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Putting the Pieces Together: Minimum Data Set (MDS) Compliance, PDPM, Quality, and CMS Phase III Requirements Related to Nutrition Webinar

Course Description:

October 1, 2019 was the effective date for the Patient-Driven Payment Model (PDPM) and new guidelines for the Minimum Data Set (MDS). November 28th, 2019 is the scheduled date for Phase III Requirements of Participation to become effective. This webinar will address the current status of these key impact areas related to food, nutrition and dining to assist providers in "putting all of the pieces together" for overall success with program implementation and compliance.

Course Objectives:

After completing this continuing education course, the learner should be able to:

1. Identify key components for sustainable success with key CMS initiatives related to Food, Nutrition and Dining.
2. Present current updates to PDPM, Minimum Data Set (MDS) and Requirements of Participation related to nutrition.
3. Discuss resources and critical collaborative steps for successful outcomes.

Speaker: Brenda Richardson, MA, RDN, LD, FAND

Disclosures: No conflict of interest exists for this webinar.

Professional Approvals:

Becky Dorner & Associates, Inc. has been a Continuing Professional Education (CPE) Accredited Provider (NU004) with the Commission on Dietetic Registration since 2002.

This course is intended for: RDNs, CDEs, NDTRs, CDMs	**CDR Activity Type and Number:** 175 Recorded webinar: 152336 Activity number:
Course CPE Hours: 1.5	**CDR Level:** 2
Suggested CDR Learning Needs Codes: 1070, 7100, 7160, 7170	**Suggested CDR Performance Indicators:** 4.2.1, 6.1.7, 14.1.4, 14.2.7

Note: Numerous Other Learning Needs Codes and Performance Indicators May Apply.

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How to Complete a CPE Course: https://www.beckydorner.com/continuing-education/how-to-complete-cpe/

Expiration Date: **November 19, 2022**

Questions? Please contact us at info@beckydorner.com or 1-800-342-0285.

Putting the Pieces Together:

CMS Phase III Requirements: Minimum Data Set (MDS), PDPM and Quality

11/20/2019

Presenter: Brenda Richardson, MA, RDN, LD, CD, FAND

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Objectives:

- Identify key components for sustainable success with key CMS initiatives related to Food, Nutrition and Dining.
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Sustainable Success Requires Bringing the "*LTC Cloud*" Down to A Management Level

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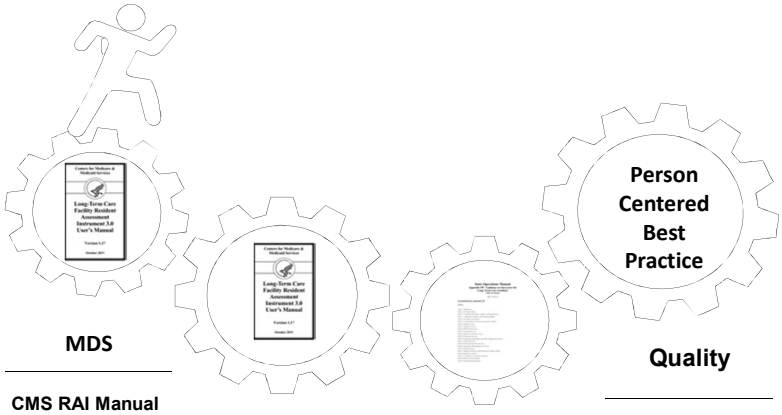
Facility Teamwork Strategy, Processes and Resources



MDS

CMS RAI Manual

PDPM

CMS MDS
RAI Manual
ICD-10

Phase III Requirements

CMS Appendix PP

Quality

Best Practice
Quality Measures
QAPI

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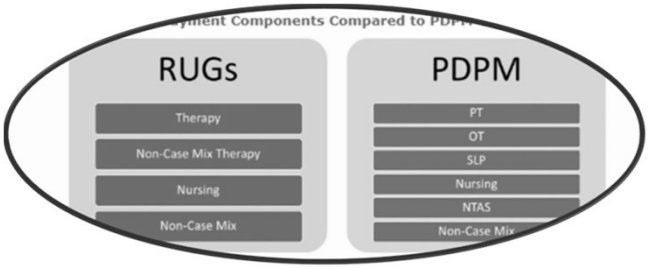
PDPM and MDS



PDPM establishes a per diem rate on the 5-day MDS for the entire stay by combining 5 different case-mix components (PT, OT, SLP, nursing, and non-therapy ancillary) with the non-case-mix component.

The rate may be changed during the Medicare Part A stay by completing the interim payment assessment (IPA) for substantial changes.

Source: AHCA PDPM Resource Center

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PDPM Component and Patient Characteristics

Figure 2. PDPM Component and Patient Characteristics Used for Case-Mix Group (CMG) Assignment

Component	Patient Characteristics	Per Diem Structure	# of Case Mix Groups
PT	- Primary reason for SNF Care ICD-10 - Functional Status – MDS Section GG Early and Late Loss	Payment Decreases After Day 20	16
OT	- Primary reason for SNF Care ICD-10 - Functional Status – MDS Section GG Early and Late Loss	Payment Decreases After Day 20	16
SLP	- Primary Reason for SNF care ICD-10 - Cognitive Status - Presence of swallowing disorder or mechanically altered diet - Other SLP related comorbidities	Average Daily Payment No Variable Payment	12
Nursing	- Clinical information from SNF Stay - Functional Status – MDS Section GG Early and Late Loss - Extensive Services Received - Presence of depression - Restorative nursing services received	Average Daily Payment No Variable Payment	25
NTAS	- Comorbidities present - Extensive services used	Payment Decreases After Day 3	6

