F692

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§483.25(g) Assisted nutrition and hydration.
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—

§483.25(g)(1) 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;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

INTENT §483.25(g)
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:

- Provides nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment;

- Recognizes, evaluates, and addresses the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration; and
- Provides a therapeutic diet that takes into account the resident's clinical condition, and preferences, when there is a nutritional indication.

DEFINITIONS §483.25(g)
Definitions are provided to clarify clinical terms related to nutritional status.

"Acceptable parameters of nutritional status" refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values.

"Artificial nutrition and hydration" are medical treatments and refer to nutrition that is provided through routes other than the usual oral route, typically by placing a tube directly into the stomach, the intestine or a vein.

"Clinically significant" refers to effects, results, or consequences that materially affect or are likely to affect an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
"Dietary supplements" refers to herbal and alternative products that are not regulated by the Food and Drug Administration and their composition is not standardized. Dietary supplements must be labeled as such and must not be represented for use as a conventional food or as the sole item of a meal or the diet.

"Health Care Provider" includes a physician, physician assistant, nurse practitioner, or clinical nurse specialist, or a qualified dietitian or other qualified nutrition professional acting within their state scope of practice and to whom the attending physician has delegated the task. For issues related to delegation to dietitians, refer to §483.60(e)(2), F808.

"Nutritional status" includes both nutrition and hydration status.

"Nutritional Supplements" refers to products that are used to complement a resident's dietary needs (e.g., calorie or nutrient dense drinks, total parenteral products, enteral products, and meal replacement products).

"Therapeutic diet" refers to a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

"Tube feeding" refers to the delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum. It is also referred to as an enteral feeding.

GUIDANCE §483.25(g)

It is important to maintain adequate nutritional status, to the extent possible, to ensure each resident is able to maintain the highest practicable level of well-being. The early identification of residents with, or at risk for, impaired nutrition or hydration status may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. 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 one 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 sensation for thirst or hunger. The resident's medical condition can also affect how well they maintain weight, such as changes in muscle mass, cognitive status, nearing end of life, or a disease process, such as kidney disease or congestive heart failure, which may cause the resident to retain fluids in the body. While impaired nutritional status is not necessarily expected as one ages, there could be times where efforts to maintain good nutrition may pose extra challenges.

Failure to identify residents at risk for compromised nutrition and hydration may be associated with an increased risk of mortality and other negative outcomes, such as impairment of anticipated wound healing, decline in function, fluid and electrolyte imbalance/dehydration, and unplanned weight change.. While food intake may be considered, ensuring a resident receives the fluids they require can more easily be overlooked. Individuals who do not receive adequate fluids are more susceptible to urinary tract infections, pneumonia, pressure injuries, skin infections, confusion, and disorientation.

A systematic approach can help staff's efforts to optimize a resident's nutritional status. This process includes identifying and assessing each resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing pertinent approaches, and monitoring the effectiveness of interventions and revising them as necessary. Weight loss, poor nutritional status, or dehydration should be considered avoidable unless the facility can prove it has assessed/reassessed the resident's needs, consistently implemented related care planned interventions, monitored for effectiveness, and ensured coordination of care among the interdisciplinary team.

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.

Through a comprehensive nutritional assessment, the interdisciplinary team clarifies nutritional issues, needs, and goals in the context of the resident's overall condition. Completion of the RAI does not remove the facility's responsibility to document a more detailed resident assessment, when indicated, to identify possible effective interventions. The nutritional assessment may utilize existing information from sources, such as the RAI, assessments from other disciplines, the existing medical record, observation, direct care staff interviews, and resident and family interviews. The assessment should identify those factors that place the resident at risk for inadequate nutrition/hydration. The nutritional assessment may include the following information:

General Appearance: General appearance includes a description of the resident's overall appearance (e.g., robust, thin, obese, or cachectic). Other findings that may affect or reflect a resident's nutritional status may be included, such as the resident's cognitive status, affect, oral health and dentition, ability to use the hands and arms, and the condition of hair, nails, and skin.

