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	§483.25(g) Naso Gastric Tubes Based on the comprehensive assessment of a resident, the facility must ensure that—	See Tag F322 or intent, guidelines, and probes for §483.25(g).
F321	**§483.25(g)(1)** A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and	
F322	**§483.25(g)(2)** A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	**Intent §483.25(g)** The intent of this regulation is that a naso-gastric tube feeding is utilized only after adequate assessment, and the resident's clinical condition makes this treatment necessary. **Interpretive Guidelines §483.25(g)** This corresponds to MDS 2.0 sections G, K, P when specified for use by the State. This requirement is also intended to prevent the use of tube feeding when ordered over the objection of the resident. Decisions about the appropriateness of tube feeding for a resident are developed with the resident or his/her family, surrogate or representative as part of determining the care plan.

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F322 cont.		Complications in tube feeding are not necessarily the result of improper care, but assessment for the potential for complications and care and treatment are provided to prevent complications in tube feeding by the facility. Clinical conditions demonstrating that nourishment via an naso-gastric tube is unavoidable include: • The inability to swallow without choking or aspiration, i.e., in cases of Parkinson's disease, pseudobulbar palsy, or esophageal diverticulum; • Lack of sufficient alertness for oral nutrition (e.g., resident comatose); and • Malnutrition not attributable to a single cause or causes that can be isolated and reversed. There is documented evidence that the facility has not been able to maintain or improve the resident's nutritional status through oral intake. **Probes: §483.25(g)** For sampled residents who, upon admission to the facility, were not tube fed and now have a feeding tube, was tube feeding unavoidable? To determine if the tube feeding was unavoidable, assess the following: • Did the facility identify the resident at risk for malnutrition? • What did the facility do to maintain oral feeding, prior to inserting a feeding tube? Did staff provide enough assistance in eating? Did staff cue resident as needed, assist with the use of assistive devices, or feed the resident, if necessary? • Is the resident receiving therapy to improve or enhance swallowing skills, as need, is identified in the comprehensive assessment?

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F322 cont.		• Was an assessment done to determine the cause of decreased oral intake/weight loss or malnutrition?
		• If there was a dietitian consultation, were recommendations followed?
		• For all sampled residents who are tube fed:
		  ◦ Is the NG tube properly placed?
		  ◦ Are staff responsibilities for providing enteral feedings clearly assigned (i.e., who administers the feeding, formula, amount, feeding intervals, flow rate)?
		  ◦ Do staff monitor feeding complications (e.g., diarrhea, gastric distension, aspiration) and administer corrective actions to allay complications (e.g., changing rate of formula administration)?
		  ◦ Are there negative consequences of tube use (e.g., agitation, depression, self-extubation, infections, aspiration and restraint use without a medical reason for the restraint)?
		  ◦ When long term use is anticipated, is G tube placement considered?
		
		Is the potential for complications from feedings minimized by:
		• Use of a small bore, flexible naso-gastric tube, unless contraindicated;
		• Securely attached the tube to the nose/face;
		• Checking for correct tube placement prior to beginning a feeding or administering medications and after episodes of vomiting or suctioning;

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F322 cont.		• Checking a resident with a newly inserted gastric tube for gastric residual volume every 2-4 hours until the resident has demonstrated an ability to empty his/her stomach;
		• Properly elevating the resident's head;
		• Providing the type, rate and volume of the feeding as ordered;
		• Using universal precautions and clean technique and as per facility/manufacturer's directions when stopping, starting, flushing, and giving medications through the tube;
		• Using hang time recommendations by the manufacturer to prevent excessive microbial growth;
		• Implement the procedures to ensure cleanliness of supplies, e.g. irrigating syringes changed on a regular bases as per facility policy. It is not necessary to change the irrigating syringe each time it is used;
		• Using a pump equipped with a functional alarm (if pump used);
		• The facility's criteria for determining that a resident may be able to return to eating by mouth (e.g., a resident whose Parkinson's symptoms have been controlled);
		  ◦ There are sampled residents meet these criteria;
		  ◦ If so, the facility has assisted them in returning to normal eating; and
		• Identify if resident triggers RAPs for feeding tubes, nutritional status, and dehydration/fluid maintenance. Consider whether the RAPs were used to assess causal factors for decline, potential for decline and lack of improvement.