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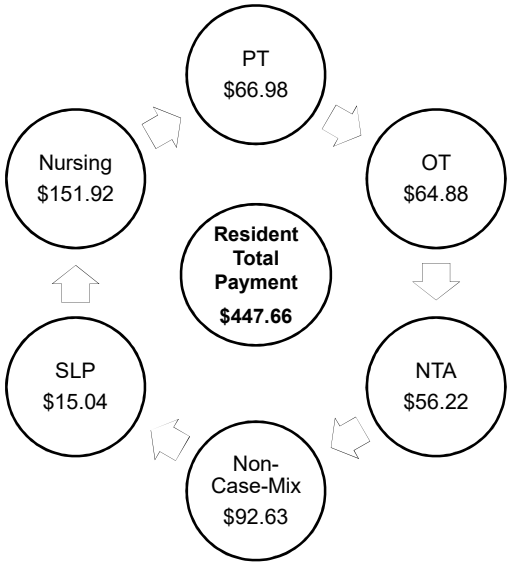
CALCULATION EXAMPLE



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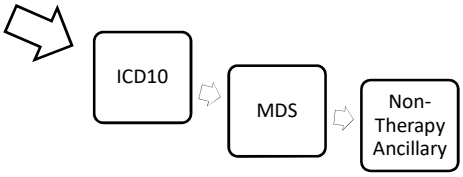
Payment Determinants

CMS will require therapy minute reporting on the Discharge MDS, however therapy minutes and related thresholds no longer drive payment.

Patients are assigned to a Case Mix Group for each component using clinical information entered in the SNF PPS Admission MDS which differs by component.

The only clinical information on the claim that impacts PDPM payments will be related to residents with HIV/AIDS.

International Classification of Diseases – Clinical Modification	**ICD-CM**	Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-CM contains a numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries, and a classification system for surgical, diagnostic, and therapeutic procedures.



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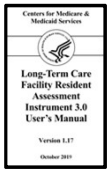
CMS RAI Version 1.17 October 2019



CMS's RAI Version 3.0 Manual — CH 2: Assessments for the RAI

PPS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

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https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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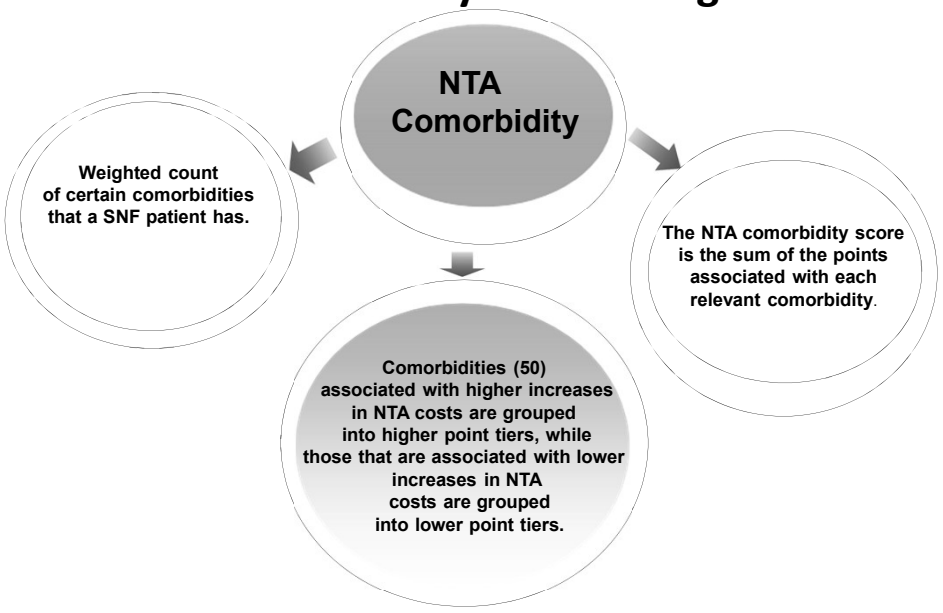
NTA Comorbidity and Scoring Score



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PDPM Payment Component: NTA: Key Nutrition Focus

Total of 50 NTA Conditions

Condition/Extensive Service	MDS Item	Points
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Parenteral IV Feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Morbid Obesity	I8000	1
Nutritional Approaches While A Resident: Feeding Tube	K0510B2	1
Active Diagnoses: Malnutrition Code	I5600	1

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Non-Therapy Ancillary (NTA) Component: Parenteral/IV Feeding

2. Determine whether the resident meets the criteria for the comorbidity: "Parenteral/IV Feeding – High Intensity" or the comorbidity: "Parenteral/IV Feeding – Low Intensity." To do so, first determine if the resident received parenteral/IV feeding during the last 7 days while a resident of the SNF using item K0510A2. If the resident did not receive parenteral/IV feeding during the last 7 days while a resident, then the resident does not meet the criteria for Parenteral/IV Feeding – High Intensity or Parenteral/IV Feeding – Low Intensity.

   If the resident did receive parenteral/IV feeding during the last 7 days while a resident, then use item K0710A to determine if the proportion of total calories the resident received through parenteral or tube feeding was 51% or more while a resident (K0710A2 = 3). If K0710A2 = 3, then the resident meets the criteria for Parenteral/IV Feeding – High Intensity. If the proportion of total calories the resident received through parenteral or tube feeding was 26-50% (K0710A2 = 2) and average fluid intake per day by IV or tube feeding was 501 cc per day or more while a resident (K0710B2 = 2), then the resident qualifies for Parenteral/IV Feeding – Low Intensity.