Height: Measuring a resident's height provides information that is relevant (in conjunction with his or her weight) to his/her nutritional status. There are various ways to estimate height if standing height cannot be readily measured.[1] A protocol for determining height helps to ensure that it will be measured as consistently as possible.

Weight: Weight can be a useful indicator of nutritional status, when evaluated within the context of the individual's personal history and overall condition. Weight goals should be based on a resident's usual body weight or desired body weight. The facility should have a procedure in place that includes, but is not limited to, establishing a consistent method of weighing a resident (e.g. using the same scale, wearing the same clothes, weighing at the same time of day, adjusting for use of a prosthetic, etc.), verifying the resident's weight upon admission, monitoring a resident's weight over time to identify weight loss/gain, verifying weight measurements when changes in weight occur, and reassessing interventions when appropriate.

Current professional standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as slow and progressive weight loss. Weighing may also be pertinent if there is a significant change in condition, food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. In some cases, weight monitoring is not indicated (e.g., the individual is terminally ill and requests only comfort care).

Examples of other factors that may impact weight and the significance of apparent weight changes include the resident's usual weight through adult life, current medical conditions, diet and supplement orders, recent changes in dietary intake, and edema.

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

Interviews with key staff members: The facility may identify key individuals who should participate in the assessment of nutritional status and related causes and consequences. For example, nursing staff provide details about the resident's nutritional intake. Physicians and non-physician practitioners help identify relevant diagnoses, identify causes of weight changes, tailor interventions to the resident's specific causes and situation, and monitor the continued relevance of those interventions. Qualified dietitians help identify nutritional risk factors and recommend nutritional interventions, based on each resident's medical condition, needs, preferences, and goals. Consultant pharmacists can help the staff and practitioners identify medications and medication interactions that may affect nutrition.

Food and fluid intake: The nutritional assessment includes an estimate of calorie, nutrient and fluid needs, and whether intake is adequate to meet those needs. It also includes information such as the route (oral, enteral or parenteral) of intake, any special food formulation, meal and snack patterns (including the time of supplement or medication consumption in relation to the meals), dislikes, and preferences (including ethnic foods and form of foods such as finger foods); meal/snack patterns, and preferred portion sizes. While there is no reliable calculation to determine an individual's fluid needs, an assessment should take into account those characteristics pertinent to the resident, such as age, medical diagnoses, activity level, etc.

Fluid loss or retention: Fluid loss or retention can cause short term weight change. Much of a resident's daily fluid intake comes from meals; therefore, when a resident has decreased appetite, it can result in fluid/electrolyte imbalance. Abrupt weight changes, change in food intake, or altered level of consciousness are some of the clinical manifestations of fluid and electrolyte imbalance. Laboratory tests (e.g., electrolytes, BUN, creatinine and serum osmolality) can help greatly to identify, manage, and monitor fluid and electrolyte status.[2]

Altered Nutrient intake, absorption, and utilization: Poor intake, continuing or unabated hunger, or a change in the resident's usual intake that persists for multiple meals, may indicate an underlying condition or illness. Examples of causes include, but are not limited to:

- The inability to consume meals provided as a result of cognitive or functional decline;
- Difficulty with chewing or swallowing food;
- An inadequate amount of food or fluid, including insufficient tube feedings;
- An uncomfortable or disruptive dining environment;
- The lack of adequate assistance or supervision;
- Adverse consequences related to medications; and
- Diseases and conditions such as cancer, diabetes mellitus, advanced or uncontrolled heart or lung disease, infection and fever, liver disease, kidney disease, hyperthyroidism, mood disorders, gastrointestinal disorders, pressure injuries or other wounds, and repetitive movement disorders (e.g., wandering, pacing, or rocking).

The use of diuretics and other medications may cause weight loss that is not associated with nutritional issues. This may result in a planned weight loss (e.g. the reduction of edema), but can also cause fluid and electrolyte imbalance/dehydration that causes a loss of appetite and weight if unmonitored.

