improved.

Where depression has been identified as a cause of anorexia and/or weight loss, treatment of the underlying depression (based on an appropriate diagnostic evaluation) may improve appetite. Use of antidepressants does not substitute for appropriate investigation and management of other underlying causes and modifiable risk factors.

Impaired Wound Healing

Healing of wounds, such as pressure ulcers, other chronic wounds, and post-surgery wounds, utilizes calories and protein. Adequate calories must be consumed so that the body will not use lean body mass (muscle) for energy and wound repair.

Because there are no wound-specific nutritional measures, nutritional interventions would include those appropriate to any hypermetabolic state.¹⁵ Care plan interventions for a resident who is not consuming enough to maintain a stable weight and has a wound, or is at risk of developing a pressure ulcer, may include providing adequate calories to maintain weight and support healing, and a daily protein intake of approximately 1.2-1.5 gm protein/Kg body weight (adjusted according to clinical need and standards of clinical practice).¹⁶ Pertinent documentation can explain the facility's determination that providing additional calories and protein was not clinically indicated or not possible.

Additional strategies for wound healing may be considered when indicated, such as short-term specific nutrient supplementation. A simple multivitamin/mineral supplement is appropriate, but current evidence does not definitively support any specific supplementation unless the resident has a specific vitamin or mineral deficiency.

(For additional guidance related to undernutrition and hydration deficits in individuals with pressure ulcers or at risk of pressure ulcers, refer to Guidance at 42 CFR 483.25(c), F314, Pressure Ulcers.)

Impaired Function

A decline in ADLs may result in an increased dependence on staff for assistance. Poor intake and/or weight loss may be related to such a decline, the potential for decline, or lack of functional improvement.

A resident with functional impairment may require assistance with eating. Based on the comprehensive interdisciplinary assessment, the facility determines and provides the level of assistance needed for adequate intake and to maintain or improve the resident's abilities. Availability of sufficient staff to assist/feed residents in a timely manner (while food is palatable) is necessary to accommodate residents who require assistance.

Chewing and Swallowing

Addressing oral and dental problems that affect eating can often help improve food intake. In some individuals with impaired swallowing, various interventions may help improve safety and reduce the risk of aspiration. For example, care plan interventions may include providing proper positioning for eating; participation in a restorative feeding program; use of assistive devices/utensils identified in the care plan; and prompt assistance as specified in the care plan (e.g., supervision, cueing, hand-over-hand, etc.) during every meal/snack where assistance is needed.

However, many factors interact to determine whether a swallowing abnormality may eventually result in clinically significant complications. A swallowing abnormality alone does not always warrant dietary restrictions. Unless other risk factors are present, aspiration pneumonia will not necessarily result from aspiration and dysphagia.¹⁷

Difficulty swallowing is a symptom with diverse causes and it is essential to look at the whole picture of the resident. Health care practitioners help identify the medical causes of eating and swallowing problems and the relative risks and benefits of modifying food consistency. For example, it may be appropriate to address medical conditions and reconsider medications that may impair swallowing or cause coughing, either directly or indirectly by causing lethargy, confusion, dry mouth, etc.

Although significant alterations of food texture may help some individuals, they may increase the risk of impaired nutrition in other residents, and may adversely affect quality of life.¹⁸ There are no documented consistently effective ways to prevent aspiration or to predict who will aspirate and develop aspiration pneumonia.¹⁹ Before restrictions on oral intake and diet texture are imposed, it is appropriate to address treatable underlying causes of apparent chewing or swallowing problems (oral or dental problems, gastroesophageal reflux disease, medication side effects, etc.). A decision to impose substantial eating restrictions (e.g., marked downgrading of diet texture or no oral intake) should consider all relevant issues and include the resident (or legal representative) in deciding whether to accept the risk in light of the benefits of less restricted eating.²⁰

Medications

It may be appropriate to change, stop, or reduce the doses of medications that are

associated either with anorexia or are causing symptoms such as lethargy or confusion that can lead to or exacerbate weight loss. When a resident is eating poorly or losing weight, some medical problems for which medications have been utilized may be of secondary importance in the short-term compared to the immediate need to stabilize weight and improve appetite.

(For additional Guidance related to medications, refer to 42 CFR 483.25(l)(1), F329, Unnecessary Drugs.)

Food Fortification and Supplementation

Examples of care plan interventions to improve food/fluid intake include fortification of foods (e.g., adding protein, fat, and/or carbohydrate to foods such as hot cereal, mashed potatoes, casseroles, desserts, etc.); offering smaller, more frequent meals (feedings); providing between-meal snacks/nourishments; increasing the portion sizes of a resident's favorite foods and meals; and providing liquid nutritional supplements.

With any nutrition program, improving food intake via wholesome foods is generally preferable to adding liquid supplements. If the resident is not able to eat more at meal time, consume between-meal snacks/nourishments or prefers the supplement, liquid supplements may help increase a resident's calorie and nutrient intake. Research has shown that caloric intake may increase if the supplement is consumed between meals, but may be ineffective when given with the meal. If a liquid supplement is used, it is recommended that it be given between meals and not with meals.²¹ Small portions of a high-calorie supplement served during medication administration ("med pass") can increase caloric intake without necessarily reducing a resident's appetite at mealtime.