   Presence of Parenteral/IV Feeding – High Intensity? (Yes/No) _____

   Presence of Parenteral/IV Feeding – Low Intensity? (Yes/No) _____

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CMS RAI Section I: Active Diagnoses in Last 7 days

CMS's RAI Version 3.0 Manual CH 3: MDS Items [I]

I: Active Diagnoses in the Last 7 Days (cont.)

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- I4900. Hemiplegia or Hemiparesis
- I5000. Paraplegia
- I5100. Quadriplegia
- I5200. Multiple Sclerosis (MS)
- I5250. Huntington's Disease
- I5300. Parkinson's Disease
- I5350. Tourette's Syndrome
- I5400. Seizure Disorder or Epilepsy
- I5500. Traumatic Brain Injury (TBI)

Nutritional

- I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. Morbid Obesity

B.

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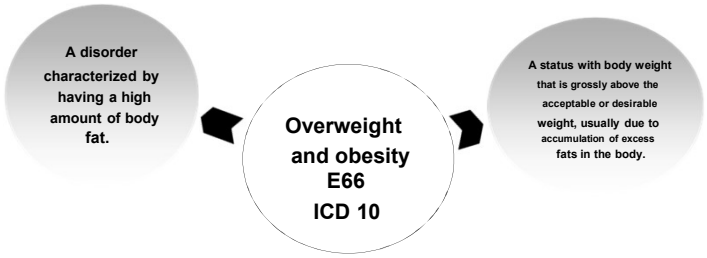
ICD 10 E66 Overweight and Obesity: The standards may vary with age, sex, genetic or cultural background. A BMI greater than 30.0 kg/m2 is considered obese, and

BMI greater than ≥40.0 kg/m2 is considered morbidly obese (morbid obesity).



https://www.icd10data.com/ICD10CM/Codes

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ICD 10 E66: BMI greater than ≥40.0 kg/m2 is considered morbidly obese (morbid obesity).

What about using a BMI >35 for Morbid Obesity with PDPM?

Related to **obesity treatment options**: **Not in ICD10 coding**

*Typical definition of morbid obesity is an adult with a BMI over 40, or a **BMI over 35 if they have a related health condition.***
These health conditions, known as comorbidities, add to the difficulties of living with of obesity. They can include high blood pressure, sleep apnea, high cholesterol, GERD, Type 2 diabetes, and osteoarthritis.

https://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf
http://www.americanobesity.org/morbidObesity.htm

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Overweight and obesity E66 ICD 10 Codes

- E66 Overweight and obesity
- E66.0 Obesity due to excess calories
- **E66.01 Morbid (severe) obesity due to excess calories**
- E66.09 Other obesity due to excess calories
- E66.1 Drug-induced obesity
- **E66.2 Morbid (severe) obesity with alveolar hypoventilation**
- E66.3 Overweight
- E66.8 Other obesity
- E66.9 Obesity, unspecified

Source: (https://www.icd10data.com/ICD10CM/Codes)

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Malnutrition E40-E46 ICD 10 Codes

- E40 Kwashiorkor
- E41 Nutritional marasmus
- E42 Marasmic kwashiorkor
- **E43 Unspecified severe protein-calorie malnutrition**
- **E44 Protein-calorie malnutrition of moderate and mild degree**
- E45 Retarded development following protein-calorie malnutrition
- **E46 Unspecified protein-calorie malnutrition**

https://www.icd10data.com/ICD10CM/Codes

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QUESTIONS PDPM and NTA Nutrition Areas Topics

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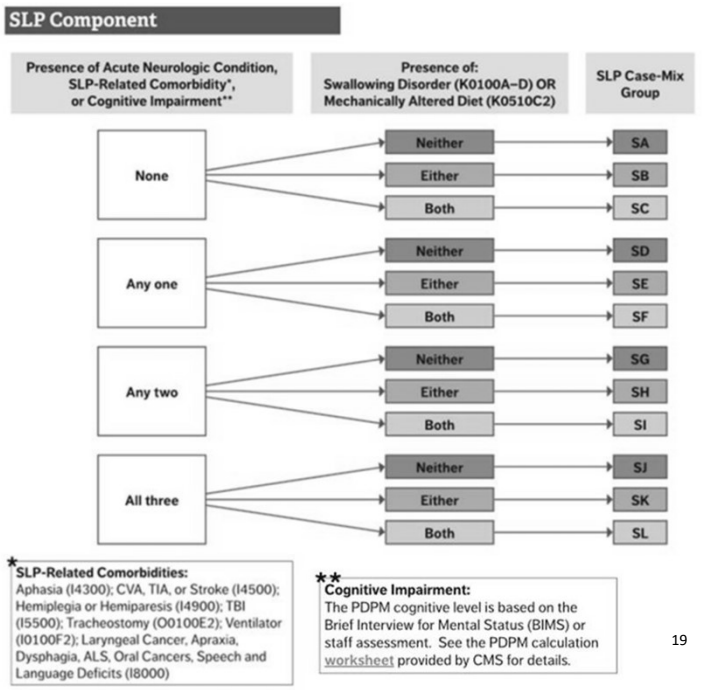
PDPM SLP Component:

Swallowing Disorder/ Mechanically Altered Diet



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CMS PDPM Calculation Worksheet for SNFs Chapter 6 RAI Manual

1. Calculation of PDPM Cognitive Level
   - Brief Interview for Mental Status (BIMS)-MDS
   - Staff Assessment
2. Calculation Payment Component: PT
   - PT Clinical Score
   - PT Function Score
   - Overall PT Classification
3. Calculation Payment Component: OT
   - OT Clinical Category
   - OT Function Score
   - Overall OT Classification

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PDPM Payment Component: SLP: Swallowing Disorder – Mechanically Altered Diet

STEP #7

Determine whether the resident has a mechanically altered diet. If K0510C2 (mechanically altered diet while a resident) is checked, then the resident has a mechanically altered diet.

