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Want More Info on F-Tags 325 and 371?

To read CMS F-tags 325 and 371 in their entirety, please visit www.cms.hhs.gov/Transmittals/ or click the link on the DMA website at www.DMAonline.org.

Think Like a Surveyor

Deficiency Free in Nutrition Status:

Using New Interpretive Guidance and Protocol for F 325

Looking for direction on F-Tag 325? Want to know your boundaries as a member of the nutrition care team? Follow this map to a better understanding of the revised interpretive guidance.

As the new regulatory interpretation of F-Tag 325 takes effect on September 1, dietary managers need to champion change and performance improvement regarding resident nutritional status. What does the new Interpretive Guidance and Investigative Protocol for Regulation F 325 mean to you, as a dietary manager? Read on to learn more about your changing role in maintaining the nutrition status of your residents.

The Role of the Dietary Manager

Dietary managers wear many hats in their facilities, among them: staff trainer, record keeper, screener, the dietary representative on the QA committee, and the "alarm sounder" when there is nutrition decline. The registered dietitian depends on the collaboration and effective management skills of the dietary manager so the RD is able to "hit the deck running" to provide adequate consultation in a limited number of hours. (For a formal breakdown on professional role delineations, please see the CDM, CFPP Scope of Practice that follows this article, or consult the CMS website for role delineations and responsibilities.)

When there is a deficiency in Nutrition Status, the entire Interdisciplinary Team (IDT) is partially responsible, but since the dietary manager is often the most accessible person, they are frequently left to answer questions and clarify procedures. As such, dietary managers must thoroughly understand the revised regulations and their implications for practice.

A Challenge to Dietary Managers

You may gripe a bit about the demands of the job and the greater expectations placed on you. But at the end of the day, it's better to become proactive rather than reactive. How? *Learn to do what a surveyor does.* Come along on this short journey and begin identifying areas of weakness that you can work on—before the survey. These tactics will help you apply the new Interpretive Guidance and new Investigative Protocol. By way of introduction, I recently retired as a specialty RD trainer of many hundreds of surveyors. I will help you help your IDT/RD strengthen your systems. Stop letting surveyors and their findings become your QA for identifying weak areas.

I hope you'll welcome these new Interpretive Guidance and Investigative Protocol revisions for the opportunities they offer! Let's start.

What Happens on September 1, 2008?

As part of the CMS (Centers for Medicare & Medicaid Services) Plan for Improved Quality of Care, the following changes will be implemented. As such, surveyors will be holding long-term care facilities more accountable for maintaining residents' nutrition status than ever before.

Revisions for F 325 Nutrition Status:

1. **Merging of Two F-Tags**: F 325 (Maintaining Nutritional Status) will also include the former F 326 Tag (Therapeutic Diet based upon assessed nutritional needs).
2. **Revised Interpretive Guidance (IG) for Surveyors** (and Providers): New IG will detail expectations, including early identification of any decline and aggressive "reversal" or prevention of compromised nutritional status.
3. **New Surveyor Investigative Protocol**: This includes specific guidance on how to evaluate a facility's systems for maintaining residents' nutritional status.
4. **Determination of Compliance and Severity Levels** (based on harm): This includes examples for surveyors, such as when to call Immediate Jeopardy (IJ) for potential for harm. (See end of article for guidance on accessing the CMS website and Appendices for Regulations, Survey Process, and IJ.)

Part I: Observing, Interviewing, Record Reviewing as a Surveyor Would

1. **Start where surveyors start**. Print a Quality Measure/Indicator Report every three months to review all high risk residents. Identify residents with fecal impactions, excessive weight loss, tube feedings (with weight loss or pressure ulcers), dehydration (and with UTI), pressure ulcers (especially those acquired in the facility). These are the identified (usually sampled) high risk residents that surveyors will be observing during survey and evaluating for their care. Have the Interdisciplinary Team (IDT) select at least 10 high-risk residents.
2. **Make your own observations as a surveyor would**. During dining and during the day, ask yourself these questions. How are nutrition services delivered to meet the identified or observed care needs? (This is the most important task of the survey.) Is staff providing assis-

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tance, encouragement, positioning, supervision? Are needs of altered status, dental and oral, met? Does there seem to be a need for adaptive aides? Is the resident able to access or ask for fluids? If the resident has limitations, what is staff doing to offer and ensure adequate nutrition? Are ordered supplementations being given and monitored? Does the resident accept or take the supplement? (Is there any recording of how the intervention was received, consumed?) If not consumed or refused, is a new intervention started?