Documentation of the resident's consumption of between-meal snacks/nourishments and liquid supplements may help the facility to monitor intake and evaluate the effectiveness of the intervention.

Maintaining Fluid and Electrolyte Balance

Clinically significant fluid/electrolyte imbalance (including dehydration) affects weight (often seen as rapid or abrupt changes) and level of consciousness, and may compromise food intake. Because much of a resident's fluid intake is provided as fluids with meals, decreased food/fluid intake can result in fluid/electrolyte imbalance. If a resident has poor intake, the care plan should also address the potential for fluid/electrolyte imbalance.²² Laboratory tests (e.g., electrolytes, BUN, creatinine, and serum osmolality) can help in the management and monitoring of fluid and electrolyte problems. Documentation in the medical record explains the basis for decisions to address abnormal lab values that indicate a potential fluid/electrolyte imbalance.

Potential care plan interventions include adjusting or stopping medications that affect fluid loss or appetite; offering a variety of fluids (cold water, fruit punch, lemonade, decaffeinated iced tea, etc.) between meals and encouraging/assisting residents to drink

them; serving each resident (except those with fluid restrictions) water with meals, in addition to the beverages on the planned menu; and keeping pitchers filled with water/ice water and a drinking glass/cup easily accessible to residents during waking hours (except those with fluid restrictions). Also see interventions related to poor food/fluid intake, F327, and the Hydration Investigative Protocol.

Use of Appetite Stimulants

Medications that are identified in the category of “appetite stimulants” are appropriate in limited circumstances. Research suggests that some of these medications may counteract the effects of factors that suppress appetite. In general, these medications should not substitute for appropriate investigation and management of underlying causes and modifiable risk factors.²³

Advanced Illness and End of Life Situations

A resident at the end of life, in the terminal stages of illness, or with multi-systems failure may have written directions for his or her treatment goals (or the resident’s surrogate or representative, in accordance with State law, has made a decision).

If the facility has implemented individualized approaches for end of life care in accordance with the resident’s wishes and has implemented appropriate efforts to try to stabilize the resident’s condition (or indicated why the condition cannot or should not be stabilized), then the failure to maintain acceptable parameters of nutritional status may be consistent with regulatory requirements.

Weight loss and altered hydration at the end of life are common and do not necessarily require interventions other than for comfort. Resident choices and clinical indications affect decisions about use of a feeding tube at the end of life. Weighing the benefits and risks of enteral feeding for residents at the end of life is important because the mortality rate after feeding tube placement is high.²⁴ Feeding tube use for cognitively-impaired residents with advanced dementia requires careful evaluation. For residents with severe dementia, studies have shown that tube feeding does not extend life, prevent aspiration pneumonia, improve function or limit suffering.²⁵

(For additional Guidance related to nutrition for individuals at the end of life, refer to 42 CFR 483.25, F309, Quality of Care.)

MONITORING

Subsequent monitoring is necessary for residents with impaired or at-risk nutritional status as well as for those who are nutritionally stable. Monitoring of nutritionally stable residents includes monthly weights, assessment of mental and functional status, and the quarterly MDS assessment.

Monitoring food and fluid intake and eating ability may help identify causes of weight

loss or gain and potential interventions to improve intake. The nursing assistant is often the staff member most familiar with the resident's symptoms such as pain/discomfort, decline in appetite, and nausea, and is knowledgeable about his/her habits and preferences.

Monitoring of residents who have impaired or at-risk nutritional status includes but is not limited to monthly weights (at a minimum), evaluation of mental and functional status, evaluation of possible new risk factors (e.g., skin ulceration or fever), the quarterly MDS, and review of the continued relevance of any current nutritional interventions (e.g., diet/tube feeding order, nutritional supplements, etc.).

Monitoring of residents who experience unplanned weight loss including reweighing at least weekly until weight is stable or increasing, and then routinely thereafter, can facilitate understanding of their responses to interventions. When weight monitoring is not indicated (e.g., resident has a terminal condition), documentation in the medical record reflects the basis for that decision.

Evaluating the care plan to determine if current interventions are being followed and if they are effective in attaining identified nutritional and weight goals allows the facility to make necessary revisions. Subsequent adjustment of interventions will depend on progress, underlying causes, overall condition, prognosis, etc. The current plan of care may need to be modified and new or additional interventions implemented. The nutrition-related goals themselves may need to be reevaluated (e.g., when evidence suggests that conditions and circumstances cannot be modified and may prevent improved or stabilized nutritional status).