Presence of Mechanically Altered Diet? (Yes/No) _____

STEP #8

Determine how many of the following conditions are present based on Steps 6 and 7:

a. The resident has neither a swallowing disorder nor a mechanically altered diet.

b. The resident has either a swallowing disorder or a mechanically altered diet.

c. The resident has both a swallowing disorder and a mechanically altered diet.

Presence of Mechanically Altered Diet or Swallowing Disorder? (Neither/Either/Both): _____

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PDPM Payment Component: SLP continued

STEP #9

Determine the resident's SLP group using the responses from Steps 1-8 and the table below.

Table 15: SLP Case-Mix Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group
None	Neither	SA
None	Either	SB
None	Both	SC
Any one	Neither	SD
Any one	Either	SE
Any one	Both	SF
Any two	Neither	SG
Any two	Either	SH
Any two	Both	SI
All three	Neither	SJ
All three	Either	SK
All three	Both	SL

PDPM SLP Classification: _____

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Total of 50 NTA Conditions

5. PDPM Payment Component: NTA: Key Nutrition Focus

Condition/Extensive Service	MDS Item	Points
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Parenteral IV Feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Morbid Obesity	I8000	1
Nutritional Approaches While A Resident: Feeding Tube	K0510B2	1
Active Diagnoses: Malnutrition Code	I5600	1

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5. PDPM Payment Component: NTA (continued)

CMS's RAI Version 3.0 Manual — CH 6: Medicare SNF PPS

STEP #3

Determine the resident's NTA group using the table below.

Table 17: NTA Case-Mix Groups

NTA Score Range	NTA Case-Mix Group
12+	NA
9-11	NB
6-8	NC
3-5	ND
1-2	NE
0	NF

PDPM NTA Classification: _____

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6. PDPM Payment Component: Nursing

7. Calculation of Variable Per Diem Payment

Days in Stay	NTA Adjustment Factors
1-3	3.00
4-100	1.00

Adjustment Factor for the NTA

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NTA Score Example of Potential Revenue Impact: Malnutrition

NTA Payment Structure & Rates

Non Therapy Ancillary Component				
NTA Score	NTA Group	NTA CMI	Days 1-3	Days 4-100
0	NF	0.72	$ 168.59	$ 56.20
1-2	NE	0.96	$ 224.78	$ 74.93
3-5	ND	1.34	$ 313.76	$ 104.59
6-8	NC	1.85	$ 433.18	$ 144.39
9-11	NB	2.53	$ 592.40	$ 197.47
12+	NA	3.25	$ 760.99	$ 253.66

Day in Stay	NTA Adjustment Factor
1-3	3.00
4-100	1.00

Unadjusted Urban Base Rates

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Keys to Prevention & Management of Malnutrition with PDPM

Identify your residents (Acuity) and nutrition services using your Facility Assessment

Have Adequate staff with Skills and Competencies

- Hours for staff/consultants
- RDNs/NDTRs/Food and Nutrition Services
- Department (Staff and Consultants)

Remember Scope of Practice

Academy of Nutrition and Dietetics (Academy) for RDNs/NDTRs

Association of Nutrition and Foodservice Professionals (ANFP) for CDMs

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Looking Ahead "Big Picture"

Unified Prospective Payment System for Post-Acute Care

- Congress mandated MedPAC develop a prototype design and estimate the impacts of a unified PAC PPS.
- MedPAC says:
  - Feasible to design a PAC PPS that spans the four settings
  - Uniformly base payments on patient characteristic
  - Recommend to begin to phase-in for 2019
  - Significant reform on regulations must take place to level the playing field

4 PAC Settings:
- **SNF**
- **Home Health**
- **LTC Hospitals**
- **Inpatient Rehab Hospitals**

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Keys to Prevention & Management of Malnutrition with PDPM (continued)

Incorporate Best Practice:

Implement Validated Nutrition Screening for Older Adults with a Scoring Matrix for Malnutrition and "At Risk" for Malnutrition

Some potential screening tools to consider:

- Mini-nutritional Assessment Tool (MNA©)
- Malnutrition Screening Tool (MST)
- Malnutrition Universal Screening Tool (MUST)

ADVANTAGES OF VALIDATED TOOL

- More likely to correctly identify clients who truly need help.
- Less likely to miss those who need intervention.
- Reduced waste of limited resources on those who do not truly need intervention.
- Helps demonstrate effectiveness related to positive health outcomes.
- User Friendly
- Not intended for completion by a specific individual/position or type.

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Keys to Prevention & Management of Malnutrition with PDPM (continued)

- Prompt Referral and Assessment by RDN with nutrition documentation to support the medical diagnosis.

- Academy and ASPEN Consensus Statement: Characteristics for the Identification and Documentation of Adult Malnutrition.

- **Global Leadership Initiative on Malnutrition (GLIM) criteria for the diagnosis of malnutrition- (complements the Academy/ASPEN Consensus Statement) .**
- **Looking at MNA/GLIM and comparative data:**

MNA Questions	GLIM Criteria for Diagnosis of Malnutrition*
Decline in food intake	Reduced food intake or assimilation
Weight loss in last 3 months	Weight loss
Mobility	Reduced muscle mass
Psychological/acute disease stress	Disease burden/inflammation
Dementia or depression	
BMI (< 19 = 0 points)	Low BMI (<20 or <22 if > = to 70 years

Practice "Person-Centered" nutrition Interventions.

