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## inperspective

# SURVEY survival

BY RETA A. UNDERWOOD, ADC

## Correcting those nutritional deficiencies

In reviewing government and industry reports benchmarking LTC quality of care, one sees that percentages rule—percentages of residents impacted by a particular Quality Indicator (QI), and percentages by which performance on that QI has progressed or regressed. It's easy to forget that behind these percentages are "real numbers" involving real people. The truth for our nursing facilities is that while a 1% shift might not be perceived as an industry trend, it may positively or negatively affect an additional 15,000 residents in a very real way.

When it comes to nutritional services, the reality is that neither the percentages nor the real numbers of deficiencies cited during the past five years have improved—they have, in fact, gotten worse. In particular, the three key nutrition F-Tags under Quality of Care (F-325-327) that can result in citations for substandard quality of care and immediate jeopardy were cited more frequently on average during the period from 1999 to 2003 than in 1998. For F-325 (acceptable parameters of nutrition), this means that 1,400 nursing facilities caring for as many as 150,000 residents were each cited annually (on average) for this key deficiency during that five-year period.

Without doubt, maintaining good nutritional parameters is a necessity, not a luxury, for every resident living in our nursing facilities. Consider these staggering numbers:

- In 2002, an estimated 700,000+ residents required some sort of help in eating, which represented tens of millions of manpower hours.
- A study published in the *Journal of the American Dietetic Association* found that nursing assistants inaccurately estimated residents' food intake more than half the time, which means that inaccuracies were recorded for hundreds of millions of meals per year.
- Average annual turnover for dietary services personnel approaches 50%, constituting tens of thousands of people, according to the "AAHSA Nursing Home Salary and Benefits Report 2002-2003," published by Hospital and Healthcare Compensation Service.

Thanks to outstanding research and data provided by Cowles Research Group in Montgomery Village, Maryland, as well as expert feedback from leading dietary professionals, here are *the realities, the challenges*, and some simple *survey survival techniques* for frequently cited nutritional and dietary deficiencies. These apply to key deficiencies beyond the three mentioned above.

**Reality #1: F-371 Sanitary Conditions** (not one of the "big three") continues to be the most cited deficiency. About 5,000 facilities fail to meet this minimum standard each year. Much of the reason for this is because "so much falls under sanitation. Sanitation is more than cleanliness. Food storage, preparation, distribution, and the serving of food under sanitary conditions are all included under F-371 Sanitary Conditions," according to Debra D. Dawson, CDM, CFPP, chairman of the board of

the Dietary Managers Association and nutrition services director of Bishop Drumm Retirement Center in Johnston, Iowa. How serious is this as a general issue throughout the United States? The American Dietetic Association's Food and Water Safety Survey from September 2003 estimates that every year there are 76 million cases of foodborne illness, 325,000 cases of food-related hospitalizations, and 5,000 corresponding deaths.

**Challenge:** Compliance with survey requirements depends on all staff, not just the dietary department, doing their jobs regarding sanitation. Consider assigning your own sub-tags in a mock survey, for example, thus allowing you to focus on any out-of-compliance areas and reinforce compliance in crucial areas, such as safe handling of food, proper storage, and implementation of proper sanitation procedures.

**Survey Survival Techniques:** Providing in-depth education on proper food storage, preparation, distribution, and serving to *all* staff is a must.

**Reality #2:** *F-364 Food prepared by methods that conserve nutritive value, flavor, and appearance; food that is palatable, attractive, and at the proper temperature. Or, simply stated, your food quality.* In 2003 alone, more than 1,200 facilities were found to be noncompliant. When was the last time you ate the pureed food served at your facility?

**Challenge:** Pureed foods, modified textures, therapeutic diets, and thickened liquids all pose unique challenges for the dietary department. Our residents, their families, and surveyors have set a higher standard and expectation than ever for the food that we serve. If we don't meet the challenge, our residents will continue to experience weight loss and dissatisfaction, and facilities will continue to be found nutritionally deficient. In interviews with Dawson; Carolyn Breeding, RD, LD, FADA, president of Dietary Consultants, Inc.; and Marianne Smith Edge, MS, RD, LD, FADA, president of the American Dietetic Association, all three agreed that the quality of food is of paramount importance and must improve industry-wide to see a rise in resident satisfaction and overall improvement of their nutritional condition.