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F324 cont.		**Probes: §483.25(h)(2)** 1. Are there a number of accidents or injuries of a specific type or on any specific shift (e.g., falls, skin injuries)? 2. Are residents who smoke properly supervised and monitored? 3. If the survey team identifies residents repeatedly involved in accidents or sampled residents who have had an accident: a. Is the resident assessed for being at risk for falls? b. What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk? c. How did the facility fit, and monitor, the use of that resident's assistive devices? d. How were drugs that may cause postural hypotension, dizziness, or visual changes monitored?
_____	**§483.25(i) Nutrition** Based on a resident's comprehensive assessment, the facility must ensure that a resident—	See F326 for intent, guidelines, procedures and probes for §483.25(i)

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F325	**§483.25(i)(1)** (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	
F326	**§483.25(i)(2)** (2) Receives a therapeutic diet when there is a nutritional problem	**Intent §483.25(i)** The intent of this regulation is to assure that the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate intervention, when there is a nutritional problem. **Interpretive Guidelines §483.25(i)** This corresponds to MDS 2.0 sections G, I, J, K and L when specified for use by the State. Parameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels). **Weight** Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide in determining nutritional status. An analysis of weight loss or gain should be examined in light of the individual's former life style as well as the current diagnosis.

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F326 cont.		Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

INTERVAL	SIGNIFICANT LOSS	SEVERE LOSS
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

The following formula determines percentage of loss:

% of body weight loss = (usual weight - actual weight) / (usual weight) x 100

In evaluating weight loss, consider the resident's usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food?

Suggested laboratory values are:

Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion)

Plasma Transferrin >60 yr.: 180-380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.)

Hemoglobin	Males: 14-17 g/dl
	Females: 12-15 g/dl
Hematocrit	Males: 41 - 53
	Females: 36 - 46
Potassium	3.5 - 5.0 mEq/L
Magnesium	1.3 - 2.0 mEg/L

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F326 cont.		Some laboratories may have different "normals." Determine range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident's clinical condition and baseline normal values. NOTE: There is no requirement that facilities order the tests referenced above. **Clinical Observations** Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting. Risk factors for malnutrition are: 1. Drug therapy that may contribute to nutritional deficiencies such as: a. Cardiac glycosides; b. Diuretics; c. Anti-inflammatory drugs; d. Antacids (antacid overuse); e. Laxatives (laxative overuse); f. Psychotropic drug overuse;

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F326 cont.		g. Anticonvulsants; h. Antineoplastic drugs; i. Phenothiazines; j. Oral hypoglycemics; 2. Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations; 3. Depression or dementia; 4. Therapeutic or mechanically altered diet; 5. Lack of access to culturally acceptable foods; 6. Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating; and 7. Cancer. Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not be possible include, but are not limited to: • Refusal to eat and refusal of other methods of nourishment; • Advanced disease (i.e., cancer, malabsorption syndrome); • Increased nutritional/caloric needs associated with pressure sores and wound healing (e.g., fractures, burns);

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F326 cont.		• Radiation or chemotherapy; • Kidney disease, alcohol/drug abuse, chronic blood loss, hyperthyroidism; • Gastrointestinal surgery; and • Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice. **"Therapeutic diet"** means a diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet, (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). **Procedures §483.25(i)** Determine if residents selected for a comprehensive review or focused review as appropriate, have maintained acceptable parameters of nutritional status. Where indicated by the resident's medical status, have clinically appropriate therapeutic diets been prescribed? **Probes: §483.25(i)** For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable: • Did the facility identify factors that put the resident at risk for malnutrition? • Identify if resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration/fluid balance. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement.