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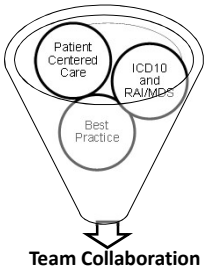
It takes a village: Identify Your Processes

- Best Practice and knowledge of RAI/Reimbursement/ICD10 coding
- Nursing/therapies
- MDS Team
- QAPI
- Health information/medical records
- Physician/physician extenders
- Residents/families/poa/community
- Health systems
- Others



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Resources

CMS Patient Driven Payment Model (PDPM):

https://www.cms.gov/Medicare/Medicare-Fee-forServicePayment/SNFPPS/PDPM.html

Professional Healthcare Organizations:
AHCA, Leading Age, Academy of Nutrition and Dietetics,
State Healthcare Organizations

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QUESTIONS PDPM SLP and "Best Practice" Topics

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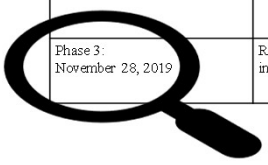
Implementation Grid

Implementation Date	Type of Change	Details of Change
Phase 1: November 28, 2016 (Implemented)	Nursing Home Requirements for Participation	New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags
Phase 2: November 28, 2017	F Tag numbering Interpretive Guidance (IG) Implement new survey process	New F Tags Updated IG Begin surveying with the new survey process
Phase 3: November 28, 2019	Requirements that need more time to implement	Requirements that need more time to implement



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Phase III Overview

- **483.12 Freedom from abuse, neglect, and exploitation:**(b)(4) Coordination w/QAPI Plan
- **483.21 Comprehensive person-centered care planning:** (b)(3)(iii) Trauma informed care
- **483.25 Quality of care:** (m) Trauma informed care
- **483.40 Behavioral health services:**(a)(1) As related to residents with a history of trauma and/or post-traumatic stress disorder
- **483.70 Administration:** (d)(3) Governing body responsibility of QAPI program
- **483.75 Quality assurance and performance improvement :** (g)(1) QAA committee the addition of the ICPO
- **483.80 Infection control** (b) Infection "preventionist" (IP) and (c) IP participation on QAA committee
- **483.85 Compliance and Ethics program**
- **483.90 Physical environment: (f)(1) Call system from each resident's bedside**

***** Proposed Revisions: Federal Register/Vol. 84, No. 138/Thursday, July 18, 2019/Proposed Rules**

- **483.60 Food and Nutrition Services (§483.60) Required qualifications for a director of food and nutrition services**

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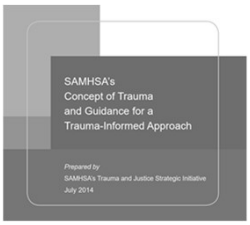
TRAUMA-INFORMED CARE
What is trauma-informed care?



- CMS does not define trauma-informed care
- Preamble indicates: Care that helps to minimize triggers and retraumatization by addressing the unique needs of the trauma survivor.
- Trauma informed care = Person-centered care + Principles set forth in SAMSHA's "Concept of Trauma and Guidance for a Trauma-Informed Approach.

- Trauma: Results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
  - *Source: Substance Abuse and Mental Health Services Administration (SAMSHA)*

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INFECTION PREVENTIONIST

INFECTIONS IN NURSING FACILITIES

- 1.6 – 3.8 million healthcare associated infections occur in nursing homes annually, leading to an estimated 150,000 hospitalizations, 388,000 deaths, and health care costs of $673 million - $2 billion.

  (Source: 81 Fed. Reg, 68688, 68808 (Oct. 4, 2016) (preamble to revised RoPs).

- Study conducted for Kaiser Health News and reported in Chicago Tribune: nationwide, 25,000 residents were transferred to acute care hospitals and died from sepsis.

(Source: Fred Schulte, Elizabeth Lucas, Kaiser Health News, Joe Mahr, Chicago Tribune, "In Illinois' understaffed nursing homes, deadly infections persist from bedsores and common injuries go untreated," Chicago Tribune (Sep. 5, 2018), at http://www.chicagotribune.com/news/watchdog/ct-met-nursing-home-sepsis-deaths-20180828-story.html.)

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REVISED REQUIREMENTS OF PARTICIPATION

Infection control, 42 CFR §483.80, addressed in all three phases

- Phase 1: infection prevention and control program, §483.80(a), (d), (e), (f) (i.e., most of the requirements were included in Phase 1 and went into effect Nov. 2016).
- Phase 2: antibiotic stewardship program, §483.80(a)(3); links to facility assessment process, §483.70(e)
- Phase 3: infection preventionist, §483.80(b); infection preventionist participates in quality assessment and assurance committee, §483.80(c).

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COMPLIANCE AND ETHICS PROGRAM

- Affordable Care Act,§6102, requires facilities to have a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care; implemented at 42 CFR §483.85.