ENDNOTES

- ¹ Bouras, E.P., Lange, S.M., & Scolapio, J.S. (2001). Rational approach to patients with unintentional weight loss. *Mayo Clinic Proceedings*, 76, 923-929.
- ² VanItallie, T.B. (2003). Frailty in the elderly: Contributions of sarcopenia and visceral protein depletion. *Metabolism*, 52(10), Supplement 2 (October), 22-26.
- ³ American Medical Directors Association. (2001). Altered Nutritional Status Clinical Practice Guideline. Columbia, Maryland.
- ⁴ The American Dietetic Association. (2005). Scope of Dietetics Practice Framework. Standards of Practice in Nutrition Care for the Registered Dietitian (RD), Standard 1: Nutrition Assessment. Retrieved February 6, 2006 from http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/career_7225_ENU_HTML.htm
- ⁵ Detsky, A.S., Smalley, P.S., & Chang, J. (1994). The rational clinical examination. Is this patient malnourished? *Journal of the American Medical Association*, 271(1), 54-58.
- ⁶ Thomas, D.R., Ashmen, W., Morley, J.E., Evans, W.J., & the Council for Nutritional Strategies in Long-Term Care. (2000). Nutritional management in long-term care: Development of a clinical guideline. *Journal of Gerontology: Medical Sciences*, 55A(12), M725-M734.
- ⁷ American Medical Directors Association. (2001). Altered Nutritional Status Clinical Practice Guideline.
- ⁸ Wilson, M.G., Thomas, D.R., Rubenstein, L.Z., Chibnall, J.T., Anderson, S., Baxi, A., Diebold, M., & Morley, J.E. (2005). Appetite assessment: Simple appetite questionnaire predicts weight loss in community-dwelling adults and nursing home residents. *American Journal of Clinical Nutrition*, 82, 1074-81.
- ⁹ Chouinard, J. (2000). Dysphagia in Alzheimer disease: A review. *Journal of Nutrition, Health and Aging*, 4(4), 214-217.
- ¹⁰ Covinsky, K.E., Covinsky, M.H., Palmer, R.M., & Sehgal, A.R. (2002). Serum albumin concentration and clinical assessments of nutritional status in hospitalized older people: Different sides of different coins? *Journal of the American Geriatrics Society*, 50, 631- 637
- ¹¹ Sullivan, D.H. (2001). What do the serum proteins tell us about our elderly patients? *Journal of Gerontology: Medical Sciences*, 56A(2), M71-M74.
- ¹² Thomas D.R., Tariq, S.H., Makhdomm S., Haddad R., & Moihuddin A. (2003). Physician misdiagnosis of dehydration in older adults. *Journal of the American Medical*

Directors Association, 4, 251–254.

¹³ Ouslander, J.G., Tymchuk, A.J., & Krynski, M.D. (1993). Decisions about enteral tube feeding among the elderly. *Journal of the American Geriatric Society*, 41, 70-77.

¹⁴ American Dietetic Association. (2005). Position of the American Dietetic Association: Liberalization of the diet prescription improves quality of life for older adults in long-term care. *Journal of the American Dietetic Association*, 105, 1955-1965.

¹⁵ Mathus-Vliegen, E. (2004). Old age, malnutrition, and pressure sores: An ill-fated alliance. *Journal of Gastroenterology: Medical Sciences*, 59A(4), 355-360.

¹⁶ Bergstrom, N., Horn, S.D., Smout, R.J., Bender, S.A., Ferguson, M.L., Taler, G., Sauer, A.C., Sharkey, S.S., & Voss, A.C. (2005). The national pressure ulcer long-term care study: Outcomes of pressure ulcer treatments in long-term care. *Journal of the American Geriatric Society*, 53(10), 1721.

¹⁷ Kikawada, M., Iwamoto, T., & Takasaki, M. (2006). Aspiration and infection in the elderly. *Drugs Aging*, 22(2), 115-130.

¹⁸ Groher, M.E. & McKaig, T.N. (1995). Dysphagia and dietary levels in skilled nursing facilities. *Journal of the American Geriatric Society*, 43(5), 528-532.

¹⁹ Feinberg, M.J., Knebl, J., & Tully, J. (1996). Prandial aspiration and pneumonia in an elderly population followed over 3 years. *Dysphagia*, 11(2), 104-109.

²⁰ Mamun, K., & Lim, J. (2005). Role of nasogastric tube in preventing aspiration pneumonia in patients with dysphagia. *Singapore Medical Journal*, 46(11), 627-631.

²¹ Morley, J.E. & Thomas, M.D. (2003). Development of guidelines for the use of orexigenic drugs in long-term care. *Annals of Long-Term Care*, June 2003, Supplement. Retrieved December 30, 2005 from <http://hmpcommunications.com/ALTC/displayArticle.cfm?ArticleID=altsupp1555>

²² Dasgupta, M., Binns, M.A., & Rochon, P.A. (2000). Subcutaneous fluid infusion in a long-term care setting. *Journal of the American Geriatric Society*, 48(7), 795-799.

²³ Morley, J.E. & Thomas, M.D. (2003). *Annals of Long-Term Care*, June 2003, Supplement.

²⁴ Grant, M.D. & Rudberg, M.A., & Brody J.A. (1998). Gastrostomy placement and mortality among hospitalized Medicare beneficiaries. *Journal of the American Medical Association*, 279, 1973-1976.