Early identification of these factors, regardless of the presence of any associated weight changes, can help the facility choose appropriate interventions to minimize any subsequent complications. Often, several of these factors affecting nutrition coexist.

Laboratory/Diagnostic Evaluation: Laboratory tests are sometimes useful to help identify underlying causes of impaired nutrition or when the clinical assessment alone is not enough to define someone's nutritional status. An additional assessment of other resident risk factors is often needed to confirm if a treatable clinical problem exists. For example, low serum albumin levels may indicate malnutrition, but may also be the result of an acute illness for reasons unrelated to nutrition. Therefore, albumin levels may not improve, despite consumption of adequate amounts of calories and protein.

The decision to order laboratory tests by the health care provider and the interpretation of subsequent results, is best done in light of a resident's overall condition and prognosis. Although laboratory tests such as albumin and pre-albumin may help in some cases in deciding to initiate nutritional interventions, there is no evidence that they are useful for the serial follow-up of undernourished individuals.[3]

NOTE: If laboratory tests were done prior to or after admission to the facility and the test results are abnormal, the physician or other licensed health care practitioner, in collaboration with the interdisciplinary team, reviews the information and determines whether to intervene or order additional diagnostic testing.

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. The care plan must address, to the extent possible,

identified causes of impaired nutritional status, reflect the resident's personal goals and preferences, and identify resident-specific interventions and a time frame and parameters for monitoring. The care plan should be updated as needed, such as when the resident's condition changes, goals are met, interventions are determined to be ineffective, or as new causes of nutrition-related problems are identified. If nutritional goals are not achieved, the care planned interventions must be reevaluated for effectiveness and modified as appropriate.

Examples of goals may include, but are not limited to:

- A target weight range.
- Desired fluid intake.
- The management of an underlying medical condition (e.g. diabetes, kidney disease, wound healing, heart failure, or infection.)
- The prevention of unintended weight loss or gain.

Weight stability, rather than weight gain, may sometimes be the most pertinent short-term or long-term objective for the nutritionally at-risk or compromised resident. After an acute illness or as part of an advanced or end-stage medical condition, the resident's weight and other nutritional parameters may not return to previous levels and may stabilize at a lower level, sometimes indefinitely.

NOTE: There should be a documented clinical basis for any conclusion that nutritional status or significant weight change are unlikely to stabilize or improve (e.g., physician's documentation as to why weight loss is medically unavoidable).

The resident and/or the resident's representative's involvement in the development of the care plan helps to ensure it is individualized and meets their personal goals and preferences. See F551, Resident Representative; F553, Right to Participate in Care Planning, or §483.21, Comprehensive Resident-Centered Care Plans, for additional guidance.

When preferences are not specified in an advanced directive, decisions related to the possible provision of supplemental or artificial nutrition should be made in conjunction with the resident, the resident's family, and/or representative in accordance with state law, taking into account relevant considerations such as condition, prognosis, and the resident's known values and choices.

NOTE: The presence of a "Do Not Resuscitate" (DNR) order does not by itself indicate that the resident is declining other appropriate treatment and services. It only indicates that the resident has chosen not to be resuscitated if cardiopulmonary functions cease.

INTERVENTIONS

Interventions related to a resident's nutritional status must be individualized to address the specific needs of the resident. Examples of care plan development considerations can include, but are not limited to:

Diet Liberalization: Based on the resident's assessment, it could be beneficial to minimize restrictions, such as therapeutic or mechanically altered diets, and provide preferred foods before using supplementation. However, it is the responsibility of the facility to:

- Talk with the resident, their family and representative (whenever possible) and provide information pertaining to the risks and benefits of a liberalized diet;
- Work with the resident's physician and other nursing home professionals (dietary manager, nurses, speech therapists, etc.), using the care planning process, to determine the best plan for the resident; and
- Accommodate the resident's needs, preferences, and goals.

Weight-Related Interventions: For at risk residents, the care plan should include nutritional interventions to address underlying risks and causes of unplanned weight loss or unplanned weight gain, based on the comprehensive or any subsequent nutritional assessment. The development of these interventions should involve the resident and/or the resident representative to ensure the resident's needs, preferences and goals are accommodated.