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Infection Control (§485.80) and Food and Nutrition Services

Work with Infection Preventionist with infection control practices related to Food and Nutrition Services:

- Foodborne Illness
- Handwashing/Glove Use/Personal Hygiene
- Flow of Food: Time/Temperature
  - Purchasing/Receiving/Preparation/Cooking/Holding/Serving
  - Pest Management
  - Cleaning/Sanitizing

Reporting of Health Issues:

- Vomiting/Diarrhea/Jaundice/Sore throat with Fever/Infection wound that is open or draining (unless properly covered)
- Reporting/Restriction/Exclusion: (Norovirus, Hepatitis A, *Shigella* spp.,Shiga-toxin producing *E. Coli* (STEC), *Salmonella* Typhi, Nontyphoidal *Salmonella*)
- Refer to FDA Food Code (https://www.fda.gov/food/fda-food-code/food-code-2017)

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Phase III and Food and Nutrition Services

Be sure the foodservice department has a QAPI plan in place and is represented at the meetings. Foodservice staff involvement critical to making your QAPI plan successful.

Consider Behavioral Health Services (§483.40) as it relates to residents with a history of trauma and/or post- traumatic stress disorder.

- Identify and assess the needs of these residents as it relates to their nutritional needs and dining environments.
- Provide training to staff related to trauma-informed care (§483.25 Quality of Care).
- Develop and implement a process to assess foodservice staff competencies and skill sets as related to caring for residents with a history of trauma and/or post-traumatic stress disorder.
- Comprehensive Resident Centered Care Plans (§483.21) address needs related to trauma-informed care.

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Phase III and Food and Nutrition Services-continued

For training:

- Compliance & Ethics: RDNs/DTRs/CDM CFPP all have Code of Ethics)
- Required training topics are to be implemented for new and existing staff, contractors, and volunteers.

Know and be in compliance with Phase I and Phase II.

Be in compliance 24/7!!! Be prepared!!!

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Facility Matrix CMS-802

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MATRIX FOR PROVIDERS

CMS-802 (11/2018)

Resident Name	Resident Room Number	Date of Admission if Admitted within the Past 30 Days	Alzheimer's / Dementia	MD, ID or RC & No PASARR Level II	Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opioid (O), Hypnotic (H), Antianxiety (AA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)	Pressure Ulcer(s) (highest stage I, II, III, IV, U, S), Facility Acquired (FA)	Worsened Pressure Ulcer(s) (any stage)	Excessive Weight Loss Without Prescribed Weight Loss Program	Tube Feeding: Enteral (E) or Parenteral (P)	Dehydration	Physical Restraints	Fall (F), Fall with Injury (FI), or Fall with Major Injury (FMA)	Indwelling Catheter	Dialysis: Peritoneal (P), Hemo (H), at facility (F) or offsite (O)	Hospice	End of Life Care / Comfort Care / Palliative Care	Tracheostomy	Ventilator	Transmission-Based Precautions	Intravenous therapy	Infections (M, MI, P, TB, VH, C, UTI)	Other
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

MATRIX INSTRUCTIONS FOR PROVIDERS

The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents.

The facility completes the resident name, resident room number and columns 1–20, which are described in detail below. Blank columns are for Surveyor Use Only.

All information entered in the form should be verified by a staff member knowledgeable about the resident population. Information must be reflective of all residents as of the day of survey.

7. **Excessive Weight Loss without Prescribed Weight Loss program:** Resident(s) with an unintended (not on a prescribed weight loss program) weight loss > 5% within the past 30 days or >10% within the past 180 days. Exclude residents receiving hospice services.
8. **Tube Feeding:** Resident(s) who receive enteral (E) or parenteral (P) feedings.
9. **Dehydration:** Resident(s) identified with actual hydration concerns takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups).

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Kitchen Observation (Mandatory) CMS-20055

Kitchen Observation

Kitchen/Food Service Observation: *Complete the initial brief kitchen tour upon arrival at the facility, with observations focused on practices that might indicate potential for foodborne illness. Make additional observations throughout the survey process in order to gather all information needed. Refer to the current FDA Food Code as needed.*

Initial Brief Tour of the Kitchen: Review the first two CEs to ensure practices prevent foodborne illness.

- ☐ Potentially hazardous foods, such as beef, chicken, pork, etc., have not been left to thaw at room temperature.
- ☐ Food items in the refrigerator(s) are labeled or dated.
- ☐ Potentially hazardous foods such as uncooked meat, poultry, fish, and eggs are stored separately from other foods (e.g., meat is thawing so that juices are not dripping on other foods).
- ☐ Hand washing facilities with soap and water are separate from those used for food preparation.
- ☐ Staff are practicing appropriate hand hygiene and glove use when necessary during food preparation activities, such as between handling raw meat and other foods, to prevent cross-contamination.
- ☐ Cracked or unpasteurized eggs are not used in foods that are not fully cooked (per observation or interview).
- ☐ Food is prepared, cooked, or stored under appropriate temperatures and with safe food handling techniques.
- ☐ Staff are employing hygienic practices (e.g., not touching hair or face without hand washing) and then handling food.

1. **During the initial brief tour, are foods stored and/or prepared under sanitary conditions?** ☐ Yes ☐ **No F812**

2. **During the initial brief tour, does the facility handle, prepare, and distribute food in a manner that prevents foodborne illness to the residents?** ☐ Yes ☐ **No F812**

Follow Up Visits to the Kitchen: If staff are preparing food during the initial brief tour, proceed with observations. If not, answer the remaining items in future trips to the kitchen.

Storage Temperatures

- ☐ Refrigerator temperatures that are at or below 41 degrees Fahrenheit (°F) (check temperatures between meal service activities to allow for stable temperatures).
- ☐ Freezer temperatures maintained at a level to keep frozen food solid.
- ☐ Internal temperatures of 41°F or lower for potentially hazardous, refrigerated foods (e.g., meat, fish, milk, egg, poultry dishes) that are not within acceptable ranges:
  - What are the temperatures?
  - What foods are involved?