²⁵ Finucane, T. (2001). Tube feeding in the demented elderly: A review of the evidence. American Geriatrics Society Annual Scientific Meeting. Retrieved December 29, 2005

from www.medscape.com/viewprogram/874_pnt

INVESTIGATIVE PROTOCOL NUTRITIONAL STATUS

Objectives

- To determine the effectiveness of the facility's response to changes in nutritional status and weight.
- To determine if identified weight change(s) are avoidable or unavoidable.
- To determine if each resident is provided with nourishing, palatable, attractive meals that meet the resident's daily nutritional and special dietary needs.
- To determine if each resident is provided services to try to maintain or improve his/her eating skills.
- To determine if the facility has practices in place, including relevant policies and procedures, to try to maintain acceptable parameters of nutritional status for each resident.

Use

Use this protocol:

- For a sampled resident who did not maintain acceptable parameters of nutritional status, to determine if the facility assessed and intervened to enable the resident to maintain acceptable parameters of nutritional status, unless the resident's clinical condition demonstrated that this was not possible;
- For a sampled resident who is at nutritional risk, to determine if the facility has identified and addressed risk factors for impaired nutritional status, or explained adequately why they could not or should not do so; and

Procedures

Briefly review the MDS, RAI, relevant nutritional assessment and care plan to identify facility evaluations, conclusions, and interventions to guide subsequent observations . For a newly admitted resident either at risk or who has impaired nutritional status, the staff is expected to begin to assess and address the nutritional issues from the day of admission. Corroborate observations by interview and record review.

1. Observation

Gather information, as appropriate, to support the investigation (e.g., diet list,

nourishment list and schedule, policies regarding bedtime (HS) snacks, etc.). Observe residents during the initial tour of the facility and throughout the survey process.

Use the Dining and Food Service Protocol while observing resident dining.

- Observe a resident's physical appearance for signs that might indicate altered nutritional status (e.g., thin or cachectic appearance or impaired oral health) and note obvious dental and oral problems.
- Resident dining observations: Observe two meals during the survey, including one meal observation on the first day of the survey and an evening meal.
 - Record information from the tray card, dining roster, or meal sheet (name, room number, diet, beverage preference, likes/dislikes, food allergies, etc.) Record what the resident is served compared to the specifications on the tray card and the menu.
 - Observe the resident eating meals and note staff assistance; adaptive equipment; resident's refusal or failure to eat most or all of the food offered; substitutes (offered if food is refused); positioning; table seating; and total meal intake. Also document issues related to dignity and residents' rights (e.g., resident's appearance and staff's approach to the resident). Determine the percent eaten and whether appropriate assistance is being provided.
 - Check the diet order in the medical record and the documentation of percent eaten for sampled residents against what was observed during the meal and nourishment observations.

For the sampled resident, observe whether staff consistently implemented the care plan over time and across various shifts. During observations of the interventions, note and/or follow up on deviations from the care plan. Determine if staff responded appropriately to the resident's needs (e.g., for assistance, positioning, supervision, etc.).

2. Interview

- Interview the resident and/or resident's representative regarding the resident's appetite, eating abilities, staff support and responsiveness to his/her needs and whether the resident is receiving foods he/she likes.
- Interview knowledgeable staff (e.g., CNA, registered dietitian, dietary supervisor/manager, charge nurse, medical director, speech pathologist, social worker, etc.) regarding the facility's policies, protocols, and practices in relation to the areas covered in the Interpretive Guidelines. For example, do the physicians help to identify and address causes of nutritional risks; do the nursing staff and practitioners participate actively in setting nutrition-related goals based

on the whole picture of a resident's condition and prognosis or do they rely solely on the recommendations of a single discipline?

- Interview family, staff, and others as applicable regarding their observations of the resident's appetite, eating abilities, recent eating patterns and trends, and how the staff respond to his/her needs.
- Interview supervisory staff if any discrepancies are noted among observation of the resident, interview of the resident and/or caregivers, and the documented assessment and care plan. Ask how supervisory staff ensure that planned interventions are carried out; and how they monitor the results of interventions to determine if modified or new interventions were needed or that the current interventions were still warranted.

3. Record Review

Review the resident's medical record to determine how the facility identified residents who were at nutritional risk, evaluated and analyzed nutritional status, identified causes of anorexia and impaired nutritional status, identified relevant interventions, implemented those interventions to try to stabilize or improve nutritional status, evaluated the benefits and risks of existing interventions, and monitored and modified approaches as indicated.

Documentation

Documentation of findings and conclusions related to nutritional status, including documentation of weight and information related to weight loss, may be found in various locations in the medical record, including interdisciplinary progress notes, nutrition progress notes, the care plan, or resident care conference notes.

Assessment

Review the RAI (including the RAPS) and other documentation, such as the history and physical exam; care plan; height and weight measurements; physician's orders (diet, tube feeding, nourishments, etc.); medications with potential to affect appetite or weight and those with significant potential drug/nutrient interactions; nutrition notes; nursing and rehabilitation documentation regarding functional status related to eating; relevant lab or diagnostic test results; activities of daily living (ADL) worksheets; documentation related to food intake; physicians' and nurses' progress notes regarding nutritional status and weight loss; and social service notes regarding preferences and psychosocial status.