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F326 cont.		• What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)? • Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes? • Was this care provided consistently? • Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?
F327	**§483.25(j) Hydration** The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	**Intent §483.25(j)** The intent of this regulation is to assure that the resident receives sufficient amount of fluids based on individual needs to prevent dehydration. **Interpretive Guidelines §483.25(j)** This corresponds to MDS 2.0 sections G, K, I, J and L when specified for use by the State. **"Sufficient fluid"** means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates (e.g., increase fluids if resident has fever or diarrhea). Risk factors for the resident becoming dehydrated are: • Coma/decreased sensorium;

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F327 cont.		• Fluid loss and increased fluid needs (e.g., diarrhea, fever, uncontrolled diabetes); • Fluid restriction secondary to renal dialysis; • Functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs (e.g., aphasia); • Dementia in which resident forgets to drink or forgets how to drink; • Refusal of fluids; and • Did the MDS trigger RAPs on hydration? What action was taken based on the RAP? Consider whether assessment triggers RAPs and are RAPs used to assess the causal factors for decline, potential for decline or lack of improvement. A general guideline for determining baseline daily fluids needs is to multiply the resident's body weight in kg times 30cc (2.2 lbs = 1kg), except for residents with renal or cardiac distress. An excess of fluids can be detrimental for these residents. **Procedures §483.25(j)** Identify if resident triggers RAPs for dehydration/fluid maintenance, and cognitive loss. **Probes: §483.25(j)** Do sampled residents show clinical signs of possible insufficient fluid intake (e.g., dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, fever), abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, blood urea nitrogen (BUN), or urine specific gravity)?

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F327 cont.		Has the facility provided residents with adequate fluid intake to maintain proper hydration and health? If not: • Did the facility identify any factors that put the resident at risk of dehydration? • What care did the facility provide to reduce those risk factors and ensure adequate fluid intake (e.g., keep fluids next to the resident at all times and assisting or cuing the resident to drink)? Is staff aware of need for maintaining adequate fluid intake? • If adequate fluid intake is difficult to maintain, have alternative treatment approaches been developed, attempt to increase fluid intake by the use of popsicles, gelatin, and other similar non-liquid foods?
F328	**§483.25(k) Special Needs** The facility must ensure that residents receive proper treatment and care for the following special services:	**Intent 483.25(k)** The intent of this provision is that the resident receives the necessary care and treatment including medical and nursing care and services when they need the specialized services as listed below. **Interpretive Guidelines §483.25(k)** This corresponds to MDS 2.0 section P when specified by for use by the State. The non-availability of program funding does not relieve a facility of its obligation to ensure that its residents receive all needed services listed in §1819(b)(4)(A) of the Act for Medicare and §1919(b)(4)(A) of the Act for Medicaid. For services not covered, a facility is required to assist the resident in securing any available resources to obtain the needed services.

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F328 cont.	**§483.25(k)(1) Injections**	**Probes: §483.25(k)(1)** For sampled residents receiving one or more of these services within 7 days of the survey: • Is proper administration technique used (i.e., maintenance of sterility; correct needle size, route)? • Are there signs of redness, swelling, lesions from previous injections? • If appropriate, is resident observed for adverse reaction after the injection? • Are syringes and needles disposed of according to facility policy and accepted Practice (e.g., Centers for Disease Control and Prevention and Occupational Safety and Health Administration guidelines)? • Do nursing notes indicate, as appropriate, the resident's response to treatment (e.g., side effects/adverse actions; problems at the injection site(s); relief of pain)?
	§483.25(k)(2) Parenteral and Enteral Fluids	**Probes: §483.25(k)(2)** This corresponds to MDS 2.0 sections K5 and 6 and P1 when specified for use by the State For residents selected for a comprehensive review, or focused review as appropriate, receiving one or more of these services within 7 days of the survey: • Are there signs of inflammation or infiltration at the insertion site? • If the IV site, tubing, or bottle/bag is changed, is sterile technique maintained? • Is the rate of administration that which is ordered by the Physician?

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F328 cont.	**§483.25(k)(3) Colostomy, Ureterostomy, or Ileostomy care**	• Has the resident received the amount of fluid during the past 24 hours that he/she should have received according to the physician's orders (allow flexibility up to 150cc unless an exact fluid intake is critical for the resident)? **Procedures §483.25(k)(2)** See §483.25(g) for enteral feedings (includes gastrostomy). **Procedures §483.25(k)(3)** This corresponds to MDS 2.0 sections G, H, and P when specified for use by the State. Identify if resident triggers RAPs for urinary incontinence, nutritional status, pressure ulcers (skin care). **Probes: §483.25(k)(3)** • If appropriate, is the resident provided with self care instructions? • Does the staff member observe and respond to any signs of resident's discomfort about the ostomy or its care? • Is skin surrounding the ostomy free of excoriation (abrasion, breakdown)? • If excoriation is present, does the clinical record indicate an onset and a plan of care to treat the excoriation?