3. **Conduct your own interviews as a surveyor would**. Interview resident, family, responsible person. Ask for feedback on how the dining program is going. Is staff responsive to eating abilities, support needs? Are food/dining preferences honored? Are substitutions and choices offered at meal time? Are nutrition interventions (snacks, frequent meals, calorie-dense foods) offered? Is the resident or family expressing that the ordered supplements have not been accepted or taken? Has there been communication of this to the staff? What other recommendations would the resident or family make? This is an opportunity to check your delivery of services as viewed by the resident and family. *An important interview is to determine if there is an ongoing understanding of risk/benefit when a resident refuses needed approaches or diet restrictions and the expected outcomes/consequences.*

4. **Prepare yourself and your staff to be interviewed by surveyors.** How are food and fluid intake and eating ability monitored? How/to whom are changes in food/fluid intake, eating ability, and weight reported? How is implementation of nutrition-related goals in the Care Plan (CP) monitored? Is there a system for recording or monitoring supplement interventions (How can the IDT

QA and Performance Improvement

CMS has partnered with the Institute for Healthcare Improvement to provide training and the PDSA—Plan, Do, Study, Act—method of performance improvement. (See IHI website listing below.) It is based on the concept that when you have identified a practice or "real work" system that needs improving, you desire an accelerated focused change or improvement. A critical part of the PDSA is to have the right team.

Here's an example of a QA project using the PDSA model:

1. **After surveying like a surveyor, the IDT findings were:**
   a. *Record Review*: Inaccurate and partially filled out food intake records and nourishment/supplement records.
   b. *Interview Review*: Nurse assistants lacked the knowledge on how to fill out ADL food intakes and were not following facility's Policy and Procedure (P&P) for recording.
   c. *Record Review*: The recording of ordered nourishment (at mealtimes and between meals) by nurse aides and by licensed nursing was unclear in the P&P. The actual practice varied: Some initialing that it was "offered" (but no indication if it was taken). Some nurse assistants did not record ordered between meal supplements anywhere, and some recorded them in the between meal "snack" column.
   d. IDT unable to monitor acceptance or effectiveness of nourishments (interventions).
2. **The QA team established and addressed findings:**
   a. *Team*: Nurse assistant, licensed nurse, and dietary staff person co-chaired.
   b. Brainstormed for goals (to improve performance outcome) and determined the best new practices.
   c. *Determined Plan*: Changed P&P, trained all staff, put new practices into place.
3. **Studied implementation of plan and re-evaluated to see if goals were met.**

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges

monitor)? What happens when the food intervention is poorly consumed? Are staff members aware of CP, especially direct care staff? (Ask nurse assistants about their knowledge of what the CP says for these residents.) How is the physician involved in evaluating and addressing decline and causes of risk and impairment (medications, med interactions)? How are dietary employees trained, especially their knowledge and practice for providing an ordered fortified diet? Is the cook or the dietary aide able to verbalize what is to be given on these diets and what substitutions are appropriate?

5. **Track timeliness of nutritional assessment and re-assessment.** Is there timely assessment for calories, protein, fluids? Is there timely monitoring of oral intakes for food/fluids to meet the assessed nutritional needs? Has there been an identification of nutrition related care needs and causes, such as chewing and swallowing problems, functional status, and eating or drinking assistance? Has there been an evaluation of medications and drug/nutrient interactions and appetite? Have relevant conditions and diagnoses been identified? Have abnormal laboratory tests been communicated to the RD, reviewed with recommended interventions (or provided justification by doctor/nursing notes if not implemented)? Is there timely notification to the RD when there is any nutritional decline (weight loss—even if not at a significant level)? Does RD have a method of telecommunication for consultation between facility visits for timely response (Example: faxing)?
6. **Review record for care planning.** Did the care plan problems and goals accurately reflect the ongoing assessment and special needs? Is the care plan accurate for what was really observed? Is there ongoing revision? Is there evaluation of outcomes, including relevance of goals and effectiveness of interventions? Is there identification of changes in resident's condition requiring revised goals and approaches? Is there involvement of resident/responsible person in reviewing and updating the plan? Does the plan reflect the physician's orders or care issues?

Part II: Identifying Weak Areas (Findings) and Developing Correction or Improvement Methods

Once you have observed, interviewed, and completed the record review as a surveyor would, the toughest part is ahead of you. What will you do with the findings? This is the intent of F 520-1 Quality Assessment and Assurance tags.

NOTE: If you have identified your own areas that need improving and are working on these areas, the survey process instructs surveyors not to write you a deficiency in this

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area. If there is a deficiency, your own QA process could be the basis of disputing the deficiency or could greatly reduce the severity level of the deficiency.