Determine if the resident's weight and nutritional status were assessed in the context of his/her overall condition and prognosis; if nutritional requirements and nutrition risk factors were identified, what criteria were used to identify nutritional risk, and if the facility sought and identified causes of the resident's nutritional risks or impairment. Determine if the facility assessment is consistent with or corroborated by documentation within the record and comprehensively reflects:

- **Weighing and Weight Changes:** Identify whether the facility uses a consistent approach to obtaining and verifying weights. Identify how the facility has determined that apparent weight loss in certain residents was due to procedural variation or was not related to inadequate nutritional intake. Review the weight history and other pertinent information to determine if there have been substantial changes or persistent gradual weight loss/gain, and if the resident was on a planned weight change program (MDS Section K will be marked). Determine if specific conditions or circumstances exist such as diuretic therapy, IV hydration, fever, infection, COPD, CHF, or dementia that may lead to weight changes. Identify whether the facility has documented efforts to address persistent unplanned weight gain.

NOTE: IV therapy that is used just to deliver medications would be unlikely to affect nutrition or hydration status.

- **Oral Intake of Foods and Fluids:** Determine how the facility monitored the intake of residents who were nutritionally at risk, and how they determined that the information was valid. Determine if there have been significant changes in the resident's overall intake, whether the resident was assessed for causes of anorexia, and if problems related to food and fluid intake (e.g., not consuming specific food groups) were recognized and addressed.
- **Nutrition Prescription/Macronutrients:** Determine if the current nutrition prescription (diet order) met the resident's calculated nutritional needs (i.e., calories, protein, and fluid requirements), including increased nutritional needs due to conditions such as hyperactivity. If the resident's weight did not stabilize or improve as anticipated, the surveyor should investigate how the facility estimated the resident's nutritional needs and whether the clinical record demonstrates why the resident's condition or status warranted any diet restrictions (e.g., calorie restrictions) despite impaired nutritional status or nutritional risk. Determine if the diet was consistent with current standards of practice regarding the benefits and risks of such restrictions. Determine how the facility accommodated individual food preferences, allergies and intolerances as well as any fluid restrictions.

NOTE: Multiple factors affect weight stability, not all of which can be readily identified. Previous calculations may have been reasonable despite the failure of weight to stabilize or improve if the facility can demonstrate: a) a valid clinical basis for preliminary calculations of nutritional requirements; b) that they identified risk factors that could impact subsequent weight gain; and c) that they adjusted calculations based on reviewing results.

- **Functional Status.** Determine if the resident requires any type of assistance to eat and drink adequately and if his/her ability to eat had improved or diminished

since the last review by staff. Determine if the facility identified the need for assistive devices/utensils, and the need for assistance with feeding (e.g., cues, hand-over-hand, and extensive assistance) based on a consistently applied protocol.

- **Medications:** Determine if the resident is receiving any medications that are known to cause clinically significant drug/nutrient interactions (DNI) or that may affect food intake or enjoyment (e.g., affecting taste, causing anorexia, increasing appetite, causing nausea/vomiting, lethargy, confusion, or marked constipation etc.).
- **Oral Health:** Determine if the facility identified problems with the teeth, mouth, or gums (e.g., oral cavity lesions, mouth pain, decayed teeth, poorly fitting dentures, or refusal to wear partials/dentures) that could affect eating.
- **Chewing and Swallowing Problems:** Determine if the facility adequately assessed and considered various medical and functional causes of chewing and swallowing problems in addition to dysphagia; based decisions to downgrade or alter consistency of diets on a careful review of the resident's overall condition; evaluated the overall benefits and risks of a more liberalized diet; and accommodated resident preferences to accept risks in favor of more liberalized food intake.
- **Affective and Behavioral Disorders:** Determine if there have been significant changes in behavior or mood since the last review that may affect intake of food/fluid and if the facility evaluated the impact of these behavior or mood disturbances on the resident's eating and nutritional status.
- **Relevant Conditions and Diagnosis:** Determine if the facility identified new or existing conditions or diagnoses that may affect overall intake, nutrient utilization, and weight stability and addressed these identified conditions or indicated why they could not or should not be addressed.
- **Hypermetabolic states:** Determine if the facility evaluated possible need for dietary modifications in individuals with hypermetabolic states due to conditions such as continuous wandering or skin breakdown, and either implemented indicated modifications or explained why the current diet was appropriate and adequate for the situation.
- **Abnormal Labs:** Determine if the facility evaluated whether it had enough information to identify a resident's nutritional status and risks; evaluated the significance of existing lab test results in relation to nutritional status and risks; and either implemented pertinent interventions or provided a rationale for not intervening.