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F328 cont.	**§483.25(k)(4) Tracheostomy Care**	**Procedures §483.25(k)(4) (Includes care of the tracheostomy site)** This corresponds to MDS 2.0 sections M and P when specified for use by the State. Observations for tracheostomy care are most appropriate for residents with new or relatively new tracheostomies, and may not be appropriate for those with tracheostomies of long standing. **Probes: §483.25(k)(4) (Includes care of the tracheostomy site)** • Is the skin around the tracheostomy clean and dry? Are the dressing and the ties clean and dry, with the cannula secure? • Does the resident have signs of an obstructed airway or need for suctioning (e.g., secretions draining from mouth or tracheotomy; unable to cough to clear chest; audible crackles or wheezes; dyspneic, restless or agitated)? • If appropriate for a specific resident, is there a suction machine and catheter immediately available? • Is there an extra cannula of the correct size at the bedside or other place easily accessible if needed in an emergency? For sampled residents receiving one or more of these services within 7 days of the survey: • Is suction machine available for immediate use, clean, working, and available to a source of emergency power? • Is there an adequate supply of easily accessible suction catheters?

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F360	**§483.35 Dietary Services** The facility must provide each resident with a nourishing, palatable, well balanced diet that meets the daily nutritional and special dietary needs of each resident.	
F361	**§483.35(a) Staffing** The facility must employ a qualified dietitian either full time, part time, or on a consultant basis. **§483.35(a)(1)** If a qualified dietitian is not employed full time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. **§483.35(a)(2)** A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic	**Intent §483.35(a)** The intent of this regulation is to ensure that a qualified dietitian is utilized in planning, managing and implementing dietary service activities in order to assure that the residents receive adequate nutrition. A director of food services has no required minimum qualifications, but must be able to function collaboratively with a qualified dietitian in meeting the nutritional needs of the residents. **Interpretive Guidelines §483.35(a)** A dietitian qualified on the basis of education, training, or experience in identification of dietary needs, planning and implementation of dietary programs has experience or training which includes: • Assessing special nutritional needs of geriatric and physically impaired persons; • Developing therapeutic diets • Developing "regular diets" to meet the specialized needs of geriatric and physically impaired persons;

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F361 cont.	Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	• Developing and implementing continuing education programs for dietary services and nursing personnel; • Participating in interdisciplinary care planning; • Budgeting and purchasing food and supplies; and • Supervising institutional food preparation, service and storage. **Procedures §483.35(a)** If resident reviews determine that residents have nutritional problems, determine if these nutritional problems relate to inadequate or inappropriate diet nutrition/assessment and monitoring. Determine if these are related to dietitian qualifications. **Probes: §483.35(a)** If the survey team finds problems in resident nutritional status: • Do practices of the dietitian or food services director contribute to the identified problems in residents' nutritional status? If yes, what are they? • What are the educational, training, and experience qualifications of the facility's dietitian?

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F362	**§483.35 (b) Standard Sufficient Staff** The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	**Interpretive Guidelines §483.35(b)** "Sufficient support personnel" is defined as enough staff to prepare and serve palatable, attractive, nutritionally adequate meals at proper temperatures and appropriate times and support proper sanitary techniques being utilized. **Procedures §483.35(b)** For residents who have been triggered for a dining review, do they report that meals are palatable, attractive, served at the proper temperatures and at appropriate times? **Probes: §483.35(b)** Sufficient staff preparation: • Is food prepared in scheduled timeframes in accordance with established professional practices? Observe food service: • Does food leave kitchen in scheduled timeframes? Is food served to residents in scheduled timeframes?
F363 (Rev. 5, 11-19-04)	**§483.35(c) Standard Menus and Nutritional Adequacy**	**Intent §483.35(c)(1)(2)(3)** The intent of this regulation is to assure that the meals served meet the nutritional needs of the resident in accordance with the recommended dietary allowances (RDAs) of the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences. This regulation also assures that there is a prepared menu by which nutritionally adequate meals have been planned for the resident and followed.