**Survey Survival Techniques:** A few key ones:

- The need to hire qualified and experienced cooks, whose food looks and tastes good, is a given. Accomplishing this starts with the hiring process, by asking prospective employees, for example, to provide a list of ingredients and supplies needed to cook "a balanced meal." You should have them estimate the food cost and staffing needed, as well, or take a quick "true or false" test relating to the job for which they are applying. You'll find that these two techniques combined will save you valuable time and money.
- One must set higher-than-usual expectations for preparing altered food consistencies; e.g., pureed meals should look as close to form as possible. Many food vendors now offer preformed pureed foods that are more cost-effective than using your own labor dollars and ingredients.
- In line with the previous point, the thickened liquids challenge continues. For facilities to consistently provide appropriate consistency of fluids, ensure compliance, and reduce resident risk, they should purchase premixed liquids or mixing products that when prepared, result typically in fewer errors.
- Apply basic quality assurance techniques, such as use of food tasters. Ask staff from all departments to rate the meals for palatability, temperature, and appearance. Asking some staff to monitor kitchen trash can help, as well. Try to learn which foods *aren't* being eaten; this could lead to important adjustments in the menu.

**Reality #3:** As already noted, F-325, representing the minimum standard under which residents will *maintain acceptable parameters of nutritional status*, was cited about 1,200 times in 2003—and about one-fourth of those were at a level G or higher,

including some at the actual harm levels of J, K, and L.

**Challenge:** Breeding says, "Accurate resident assessment is necessary but is also a challenge to complete. The registered dietitian's role has expanded in recent years from that of a clinician into a broader role that often includes being a manager, supervisor, educator, surveyor, purchaser, and mentor, yet without the added time or benefits. Some are simply stretched too thin to adequately do the job." She adds that none of this detracts from the fact that, with resident needs depending on specialized nutritional interventions, accurate data must be collected by a qualified professional when conducting an assessment.

**Survey Survival Techniques:** Nutritional systems for dealing with specific needs are musts for most facilities, e.g., for the nutritionally at risk and those needing therapeutic diet and hydration programs. All such systems share common components, including:

- Setting a *standard of care* and sticking to it.
- Establishing *policies* and *procedures* that become instructions to staff. They should be easy to follow and outline every step to be performed.
- Identifying the *forms*, *tools*, and *equipment* needed for specific implementation, and providing instructions for why, when, where, and how they are to be used.
- *Allocating the necessary funds* for the system to work.
- Developing an *education module* that includes the method of instruction, pre- and post-training exams, and demonstrated competency.
- *Designating responsibility*, and offering positive recognition and opportunities for professional advancement.
- Applying a *quality assurance mechanism* for that system.

**Reality #4:** F-326 determines if residents *receive a therapeutic diet when there is a nutritional problem*. Identifying proven therapeutic diets continues to be a challenge, as evidenced by the more than 400 facilities cited in 2003, including some at immediate jeopardy levels. One of the most controversial aspects of treatment is when "real" food is no longer an option for a resident. Often viewed as a quality-of-care versus a quality-of-life situation, many residents' diets are downgraded to a less desirable consistency. Until recently, this was typically done without scientifically supported research and data for providing mechanically altered consistencies and therapeutic diets.

**Challenge:** According to Edge, "The new dysphagia diet was developed by the American Dietetic Association's practice group on Dietetic in Physical Medicine & Rehabilitation largely due to the lack of scientific research to support the previous standard of practice performed throughout the country. The goals of the national dysphagia diet are to become the new standard of practice, and to be communicated across the continuum of care with a limited number of different diet preparations. This will truly be an effort to standardize intervention in the treatment of dysphagia! What needs to be done for this to happen? Education—education of the doctors and other practitioners, as well as of the staff who are preparing the food."

**Survey Survival Techniques:** Many facilities have improved the intake and the nutritional status of their residents by liberalizing diets and enhancing the preparation of appropriate foods. To implement this, assess your residents to make sure that they are on the most appropriate liberalized diet available. Second, develop a new standard of care for your facility, and develop policies and procedures that include this new scientifically researched diet. Go to [www.eatright.org](http://www.eatright.org) to order your copy of the *National Dysphagia Diet: Standardization for Optimal Care* and support materials.

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