- **Overall Prognosis/Condition:** Determine if the resident is progressing towards nutritional goals established by the care team; and when nutritional goals have not been met, whether alternate interventions were identified or it was explained why current interventions continued to be appropriate.
- **Resident Choice:** Determine if the facility permits residents to make choices about nutritional interventions; gave the resident (or the resident's legal representative) the option to accept risks related to diet and food consistency restrictions; addressed advance directives and other relevant declarations of wishes regarding aggressive nutrition support; honored the resident's wishes regarding the withholding or withdrawing of undesired interventions such as tube feeding; and periodically asks the resident if he/she wishes to update their current advance directive status concerning nutrition/hydration support.

NOTE: Completion of the comprehensive assessment is not required until 14 days after admission. For newly admitted residents, before the 14 day assessment is complete, address inadequate assessment and care planning to meet the resident's needs under F281. The facility may have completed a 5-day assessment for the Medicare beneficiary. Use the 5-day assessment as the comprehensive assessment only if it was completed with the RAPS.

Care Plan

Review the care plan to determine if the facility developed interventions based on the resident's specific conditions, risks, needs, behaviors, and preferences and current standards of practice, and included measurable objectives and timetables, with pertinent interventions and services.

Determine if the care plan addresses, as appropriate:

- The staff responsible for implementing the plan;
- Information regarding diet, nourishments, snacks etc.;
- Environmental factors to optimize resident intake during meals (e.g., positioning, minimal background noise, etc.);
- The need for dining assistance and assistive devices/equipment; and
- Provision for special nutritional needs based on resident choice.

If care plan concerns are noted, interview staff responsible for care planning about the rationale for the current plan of care. If questions remain after reviewing documentation in the medical record surveyors should discuss the facility's decision regarding nutrition, hydration, and use of a feeding tube with the resident's physician or the medical director

(e.g., if the attending physician is unavailable).

NOTE: The comprehensive care plan does not need to be completed until seven days after the comprehensive assessment (the assessment completed with the RAPS). Inadequate care planning to meet the needs of a newly admitted resident should be addressed under F281. Additionally, lack of physician orders for immediate care (until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan) should be addressed under F271.

Care Plan Revision

Determine if the staff have monitored the resident's response to interventions for maintaining/improving nutritional status and have evaluated and revised the care plan based on the resident's response and outcomes, or justified continuation of the current plan. Review the record and interview staff for information and/or evidence that:

- Staff have evaluated nutrition-related outcomes of the plan (including the relevance of care plan goals and effects of interventions) periodically;
- Staff have identified changes in the resident's condition that require revised goals and care approaches; and
- The resident and/or the responsible person are involved in reviewing and updating the plan.

4. Interviews with Health Care Practitioners and Professionals

If the interventions defined, or the care provided, appear to be inconsistent with recognized standards of practice, interview one or more health care practitioners and professionals as necessary (e.g., physician, hospice nurse, dietitian, facility charge nurse, or director of nursing, medical director). These individuals should be able to provide information about the evaluation and management of the resident's physical and psychosocial symptoms and needs. Depending on the issue, ask about:

- How it was determined that chosen interventions were appropriate;
- Identified needs for which there were no interventions;
- Changes in condition that may justify additional or different interventions; or
- How staff validated the effectiveness of current interventions.

5. Review of Facility Practices

This involves a review of policies and procedures, staffing and staff training, functional responsibilities, contracts, etc. and interviews with management. If there is a pattern of

residents who have not maintained acceptable parameters of nutritional status without adequate clinical justification, determine if quality assurance activities were initiated in order to evaluate the facility's approaches to nutrition and weight issues.

DETERMINATION OF COMPLIANCE (Task 6, Appendix P)

Synopsis of regulation (F325)

This regulation requires that, based on the resident's comprehensive assessment, the facility ensures that each resident maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible.

Criteria for Compliance

The facility is in compliance with 42 CFR 483.25(i) F325, Nutrition, if staff have:

- Assessed the resident's nutritional status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status;
- Analyzed the assessment information to identify the medical conditions, causes and/or problems related to the resident's condition and needs;
- Defined and implemented interventions for maintaining or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice, or explained adequately in the medical record why they could not or should not do so; and
- Monitored and evaluated the resident's response or lack of response to the interventions; and revised the approaches as appropriate, or justified the continuation of current approaches.

If not, failure to maintain acceptable parameters of nutritional status is avoidable, cite at F325.

Noncompliance with F325

After completing the investigative protocol, the survey team must analyze the data to determine whether noncompliance with the regulation exists. A clear understanding of the facility's noncompliance with requirements (i.e., deficient practices) is imperative in determining the relationship of the deficient practice(s) to the actual harm or potential for harm to the resident. Noncompliance must be established before determining severity.

Noncompliance with F325 may include (but is not limited to) one or more of the following, including failure to:

- Identify and apply relevant policies and procedures to maintain acceptable parameters of residents' nutritional status;
- Accurately and consistently assess a resident's nutritional status on admission and as indicated thereafter;
- Identify a resident at nutritional risk and address risk factors for impaired nutritional status, or explain adequately why they could not or should not do so;
- Implement monitor, and modify interventions (as needed), in accordance with the resident's needs and current standards of practice, to maintain acceptable parameters of nutritional status;
- Provide clinical justification for the unavoidable development of, or failure to improve, impaired nutritional status; and
- Involve the physician as appropriate in evaluating and managing the resident's nutritional risks and impaired nutritional status.