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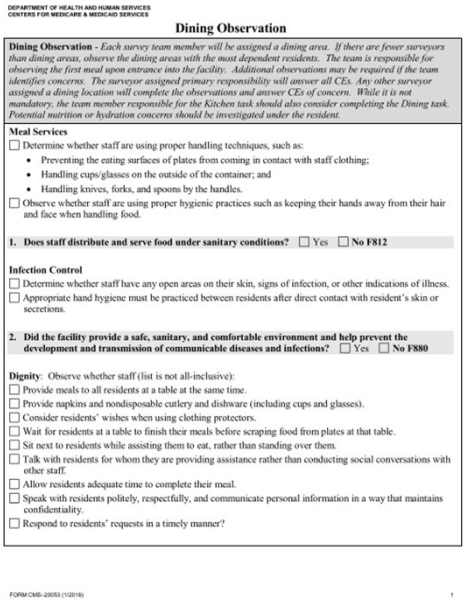
Dining Observation Mandatory CMS-20053



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Dining Observation

Dining Observation - *Each survey team member will be assigned a dining area. If there are fewer surveyors than dining areas, observe the dining areas with the most dependent residents. The team is responsible for observing the first meal upon entrance into the facility. Additional observations may be required if the team identifies concerns. The surveyor assigned primary responsibility will answer all CEs. Any other surveyor assigned a dining location will complete the observations and answer CEs of concern. While it is not mandatory, the team member responsible for the Kitchen task should also consider completing the Dining task. Potential nutrition or hydration concerns should be investigated under the resident.*

Meal Services

☐ Determine whether staff are using proper handling techniques, such as:
- Preventing the eating surfaces of plates from coming in contact with staff clothing;
- Handling cups/glasses on the outside of the container; and
- Handling knives, forks, and spoons by the handles.

☐ Observe whether staff are using proper hygienic practices such as keeping their hands away from their hair and face when handling food.

1. Does staff distribute and serve food under sanitary conditions? ☐ Yes ☐ **No F812**

Infection Control

☐ Determine whether staff have any open areas on their skin, signs of infection, or other indications of illness.
☐ Appropriate hand hygiene must be practiced between residents after direct contact with resident's skin or secretions.

2. Did the facility provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections? ☐ Yes ☐ **No F880**

Dignity: Observe whether staff (list is not all-inclusive):
☐ Provide meals to all residents at a table at the same time.
☐ Provide napkins and nondisposable cutlery and dishware (including cups and glasses).
☐ Consider residents' wishes when using clothing protectors.
☐ Wait for residents at a table to finish their meals before scraping food from plates at that table.
☐ Sit next to residents while assisting them to eat, rather than standing over them.
☐ Talk with residents for whom they are providing assistance rather than conducting social conversations with other staff.
☐ Allow residents adequate time to complete their meal.
☐ Speak with residents politely, respectfully, and communicate personal information in a way that maintains confidentiality.
☐ Respond to residents' requests in a timely manner?

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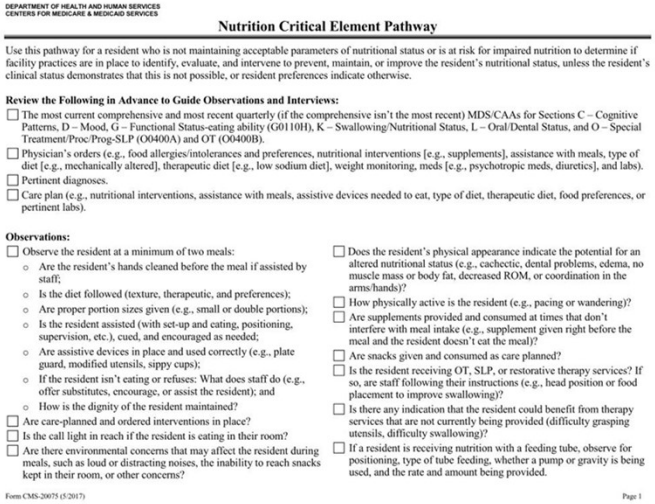
Nutrition Form CMS-20075



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Nutrition Critical Element Pathway

Use this pathway for a resident who is not maintaining acceptable parameters of nutritional status or is at risk for impaired nutrition to determine if facility practices are in place to identify, evaluate, and intervene to prevent, maintain, or improve the resident's nutritional status, unless the resident's clinical status demonstrates that this is not possible, or resident preferences indicate otherwise.

Review the Following in Advance to Guide Observations and Interviews:

☐ The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C – Cognitive Patterns, D – Mood, G – Functional Status-eating ability (G0110H), K – Swallowing/Nutritional Status, L – Oral/Dental Status, and O – Special Treatment/Proc/Prog-SLP (O0400A) and OT (O0400B).
☐ Physician's orders (e.g., food allergies/intolerances and preferences, nutritional interventions [e.g., supplements], assistance with meals, type of diet [e.g., mechanically altered], therapeutic diet [e.g., low sodium diet], weight monitoring, meds [e.g., psychotropic meds, diuretics], and labs).
☐ Pertinent diagnoses.
☐ Care plan (e.g., nutritional interventions, assistance with meals, assistive devices needed to eat, type of diet, therapeutic diet, food preferences, or pertinent labs).

Observations:

☐ Observe the resident at a minimum of two meals:
- Are the resident's hands cleaned before the meal if assisted by staff;
- Is the diet followed (texture, therapeutic, and preferences);
- Are proper portion sizes given (e.g., small or double portions);
- Is the resident assisted (with set-up and eating, positioning, supervision, etc.), cued, and encouraged as needed;
- Are assistive devices in place and used correctly (e.g., plate guard, modified utensils, sippy cups);
- If the resident isn't eating or refuses: What does staff do (e.g., offer substitutes, encourage, or assist the resident); and
- How is the dignity of the resident maintained?