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F363 cont.	**§483.35(c)(1)** Menus must: (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;	**Procedures §483.35(c)(1)** For sampled residents who have a comprehensive review or a focused review, as appropriate, observe if meals served are consistent with the planned menu and care plan in the amounts, types and consistency of foods served. If the survey team observes deviation from the planned menu, review appropriate documentation from diet card, record review, and interviews with food service manager or dietitian to support reason(s) for deviation from the written menu. **Probes: §483.35(c)(1)** Are residents receiving food in the amount, type, consistency and frequency to maintain normal body weight and acceptable nutritional values? If food intake appears inadequate based on meal observations, or resident's nutritional status is poor based on resident review, determine if menus have been adjusted to meet the caloric and nutrient intake needs of each resident. If a food group is missing from the resident's daily diet, does the facility have an alternative means of satisfying the resident's nutrient needs? If so, does the facility perform a follow-up? Menu adequately provides the daily basic food groups: • Does the menu meet basic nutritional needs by providing daily food in the groups of the food pyramid system and based on individual nutritional assessment taking into account current nutritional recommendations? NOTE: A standard meal planning guide (e.g., food pyramid) is used primarily for menu planning and food purchasing. It is not intended to meet the nutritional needs of all residents. This

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F363 cont.		guide must be adjusted to consider individual differences. Some residents will need more due to age, size, gender, physical activity, and state of health. There are many meal planning guides from reputable sources, i.e., American Diabetes Association, American Dietetic Association, American Medical Association, or U.S. Department of Agriculture, that are available and appropriate for use when adjusted to meet each resident's needs.
	§483.35(c)(2) and (3) Menus and Nutritional Adequacy	
	§483.35(c)(2) Be prepared in advance; and	**Probes: §483.35(c)(2)** Menu prepared in advance: Are there preplanned menus for both regular and therapeutic diets?
	§483.35(c)(3) Be followed.	**Probes: §483.35(c)(3)** Menu followed: • Is food served as planned? If not, why? There may be legitimate and extenuating circumstances why food may not be available on the day of the survey and must be considered before a concern is noted.
F364	**§483.35(d) Food** Each resident receives and the facility provides:	**Intent §483.35(d)(1)(2)** The intent of this regulation is to assure that the nutritive value of food is not compromised and destroyed because of prolonged food storage, light, and air exposure; prolonged cooking of foods in a large volume of water and prolong holding on steam table, and the addition of baking soda.

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F364 cont.	(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature;	Food should be palatable, attractive, and at the proper temperature as determined by the type of food to ensure resident's satisfaction. Refer to §483.15(e) and/or §483.15(a). **Interpretive Guidelines §483.35(d)(1)** "Food-palatability" refers to the taste and/or flavor of the food. "Food attractiveness" refers to the appearance of the food when served to residents. **Procedures §483.35(d)(1)** Evidence for palatability and attractiveness of food, from day to day and meal to meal, may be strengthened through sources such as: additional observation, resident and staff interviews, and review of resident council minutes. Review nutritional adequacy in §483.25(i)(l). **Probes: §483.35(d)(1)(2)** Does food have a distinctly appetizing aroma and appearance, which is varied in color and texture? Is food generally well seasoned (use of spices, herbs, etc.) and acceptable to residents? Conserves nutritive value: • Is food prepared in a way to preserve vitamins? Method of storage and preparation should cause minimum loss of nutrients. Food temperature: • Is food served at preferable temperature (hot foods are served hot and cold foods are served cold) as discerned by the resident and customary practice? Not to be confused with the proper holding temperature.