Environmental Factors: Appetite is often enhanced by the appealing aroma, flavor, form, and appearance of food. Resident-specific facility practices that may help improve intake include providing a pleasant dining experience (e.g., flexible dining environments, styles and schedules), providing meals that are palatable, attractive and nutritious (e.g., prepare food with seasonings, serve food at proper temperatures, etc.), and making sure that the environment where residents eat (e.g., dining room and/or resident's room) is conducive to dining.

Disease Processes: A resident's clinical condition may have a significant impact on the types of interventions considered. The facility is responsible for identifying relevant diagnoses (e.g. wound healing, anorexia, end-of-life, etc.) and appropriate interventions to address specific needs, as applicable.

Functional Factors: These include resident conditions that interfere with their ability to physically perform the task of eating or drinking adequately, such as the ability to use one's hands, vision, chewing and swallowing capabilities, or the ability to reposition one's self at the table. The underlying causes should be assessed to identify which interventions may be most effective. For example, a resident may experience a decline in his or her ability to chew food. If the underlying cause is poorly fitting dentures that are causing pain or are loose in the mouth, the intervention of modifying the food texture would not address the primary cause.

The interventions used to address functional factors will depend on the resident's specific areas of concern and can vary. Some interventions used to address functional factors include using specialized dishes and utensils, having eye glasses or hearing aids in use, ensuring dentures are securely placed, participating in a restorative eating program, or having direct assistance by staff or family. Other interventions may include ensuring food and drinks are readily accessible and in close physical proximity to individuals with mobility impairments.

Modification of food and fluid consistency may be an appropriate intervention, however it may unnecessarily decrease quality of life and impair nutritional status by affecting appetite and reducing intake.[4] Many factors influence whether a swallowing abnormality eventually results in clinically significant complications, such as aspiration pneumonia. Identification of a swallowing abnormality alone does not necessarily warrant dietary restrictions or food texture modifications. No interventions consistently prevent aspiration and no tests consistently predict who will develop aspiration pneumonia.[5] For example, tube feeding may be associated with aspiration, and is not necessarily a desirable alternative to allowing oral intake, even if some swallowing abnormalities are present.[6,7]

Medications: Medications may be helpful in improving a resident's nutritional status. Some ways medications may help a resident can be to increase appetite, reduce acid reflux, or reduce nausea. Some medications may have the unintended effect of impairing a resident's nutritional or hydration status and the resident may experience a lack of appetite, nausea, dry mouth, or other unintended effects. Interventions may be required to address these. For example, a resident may require frequent sips of a drink during a meal if they experience dry mouth. It may also be appropriate to consider changing, stopping, or reducing the doses of those medications as appropriate. For additional guidance related to medications, refer to §483.45(d), F757, Unnecessary Drugs, or §483.45(e), F758, Psychotropic Drugs.

Food Intake: Improving intake with wholesome foods is generally preferable to adding nutritional supplements. However, if the resident is not able to eat recommended portions at meal times, to consume between-meal snacks/nourishments, or if he/she prefers the nutritional supplement, supplements may be tried to increase calorie and nutrient intake. Taking a nutritional supplement during medication administration may also increase caloric intake without reducing the resident's appetite at mealtime.

Examples of other interventions to improve food intake include:

- Fortification of foods (e.g., adding protein, fat, and/or carbohydrate to foods such as hot cereal, mashed potatoes, casseroles, and desserts);
- Offering smaller, more frequent meals;
- Providing between-meal snacks or nourishments; or
- Increasing the portion sizes of a resident's favorite foods and meals; and providing nutritional supplements.

To date, the evidence is limited about benefits from appetite stimulants. While their use may be appropriate in specific circumstances, they are not a substitute for appropriate investigation of potentially modifiable risk factors and underlying causes of weight loss.