Potential Tags for Additional Investigation

If noncompliance with 42 CFR 483.25(i) has been identified, the survey team may have determined during the investigation of F325 that concerns may also be present with related process and/or structure requirements. Examples of related process and/or structure requirements that should be considered when noncompliance with F325 is identified include the following:

- 42 CFR 483.10(b)(4), F155, Notice of rights and services
 - Determine if the resident, the resident's surrogate, or representative refused proposed dietary restrictions, and downgraded diet textures and liquid consistencies, based on a balanced explanation of the relative risks and benefits of such restrictions, and if the facility accommodated those preferences.
- 42 CFR 483.10(b)(11), F157, Notification of changes
 - Determine if staff notified the physician and family of changes in the resident's condition or failure of the resident to maintain acceptable parameters of nutritional status despite the treatment plan.
- 42 CFR 483.20(b)(1), F272, Comprehensive assessments

- Determine if the facility comprehensively assessed the resident's nutritional status and the factors that put the resident at risk for failure to maintain acceptable parameters of nutritional status.
- 42 CFR 483.20(k), F279, Comprehensive care plans
 - Determine if the facility developed a care plan that includes measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment.
- 42 CFR 483.20(k)(2)(iii), F280, Comprehensive care plan revision
 - Determine if the care plan was periodically reviewed and revised as necessary to maintain acceptable parameters of nutritional status.
- 42 CFR 483.20(k)(3)(ii), F282, Provision of care in accordance with the care plan
 - Determine if qualified persons implemented the resident's care plan, consistent with the defined interventions.
- 42 CFR 483.25, F309, Quality of care
 - Determine if a resident receiving palliative care is allowed and assisted to eat and drink consistent with his/her preferences and needs.
- 42 CFR 483.25(j), F327, Hydration
 - Determine if if the resident receives sufficient fluid to maintain proper hydration.
- 42 CFR 482.30(a), F353, Nursing services - sufficient staff
 - Determine if sufficient nursing staff are provided to identify and evaluate changes in the resident condition, to assess the resident, to plan and assure interventions are implemented to maintain acceptable parameters of nutritional status, to assist residents with eating in a timely manner (so food remains palatable), to monitor and evaluate the implementation of the interventions and resident response, and to follow-up with the physician regarding treatment.
- 42 CFR 483.35(a), F361, Dietary services - staffing
 - Determine if a qualified dietitian is employed full-time to identify resident's dietary needs, and to plan and implement dietary programs. If a qualified dietitian is not employed full-time, the designated person who serves as director of food service receives scheduled consultation from a

qualified dietitian in sufficient frequency and duration to plan, manage, and implement dietary service activities and to assure that residents receive adequate nutrition.

- 42 CFR 483.40(a), F385, Physician services – physician supervision
 - Determine if the physician has participated in evaluating medical conditions and treatments that affect appetite and weight loss, helped evaluate the pertinence and relative benefits and risks of proposed interventions, including restrictions, responded appropriately to the need for treatment orders to maintain acceptable parameters of nutritional status, and responded appropriately to notification of medical complications and risk factors related to nutritional status.
- 42 CFR 483.75(g), F499, Staff qualifications
 - Determine if the Dietitian is licensed, certified, or registered in accordance with State law.
- 42 CFR 483.75(h), F500, Use of outside resources
 - Determine if the professional services of a Dietitian are furnished by an outside resource, when the facility does not employ a qualified Dietitian. The Consultant Dietitian services meet professional standards and principles and are timely.
- 42 CFR 483.75(i)(2), F501, Medical director
 - Determine if the medical director has assured that the facility adopts and uses relevant policies and procedures for maintaining acceptable parameters of nutritional status, and that these are based on pertinent practices, guidelines, and current care standards; and if the medical director has interacted with the physician supervising the care of the resident, when requested by staff to intervene on behalf of the resident who is not maintaining acceptable parameters of nutritional status.

V. DEFICIENCY CATEGORIZATION (Part V, Appendix P)

After the survey team has completed its investigation, analyzed the data, reviewed the regulatory requirements, and identified the deficient practices that demonstrate that the facility failed to ensure that residents maintained acceptable parameters of nutritional status and that noncompliance exists, the team must determine the severity of the deficient practice(s) and the resultant harm or potential for harm to the resident.