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F365	**§483.35(d)(3)** Food prepared in a form designed to meet individual needs; and	
F366	**§483.35(d)(4)** Substitutes offered of similar nutritive value to residents who refuse food served.	**Procedures §483.35(d)(3)(4)** Observe trays to assure that food is appropriate to resident according to assessment and care plan. Ask the resident how well the food meets their taste needs. Ask if the resident is offered or is given the opportunity to receive substitutes when refusing food on the original menu. **Probes: §483.35(d)(3)(4)** Is food cut, chopped, or ground for individual resident's needs? Are residents who refuse food offered substitutes of similar nutritive value? **Interpretive Guidelines §483.35(d)(4)** A food substitute should be consistent with the usual and ordinary food items provided by the facility. For example, if a facility never serves smoked salmon, they would not be required to serve this as a food substitute; or the facility may, instead of grapefruit juice, substitute another citrus juice or vitamin C rich juice that the resident likes.

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F367	(Rev. 19, Issued: 06-01-06, Effective/Implementation: 06-01-06) **§483.35(e) Therapeutic Diets** Therapeutic diets must be prescribed by the attending physician.	**Intent §483.35(e)** The intent of this regulation is to assure that the resident receives and consumes foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the treatment and plan of care. **Interpretive Guidelines §483.35(e)** "Therapeutic Diet" is defined as a diet ordered by a physician as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). "Mechanically altered diet" is one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' order. **Procedures §483.35(e)** If the resident has inadequate nutrition or nutritional deficits that manifests into and/or are a product of weight loss or other medical problems, determine if there is a therapeutic diet that is medically prescribed. **Probes: §483.35(e)** Is the therapeutic diet that the resident receives prescribed by the physician? Also, see §483.25(i), Nutritional Status.

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F368	**§483.35(f) Frequency of Meals** (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. (2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below. (3) The facility must offer snacks at bedtime daily. (4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	**Intent §483.35(f)(1-4)** The intent of this regulation is to assure that the resident receives his/her meals at times most accepted by the community and that there are not extensive time lapses between meals. This assures that the resident receives adequate and frequent meals. **Interpretive Guidelines §483.35(f)(1-4)** A "substantial evening meal" is defined as an offering of three or more menu items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements. "Nourishing snack" is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the "nourishing snack" will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility, (e.g., Is the offered snack usually satisfying?) **Procedures §483.35(f)(1-4)** Observe meal times and schedules and determine if there is a lapse in time between meals. Ask for resident input on meal service schedules, to verify if there are extensive lapses in time between meals

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F369	**§483.35(g) Assistive Devices** The facility must provide special eating equipment and utensils for residents who need them.	**Intent §483.35(g)** The intent of this regulation is to provide residents with assistive devices to maintain or improve their ability to eat independently. For example, improving poor grasp by enlarging silverware handles with foam padding, aiding residents with impaired coordination or tremor by installing plate guards, or providing postural supports for head, trunk, and arms. **Procedures §483.35(g)** Review sampled residents comprehensive assessment for eating ability. Determine if recommendations were made for adaptive utensils and if they were, determine if these utensils are available and utilized by resident. If recommended but not used, determine if this is by resident's choice. If utensils are not being utilized, determine when these were recommended and how their use is being monitored by the facility and if the staff is developing alternative recommendations
	(Rev. 19, Issued: 06-01-06, Effective/Implementation: 06-01-06) **§483.35(h) Paid feeding assistants—** **(1) State-approved training course.** A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if—	Guidance expected in 2007.

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	(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. **(2) Supervision.** (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. **(3) Resident selection criteria.** (i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.	

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	(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. **§483.35(q) Required training of feeding assistants.** A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160 of this part.	

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	(Rev. 19, Issued: 06-01-06, Effective/Implementation: 06-01-06) **§483.35(i) Sanitary Conditions** The facility must—	
F370	**(Rev. 19, Issued: 06-01-06, Effective/Implementation: 06-01-06)** **§483.35(i)(1)** Procure food from sources approved or considered satisfactory by Federal, State or local authorities;	
F371	**(Rev. 19, Issued: 06-01-06, Effective/Implementation: 06-01-06)** **§483.35(i)(2)** Store, prepare, distribute, and serve food under sanitary conditions; and	**Intent §483.35(i)(2)** The intent of this regulation is to prevent the spread of food borne illness and reduce those practices which result in food contamination and compromised food safety in nursing homes. Since foodborne illness is often fatal to nursing home residents, it can and must be avoided. **Interpretive Guidelines §483.35(i)(2)** "Sanitary conditions" is defined as storing, preparing, distributing, and serving food properly to prevent food borne illness. Potentially hazardous foods must be subject to continuous time/temperature controls in order to prevent either the rapid and progressive growth of infectious or toxigenic micro-organisms such as Salmonella or the slower growth of Clostridium Botulinum. In addition, foods of plant origin become potentially hazardous when the skin, husk, peel, or rind is breached, thereby possibly contaminating the fruit or vegetable with disease causing micro-organisms. Potentially hazardous food tends to focus on animal products, including but not limited to milk, eggs and poultry.