1. **Are there weak areas that surveyors could have "findings?"** May include:
   a. DID NOT have early identification of decline in high risk nutrition areas.
   b. DID NOT have timely re-assessment for increased needs when there was a decline.
   c. DID NOT have "aggressive" efforts by facility to stop or prevent further unintended weight loss.
   d. DID NOT plan and provide for the maintenance of nutritional status.
   e. DID NOT have "systems" in place to ensure that direct care staff members were aware or providing planned approaches and interventions. Nurse assistants did not know or do what was in the care plan.
   f. DID NOT have methods for recording or monitoring supplement/interventions for effectiveness.
   g. DID NOT change or try new interventions when current ones did not maintain nutritional status.
2. **Do you have specific methods/CQI used to identify residents at risk in a timely manner and provide adequate follow up?**
   a. Is there IDT communication and sharing related to high risk residents during assessing and care planning?
   b. Are there specific goals for stopping weight loss and improving nutritional status?
   c. What is done when the interventions are not working as planned?
   d. What is done when there is not consistent and accurate record keeping (for weights, intakes, interventions)?
   e. How are the assistance and cueing ensured for those who need it?
   f. How is the physician notified of decline and how is there follow up on all recommendations?
3. **What interventions are there to improve food/fluid intake?** (Suggested in the new IG)
   a. Are there enhanced or fortified foods with added protein, fat, and/or carbohydrate such as hot cereal, starches (mashed potatoes), casseroles, desserts, juices, double strength milk?
   b. Are the ordered interventions followed and dietary staff aware of recipes, policies, and what is to be substituted if the resident dislikes the planned interventions?
   c. Is there assessment to ensure that the smaller portion or more frequent meals are adequate for resident's assessed needs?
   d. Are there a variety of interventions including between-meal snacks and nourishments, providing high calorie supplement with med pass, and increasing the portion sizes of resident's favorite foods and snacks?

Part III: Other Areas to Evaluate as a Surveyor Would

1. **Is fluid and electrolytic balance ensured? These affect the level of consciousness and may compromise food intake.** Are abnormal labs monitored and managed such as electrolytes, BUN, creatinine, serum osmolality? Is there adjusting of medication that affect fluid loss/appetite? Is there offering and encouragement of a variety of fluids between meals? Is there offering of water and beverage choice at mealtime (per Dining Protocol), except with restrictions? Are water pitchers accessible—and is there a provision for residents on thickened liquids? Are there hydration carts and other fluids readily available throughout the day (with diet

Understanding the Severity Decisions by Surveyors for Potential Harm (and for Immediate Jeopardy):

1. **Presence of harm/negative outcome/potential due to failure of care:** Unplanned weight change, inadequate food/fluid intake, impairment of anticipated wound healing, functional decline, fluid/electrolyte imbalance.
2. **Degree of harm (actual or potential) related to the noncompliance:** How facility practice caused, resulted in, allowed, or contributed to harm/potential? If harm has occurred, at what level? If harm has not occurred, determine how likely the potential is for serious injury, impairment, death, compromise, or discomfort to resident.
3. **Immediacy of correction required:** Determine whether the noncompliance requires immediate correction to prevent serious injury, harm, impairment, or death to one or more residents.

and fluid restrictions list), including a variety of fluids like popsicles, gelatin, ice cream, and sodas?

2. **Are there specific approaches for nutritional needs of residents on dialysis?** Is there a care plan in the chart from the dialysis center as well as the SNF? Is there continuity of care between the two centers? Do the dietitians from both communicate regarding care of the resident? Are dialysis labs and weights sent to SNF? If resident is on a "restricted renal house diet," does the restricted protein level meet the assessed protein needs? Is there consideration for liberalizing diets?
3. **What are the evaluations for end of life?** Residents may be unable to maintain acceptable parameters of nutritional status. Are there appropriate interventions to stabilize the conditions? Or is there indication why the condition cannot or should not be stabilized? Is there careful evaluation and consideration in determining the use of a feeding tube? Are advance directive wishes honored? Are resident wishes and comfort provided for end of life? (See F 309 Quality of Care tag.)
4. **What are the evaluations for residents on hospice?** Is there a hospice care plan in the chart as well as a facility care plan? Is there proof of a coordinated effort between the two agencies and an interdisciplinary plan of care? Do all staff (licensed, direct care) know the care needs? Is there a continuation of nutrition interventions even when the resident is put on hospice? (Example: If the resident is willing to take or drink supplements.) Are resident wishes respected (such as not weighing)?

Much is expected of us in this highly regulated area of care giving, to ensure the nurturing and care of vulnerable residents who depend on us. Ask yourself these questions: Do you feel that your job is important and vital to the care of residents? Have you embraced and overcome changes and challenges in the past? Will you now?

May your efforts be rewarded and your surveys go well. Soldier on! ■

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WEB RESOURCES

www.cms.hhs.gov-Accessing Regulations & Surveyor Guidance: Go to-> Regulations/Guidance->Click on Manuals->Go to right hand and scroll to "Internet Only"->Go to Publications: 100-07 State Operations Manual (SOM)->Scroll down to "APPENDICES": Appendix "P" is the regulations and IG; Appendix "PP" is the surveyor process; Appendix "Q" is surveyor guidance on IJ.