Maintaining Fluid and Electrolyte Balance: Poor fluid intake, abnormal lab values for electrolytes, some medications, and resident conditions may all affect a resident's fluid/electrolyte balance. Offering a variety of fluids during and between meals, assisting residents with drinking, keeping beverages available and within reach, and evaluating medications for placing a resident at risk for dehydration are examples of interventions that may be used to improve a resident's fluid balance. Alternate fluids, such as popsicles, gelatin, and ice cream, may also be offered. For some residents, a fluid restriction may be required to address conditions, such as edema or congestive heart failure, and may place them at greater risk for dehydration.

Feeding Tubes: Feeding tubes may be used to provide adequate nutrition to a resident who is not able to achieve it with other interventions. The liquid nourishment that is administered through a feeding tube is complete nourishment that must be prescribed to meet all the nutritional needs of the resident. Use F692 to guide the investigation into concerns regarding the nutritional adequacy of the prescribed formula. Concerns regarding care of feeding tubes, and/or complications related to their use should be investigated at F693.

NOTE: For residents with end stage dementia, the use of tube feeding does not necessarily extend life, prevent aspiration pneumonia, improve function or limit suffering. For additional guidance related to feeding tubes, see 42 CFR §483.25(g)(4)-(5), F693, Enteral Nutrition.

Total Parenteral Nutrition (TPN): TPN is a method of providing nutrition where a liquid formula is given into a vein through an intravenous catheter (IV) to provide most of the nutrients a resident needs. This method is used when a resident cannot or should not eat or drink by mouth. A resident with TPN may require additional monitoring, such as more frequent weights, to ensure the treatment is effective. For additional guidance, see 42 CFR §483.25(h), F694, Parenteral Fluids.

NOTE: If the resident and/or the resident's representative exercises his/her right to choose and declines interventions designed to improve or maintain their nutritional or hydration status, the facility is responsible for discussing the risks and benefits associated with that decision and offer alternatives, as appropriate. The comprehensive care plan should describe any interventions offered, but declined by the resident or resident's representative. See F656, Comprehensive Care Plans.

MONITORING

On-going monitoring of care planned interventions is necessary for all residents. On-going monitoring should include, but is not limited to:

- Interviewing the resident and/or resident representative to determine if their personal goals and preferences are being met.
- Directly observing the resident.
- Interviewing direct care staff to gain information about the resident, the interventions currently in place, what their responsibilities are for reporting on these interventions, and possible suggestions for changes, if necessary.
- Reviewing the resident-specific factors identified as part of the comprehensive resident assessment and any supplemental nutrition assessment, as needed to determine if they are still relevant or if new concerns have emerged, such as new diagnoses or medications.
- Evaluating the care plan to determine if current interventions are being implemented and are effective. This can include reviewing weight records, meal monitors, intake and output logs, nurses' notes, lab values, and physician or dietitian assessments.

INVESTIGATIVE PROTOCOL

Use the Nutrition and Hydration Critical Element (CE) Pathway, for the concerns being evaluated, along with the above interpretive guidelines when determining if the facility provides the necessary care and services to meet the resident's needs.

Summary of Procedure

Briefly review the most recent comprehensive assessments, comprehensive care plan and orders to determine whether the facility has assessed, identified and addressed as appropriate, the resident's nutritional and hydration needs. This information will guide observations and interviews to be made in order to corroborate concerns identified. **NOTE**: In addition to actual or potential physical harm, always *observe for visual cues of psychosocial distress and* consider whether psychosocial harm has occurred when determining severity level (See *guidance on Severity and Scope Levels and* Psychosocial Outcome Severity Guide *located in the Survey Resources zip file located at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes*).

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F692, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- Accurately and consistently assess a resident's nutritional status on admission and as needed thereafter;
- Identify a resident at nutritional risk and address risk factors for impaired nutritional status, to the extent possible;
- 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;
- Notify the physician as appropriate in evaluating and managing causes of the resident's nutritional risks and impaired nutritional status;
- Identify and apply relevant approaches to maintain acceptable parameters of residents' nutritional status, including fluids;
- Provide a therapeutic diet when ordered;
- Offer sufficient fluid intake to maintain proper hydration and health.