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F371 cont.		Improper holding temperature is a common contributing factor of foodborne illness. The facility must follow proper procedures in cooking, cooling, and storing food according to time, temperatures, and sanitary guidelines. Improper handling of food can cause salmonella and E-Coli contamination. The 1993 FDA Food Code advises the following precautions: NOTE: The 1993 FDA Food Code is not regulation and cannot be enforced as such. The food temperatures cited that are recommended in the 1993 FDA Food Code are target temperatures and give a margin of safety in temperature ranges and to avoid known harmful temperatures. Refrigerator storage of food to prevent food borne illness includes storing raw meat away from vegetables and other foods. Raw meat should be separated from cooked foods and other foods when refrigerated on its own tray on a bottom shelf so meat juices do not drip on other foods. Foods of both plant and animal origin must be cooked, maintained and stored at appropriate temperatures. • Foods of both plant and animal origin must be cooked, and maintained, and stored at appropriate temperatures. These temperatures are better utilized as food hold temperatures rather than the food temperatures as residents receive the food. • Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140° F, and cold foods at or below 41° F and freezer temperatures should be at 0° F or below. Refrigerator temperatures should be maintained at 41° F or below. The 1993 FDA Food Code can be used as an authoritative guide to clarify regulatory requirements on how to prepare and serve food to prevent foodborne illness. As the public becomes more informed and educated on how to prevent foodborne illness, this code will become the standard of practice the same as the 1976 Food Service Sanitation Manual did prior to 1993. **Procedures §483.35(i)(2)** Observe storage, cooling, and cooking of food. Record the time and date of all observations. If a problem is noted, conduct additional observations to verify findings.

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F371 cont.		Observe that employees are effectively cleaning their hands prior to preparing, serving and distributing food. Observe that food is covered to maintain temperature and protect from other contaminants when transporting meals to residents. Refrigerated storage: • Check all refrigerators and freezers for temperatures. Use the facility's or the surveyor's own properly sanitized thermometer to evaluate the internal temperatures of potentially hazardous foods with a focus on the quantity of leftovers and the container sizes in which bulk leftovers are stored. Food preparation: • Use a sanitized thermometer to evaluate food temperatures. In addition, how do kitchen staff process leftovers? • Are they heated to the appropriate temperatures? • How is frozen food thawed? • How is potentially hazardous food handled during multi-step food preparation (e.g., chicken salad, egg salad)? • Is hand contact with food minimized? Food service: • Using a properly sanitized thermometer, check the temperatures of hot and cold food prior to serving. • How long is milk held without refrigeration prior to distribution?

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F371 cont.		Food distribution: • Is the food protected from contamination as it is transported to the dining rooms and residents' rooms? Pest free: • Is the area pest free? (See §483.70(h)(4).) Look for signs of pests such as mice, roaches, rats, flies. Preventing Contamination: • Are handwashing facilities convenient and properly equipped for dietary services staff Use? (Staff uses good hygienic practices and staff with communicable disease or infected skin lesions do not have contact with food if that contact will transmit the disease.) Hazard Free: • Are toxic items (such as insecticides, detergent, polishes) properly stored, labeled, and used separate from the food? **Probes: §483.35(i)(2)** Observe food storage rooms and food storage in the kitchen. • Are containers of food stored off the floor and on clean surfaces in a manner that protects it from contamination? • Are other areas under storage shelves monitored for cleanliness to reduce attraction of pest. • Are potentially hazardous foods stored at 41° F or below and frozen foods kept at 0° F or below? • Do staff handle and cook potentially hazardous foods properly?

