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State: Indiana	**Task: Nursing Home**
Owner:	**Policy No: 1**

SAMPLE POLICY: SCHEDULE NUTRITION AT RISK / SUPPLEMENTAL WORK AND TRANSITION (NAR/SWAT) MEETINGS

Corresponding Federal Regulations

Quality of Care

F692 483.25(g) Assisted Nutrition and Hydration- (this includes nasogastric and gastrotomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy and enteral fluids). The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional and hydration status and that the facility will:

A. Provide nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment;
B. Recognize, evaluate, and address the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration; and
C. Provide a therapeutic diet that considers the resident's clinical condition and preferences when there is a nutritional indication.

F692 at 483.25(g)(I) resident maintains acceptable parameters of nutritional status, such as usual body weight, or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.

F692.25(g)(2) resident is offered sufficient fluid intake to maintain proper hydration and health.

F692.25(g)(3) resident is offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet.

A. Guidance to Surveyor includes why we, in long-term care, schedule meetings to review weight, skin and nutrition for the residents. This guidance demonstrates for the long-term care facility what the review should include and what, if any, areas of concern should be addressed, care planned, orders developed, assessments to be considered and documented results of the meeting.
B. Guidance to Surveyor: body weight and laboratory results can often be stabilized or improved with time but may not be correctable in some individuals. Intake alone is not the only factor that can affect nutritional status. Resident conditions and co-morbidities may prevent improved nutritional or hydration status, despite improved intake. Many factors can influence weight and nutritional status as the resident ages. The body may not absorb or use nutrients as effectively, there may be changes in the ability to taste food, or there may be a decreased weight, such as 'muscle mass,' and/or a decreased sensation for thirst or hunger. Medical conditions that can impact how well the resident maintains weight include impaired cognitive status, nearing the end of life, or a disease process, such as kidney disease or congestive heart failure that may cause the resident to retain fluids in the body.

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C. Failure to identify residents at risk for compromised nutrition and hydration may be associated with increased risk of mortality and other negative outcomes such as wound healing, decline in function, fluid and electrolyte imbalance/dehydration, and unplanned weight changes. While food intake may be considered, ensuring a resident receives the fluids they require can be overlooked. In addition, compromised individuals who fail to receive adequate fluids are more susceptible to urinary tract infections, pneumonia, pressure injuries, skin infections, confusion, and disorientation.

DEFINITIONS

Assessment - a comprehensive nutritional assessment should be completed on any resident identified as being at risk for unplanned weight loss/gain and/or compromised nutritional status. This includes general appearance, height, weight and adding diet and supplemental orders. Laboratory/diagnostic evaluations are sometimes needed to confirm if a treatable clinical problem exists.

Care Planning - information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences.

Interventions - interventions related to a resident's nutritional status must be individualized to address the specific needs of the resident. Examples include, but are not limited to:

A. Diet liberalization, such as therapeutic or mechanically altered diets and preferred diets;
B. Weight related interventions should involve the resident and/or the resident's representative to ensure the resident's needs, preferences and goals are accommodated;
C. Medications may be helpful in improving the resident's nutritional status. Some medications help improve the appetite and/or reduce acid reflux. As well, some medications may impair a resident's nutritional or hydration status. Medications may cause dry mouth, appetite, nausea, and interventions should be put into place;
D. Food intake is preferable to adding nutrition supplements. Fortified protein food can assist in weight gain as well as adding supplements that increase the appetite;
E. Maintaining Fluid and Electrolyte Balance: poor fluid intake can cause an imbalance in lab values and electrolytes; and
F. Feeding Tubes: must be carefully monitored – concerns for feeding tubes should be investigated at F693. Remember that residents who receive a feeding tube should not be losing weight – an investigation is needed, findings addressed, and a plan put into place.

KEY ELEMENTS

F692 Non-compliance - Surveyors will investigate to show that the facility failed to do one or more of the following before citing noncompliance:

A. Accurately and consistently assessed a resident's nutritional status on admission and as needed thereafter. (This is why most facilities keep new admissions on NAR or SWAT for the first four weeks in the building at a minimum);
B. Assess and Treat Pressure Areas:
    - ☐ Did staff conduct a head-to-toe assessment of the resident upon admission/readmission?
    - ☐ Was the physician notified of the pressure area(s) and were physician orders with frequency of treatment received for the pressure area(s)?

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- ☐ At least weekly observations of the pressure area should include:
  - Site
  - Odor
  - Stage
  - Measurements
  - Current treatment

  Note: consider changing a treatment that does not indicate progress of the area in size, stage, drainage, and/or odor every two to three weeks.

- ☐ If the pressure area is unavoidable, include a documented statement outlining the reason and signed by the physician. Examples of an unavoidable area could include:
  - Stage 3-4 area on coccyx
  - A resident who is actively passing away
  - Other debilitating disease that could cause an inability to properly position the resident off the area(s).

C. Identified a resident at nutritional risk and addressed risk factors for impaired nutritional status to the extent possible;
D. Identify, implement, monitor, and modify interventions (as appropriate) consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status;
E. Notify the physician as appropriate in evaluating and managing causes of the resident's nutritional risks and impaired nutritional status;
F. Identify and apply relevant approaches to maintain acceptable parameters of resident's nutritional status, including fluids;
G. Provide a therapeutic diet when ordered;
H. Offer sufficient fluid intake to maintain proper hydration and health.

There are several levels of noncompliance

A. Level 4 Immediate Jeopardy
B. Level 3 Noncompliance Actual Harm that is not Immediate Jeopardy
C. Level 2 Noncompliance No Actual Harm with Potential for More Than Minimal Harm that Is Not Immediate Jeopardy
D. Level 1 No Actual Harm with Potential for Minimal Harm

Quality of Care citations can result in Substandard Care as one of the three categories in the federal regulations.

A. Quality of Care
B. Quality of Life and Resident Behavior
C. Facility Assessments

Noncompliance in other regulations can be cited at all levels, but the three mentioned above are at risk for Substandard Care if cited. Note: Substandard Care can result in monetary fines and possible denials of admission, as well as other added penalties.

REFERENCE: CMS PP Appendix

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