NOTE: Weight loss, abnormal protein and electrolyte lab values, and dehydration are not, by themselves, sufficient to support noncompliance at F692. Additionally, a resident does not need to experience weight loss, abnormal protein levels, D or dehydration to show noncompliance.

DEFICIENCY CATEGORIZATION

Examples of Severity Level 4 Noncompliance: Immediate Jeopardy to Resident Health or Safety include but are not limited to:

- Repeated, systemic failure to assess and address a resident's nutritional status and to implement pertinent interventions based on such an assessment resulted in continued significant or severe weight loss and functional decline;
  Repeated failure to assist a resident who required assistance with meals and drink resulted in or made likely the development of life-threatening symptom(s), or the development or continuation of severely impaired nutritional status;
- Dietary restrictions or downgraded diet textures, such as mechanical soft or pureed textures, were provided by the facility against the resident's expressed preferences and resulted in substantial and ongoing decline in food intake resulting in significant or severe unplanned weight loss with accompanying irreversible functional decline to the point where the resident was placed on Hospice; or
- The failure to provide an ordered potassium restricted therapeutic diet resulted in evidence of cardiac dysrhythmias or other changes in medical condition due to hyperkalemia.

Examples of Severity Level 3 Noncompliance: Actual Harm that is not Immediate Jeopardy includes but are not limited to:

- The failure to revise and/or implement the care plan addressing the resident's impaired ability to feed him/herself resulted in significant, not severe, unplanned weight change and impaired wound healing (not attributable to an underlying medical condition);
- The failure to identify a decrease in food intake, which resulted in a significant, unintended weight loss from declining food and fluids, which resulted in the resident becoming weakened and unable to participate in activities of daily living;

- The failure to assess the relative risks and benefits of restricting or downgrading diet and food consistency or to accommodate a resident's choice to accept the related risk resulted in declining food/fluid intake and significant weight loss;
- The failure to accommodate documented resident food dislikes and preferences resulted in poor food/fluid intake and a decline in function; or
- The failure to provide a gluten-free diet (one free of wheat, barley, and rye products) as ordered for a resident with known celiac disease (damage to the small intestine related to gluten allergy) resulted in the resident developing persistent gastrointestinal symptoms including significant, not severe, weight loss, chronic diarrhea, and occasional vomiting.

Examples of Severity Level 2 Noncompliance: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy include but are not limited to:

- Failure to obtain accurate weight(s) and to verify weight(s) as needed;
- The facility's intermittent failure to provide required assistance with eating resulted in poor intake, however, the resident met identified weight goals;
- Failure to provide additional nourishment when ordered for a resident, however, the resident did not experience significant or severe weight loss; and
- Failure to provide a prescribed sodium-restricted therapeutic diet (unless declined by the resident or the resident's representative or not followed by the resident); however, the resident did not experience medical complications such as heart failure related to sodium excess.

Severity Level 1: No Actual Harm with Potential for Minimal Harm

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

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

During the investigation of F692, the surveyor may have determined that concerns may also be present with related outcome, process and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present. Some examples of related requirements that should be considered include §483.20 Resident Assessment, §483.21 Comprehensive Person-Centered Care Planning, §483.24 Quality of Life, §483.30 Physician Services, §483.35 Nursing Services, §483.60 Food and Nutrition Services, §483.70 Administration, and §483.75 QAPI.

[1] *Walker, G. (Ed.) (2005). Pocket Guide for Nutrition Assessment. Chicago, IL: Consulting Dietitians in Healthcare Facilities.*

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[3] *Covinsky, K.E., Covinsky, M.H., Palmer, R.M., & Sehgal, A.R. (2002). Serum albumin concentration and clinical assessments of nutritional status in hospitalized older people: Different sides of different coins? Journal of the American Geriatrics Society, 50(4) 631-637.*

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

[5] *Loeb, M.B., Becker, M., Eady, A., & Walker-Dilks, C. (2003). Interventions to prevent aspiration pneumonia in older adults: A systematic review. Journal of the American Geriatrics Society, 51(7), 1018-1022.*

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

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