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F371 cont.		• Are potentially hazardous foods kept at an internal temperature of 41° F or below in cold food storage unit, or at an internal temperature of 140° F or above in a hot food storage unit during display and service? • Is food transported in a way that protects against contamination (i.e., covered containers, wrapped, or packaged)? • Is there any sign of rodent or insect infestation. Dishwashing: • The current 1993 Food Code, DHHS, FDA, PHS recommends the following water temperature and manual washing instructions: Machine: 1. Hot Water: a. 140° F Wash (or according to the manufacturer's specifications or instructions). b. 180° F Rinse (180°, 160° or greater at the rack and dish/utensils surfaces). 2. Low Temperature: a. 120° F +25 ppm (parts per million) Hypochlorite (household bleach) on dish Surface. Manual: 1. 3 Compartment Sink (wash, rinse and sanitize): Sanitizing solution used according to manufacturer's instructions. a. 75 degrees F - 50 ppm Hypochlorite (household bleach) or equivalent, or 12.5 ppm of Iodine. b. Hot Water Immersion at 170? F for at least 30 seconds. Are food preparation equipment, dishes, and utensils effectively sanitized and cleaned to destroy potential disease carrying organisms and stored in a protected manner?

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F372	(Rev. 19, Issued: 06-01-06, Effective/Implementation: 06-01-06) **§483.35(i)(3)** Dispose of Garbage and Refuse Properly.	**Interpretive Guidelines §483.35(i)(3)** The intent of this regulation is to assure that garbage and refuse be properly disposed of. **Procedures §483.35(i)(3)** Garbage/refuse: Observe garbage and refuse container construction and outside storage receptacles. **Probes: §483.35(i)(3)** Are garbage and refuse containers in good condition (no leaks), and is waste properly contained in dumpsters or compactors with lids or otherwise covered? Are areas such as loading docks, hallways, and elevators used for both garbage disposal and clean food transport kept clean, free of debris and free of foul odors and waste fat? Is the garbage storage area maintained in a sanitary condition to prevent the harborage and feeding of pests? Are garbage receptacles covered when being removed from the kitchen area to the dumpster?

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F464	**§483.70(g) Dining and Resident Activities** The facility must provide one or more rooms designated for resident dining and activities. These rooms must— **§483.70(g)(1)** Be well lighted; **§483.70(g)(2)** Be well ventilated, with nonsmoking areas identified;	(Rev. 12, Issued: 10-14-05, Effective: 10-14-05, Implementation: 10-14-05) **Interpretive Guidelines §483.70(g)(1)** "Well lighted" is defined as levels of illumination that are suitable to tasks performed by a resident. **Probes: §483.70(g)(1)** Are there adequate and comfortable lighting levels? Are illumination levels appropriate to tasks with little glare? Does lighting support maintenance of independent functioning and task performance? **Interpretive Guidelines §483.70(g)(2)** "Well ventilated" is defined as good air circulation, avoidance of drafts at floor level, and adequate smoke exhaust removal. "Nonsmoking areas identified" is defined as signs posted in accordance with State law regulating indoor smoking policy and facility policy. **Probes: §483.70(g)(2)** How well is the space ventilated? Is there good air movement? Are temperature, humidity, and odor levels all acceptable? Are non-smoking areas identified?

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F464 cont.	**§483.70(g)(3)** Be adequately furnished; and **§483.70(g)(4)** Have sufficient space to accommodate all activities.	**Interpretive Guidelines §483.70(g)(3)** An "adequately furnished" dining area accommodates different residents' physical and social needs. An adequately furnished organized activities area accommodates the specific activities offered by the facility. **Probes: §483.70(g)(3)** How adequate are furnishings? Are furnishings structurally sound and functional (e.g., chairs of varying sizes to meet varying needs of residents, wheelchairs can fit under the dining room table)? **Interpretive Guidelines §483.70(g)(4)** "Sufficient space to accommodate all activities" means that the space available is adaptable to a variety of uses and residents' needs. **Probes: §483.70(g)(4)** How sufficient is space in dining, health services, recreation and program areas to accommodate all activities? Are spaces adaptable for all intended uses? Is resident access to space limited? Do residents and staff have maximum flexibility in arranging furniture to accommodate residents who use walkers, wheelchairs, and other mobility aids? Is there resident crowding?