The key elements for severity determination for F325 are as follows:

1. Presence of harm/negative outcome(s) or potential for negative outcomes because of lack of appropriate treatment and care. Actual or potential harm/negative outcomes for F325 may include but are not limited to:
 - Undesired weight change;
 - Inadequate food/fluid intake;
 - Impairment of anticipated wound healing;
 - Functional decline; and
 - Fluid/electrolyte imbalance.
2. Degree of harm (actual or potential) related to the noncompliance. Identify how the facility practices caused, resulted in, allowed, or contributed to the actual or potential for harm.
 - If harm has occurred, determine if the harm is at the level of serious injury, impairment, death, compromise, or discomfort; and
 - If harm has not yet occurred, determine how likely the potential is for serious injury, impairment, death, compromise or discomfort to occur to the resident.
3. The immediacy of correction required. Determine whether the noncompliance requires immediate correction in order to prevent serious injury, harm, impairment, or death to one or more residents.

The survey team must evaluate the harm or potential for harm based upon the following levels of severity for tag F325. First, the team must rule out whether Severity Level 4, Immediate Jeopardy to a resident's health or safety exists by evaluating the deficient practice in relation to immediacy, culpability, and severity. (Follow the guidance in Appendix Q.)

Severity Level 4 Considerations: Immediate Jeopardy to resident health or safety

Immediate Jeopardy is a situation in which the facility's noncompliance:

- With one or more requirements of participation has caused/resulted in, or is likely to cause, serious injury, harm, impairment, or death to a resident; and
- Requires immediate correction as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.

NOTE: The death or transfer of a resident, who was harmed as a result of facility practices, does not remove a finding of immediate jeopardy. The facility is required to implement specific actions to correct the deficient practices which allowed or caused the immediate jeopardy.

Examples of deficient practices that may constitute noncompliance at Level 4 may include, but are not limited to:

- Continued weight loss and functional decline resulting from substantial failure to assess a resident's nutritional needs and current nutritional status and/or implement any pertinent interventions based on such an assessment.
- Continued weight loss or failure to achieve anticipated nutritional goals resulting from repeated failure to assist a resident who would have otherwise been able to ingest adequate amounts of food and fluid.
- Recurrent failure to provide the correct volume of enteral feeding (tube feeding) ordered by the physician, or to provide enough food and fluids to meet calculated requirements which results in weight loss.
- Decline in food and/or fluid intake that could result in a decline in acceptable parameters of nutritional status from imposing dietary restrictions or downgraded diet textures or fluid consistency against the clearly expressed preferences of the resident.

If immediate jeopardy has been ruled out based upon the evidence, then evaluate whether actual harm that is not immediate jeopardy exists at Severity Level 3 or the potential for more than minimal harm at Level 2 exists.

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy

Level 3 indicates noncompliance that results in actual harm that is not immediate jeopardy. The negative outcome can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being.

Severity Level 3 includes:

- Undesired weight change in combination with inadequate food/fluid intake;
- Undesired weight change in combination with:
 - Impaired wound healing that cannot be otherwise related to the resident's underlying medical conditions;
 - Functional decline; and/or

- Impaired hydration or fluid/electrolyte imbalance.
- Inadequate food intake in combination with:
 - Impaired wound healing that cannot be otherwise related to the resident's underlying medical conditions;
 - Functional decline; and/or
 - Impaired hydration or fluid/electrolyte imbalance.

Examples of deficient practices associated with avoidable negative outcomes for Severity Level 3 may include, but are not limited to:

- Inadequate food intake and impaired wound healing (not attributable to an underlying medical condition) due to the facility's failure to revise and/or implement the care plan to address the resident's impaired ability to feed him/herself.
- Loss of weight from declining food and fluid intake due to the facility's failure to assess and address the resident's use of medications that are associated with anorexia or other symptoms, such as lethargy or nausea, that affect appetite and food intake.
- Undesired 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 diets and food textures or to obtain or accommodate resident preferences in accepting related risks.
- Decline in function from poor food/fluid intake due to the facility's failure to accommodate documented resident food dislikes and provide appropriate substitutes.

NOTE: If Severity Level 3 (actual harm that is not immediate jeopardy) has been ruled out based upon the evidence, then evaluate as to whether Severity Level 2 (no actual harm with the potential for more than minimal harm) exists.

Severity Level 2 Considerations: No Actual Harm with potential for more than minimal harm that is Not Immediate Jeopardy

Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well being. The potential exists for greater harm to occur if interventions are not provided.

For Level 2 severity, the resident was at risk for or has experienced the presence of one or more of the five negative outcome(s) (i.e., undesired weight change, inadequate food/fluid intake, impairment of anticipated wound healing, functional decline, and/or fluid/electrolyte imbalance) due to the facility's structure and process, thereby compromising the resident's ability to maintain acceptable parameters of nutritional status. Examples of avoidable negative outcomes may include, but are not limited to:

- Failure to obtain accurate weights and to verify weights as needed, even though the resident did not lose weight.
- Poor intake due to facility's intermittent failure to provide required assistance with eating, but the resident did not lose weight or fail to meet identified weight goals.
- Failure to provide additional food or tube feeding that was ordered for a resident, but the individual did not experience weight loss.
- Potential for undesired weight change due to recurrent discrepancies between the tray card specifications and what was provided.

Severity Level 1: No actual harm with potential for minimal harm

The failure of the facility to provide appropriate care and services to maintain acceptable parameters of nutritional status and minimize negative outcomes places residents at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.