☐ Are care-planned and ordered interventions in place?
☐ Is the call light in reach if the resident is eating in their room?
☐ Are there environmental concerns that may affect the resident during meals, such as loud or distracting noises, the inability to reach snacks kept in their room, or other concerns?
☐ Does the resident's physical appearance indicate the potential for an altered nutritional status (e.g., cachectic, dental problems, edema, no muscle mass or body fat, decreased ROM, or coordination in the arms/hands)?
☐ How physically active is the resident (e.g., pacing or wandering)?
☐ Are supplements provided and consumed at times that don't interfere with meal intake (e.g., supplement given right before the meal and the resident doesn't eat the meal)?
☐ Are snacks given and consumed as care planned?
☐ Is the resident receiving OT, SLP, or restorative therapy services? If so, are staff following their instructions (e.g., head position or food placement to improve swallowing)?
☐ Is there any indication that the resident could benefit from therapy services that are not currently being provided (difficulty grasping utensils, difficulty swallowing)?
☐ If a resident is receiving nutrition with a feeding tube, observe for positioning, type of tube feeding, whether a pump or gravity is being used, and the rate and amount being provided.

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CMS Website

Regulations:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

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QUESTIONS Phase III

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Sustainable Success Requires Bringing the "*LTC Cloud*" Down to A Management Level

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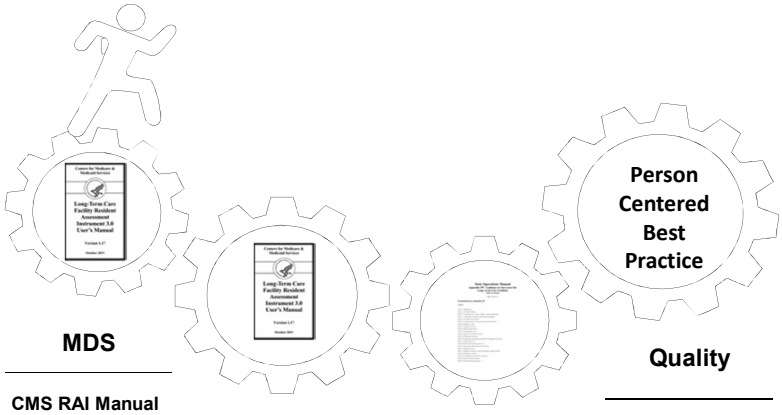
Facility Teamwork Strategy, Processes and Resources



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Putting the Pieces Together:

Minimum Data Set (MDS) Compliance, PDPM, Quality and CMS Phase III Requirements Related to Nutrition

11/20/2019

Presenter: Brenda Richardson, MA, RDN, LD, CD, FAND

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QUESTIONS

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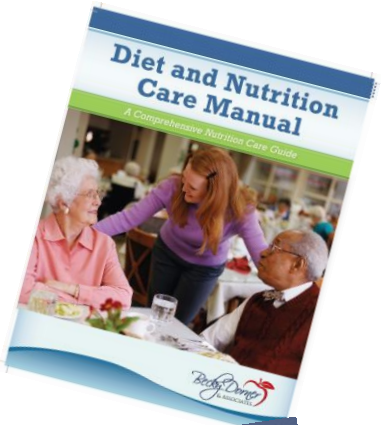
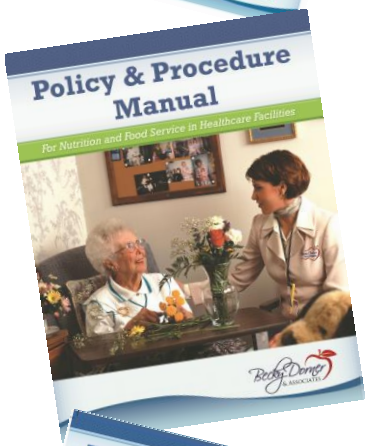
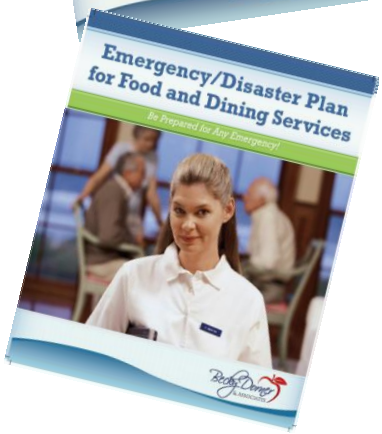


Our most popular publications include:

- Diet and Nutrition Care Manuals (2019 Comprehensive or Simplified)
- Policy and Procedure Manual (2019)
- Emergency/ Disaster Plan for Food and Dining Services (2018)





More titles (see website for all titles – added frequently):

- Pocket Guide to Eating Disorders, 2nd Edition Course (2019)
- Food & Fitness after 50 (2019)
- Pocket Guide to Parenteral Nutrition, 2nd Edition Course (2019)
- Minimum Data Set (MDS) 3.0 RAI Manual v1.17 Course (2019)
- ASPEN Enteral Nutrition Handbook, 2nd Edition Course (2019)
- CMS State Operations Manual Appendix PP Course (2019)
- Sports Nutrition: A Handbook for Professionals, 3rd Edition (2019)
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- Kathy Warwick, RD, CDE, Owner, Professional Nutrition Consultants, LLC, Madison, Mississippi