

# Nutrition, Weight Loss, Hydration and Tube Feedings

Effective November 28, 2017

## **F692 §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<sup>2</sup>, 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<sup>3</sup>, cognitive status<sup>4</sup>, 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.<sup>5</sup> 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.

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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.<sup>6</sup> 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

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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:

$\% \text{ of body weight loss} = (\text{usual weight} - \text{actual weight}) / (\text{usual weight}) \times 100$

**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 rele-

vance 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.<sup>7</sup>

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**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<sup>8</sup>. 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.<sup>9</sup> 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.<sup>9</sup>

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

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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.<sup>12</sup> Many factors influence whether a swallowing abnormality eventually results in clinically significant complications, such as aspiration pneumonia.<sup>13</sup> 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.<sup>14</sup> 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.<sup>15,16</sup>

**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<sup>17</sup>. 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 mealtimes.

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

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resident's nutritional and hydration needs. This information will guide observations and interviews to be made in order to corroborate concerns identified.

NOTE: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).

## 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

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

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

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- 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.

### **F693**

#### **§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)(4)-(5) Enteral Nutrition

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

DEFINITIONS §483.25(g)(4)-(5)

"Bolus feeding" is the administration of a limited volume of enteral formula over brief periods of time.

"Continuous feeding" is the uninterrupted administration of enteral formula over extended periods of time.

"Enteral feeding" (also referred to as "tube feeding") is the delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum.

"Feeding tube" refers to a medical device used to provide liquid nourishment, fluids, and medications by bypassing oral intake. There are two basic categories, naso-gastric and gastrostomy. The type of feeding tube used must be based on clinical assessment and needs of the resident since there are various kinds of feeding tubes within each category.

"Gastrostomy tube" ("G-tube") is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications. The most common type is a percutaneous endoscopic gastrostomy (PEG) tube

"Jejunostomy tube" (a.k.a. "percutaneous endoscopic jejunostomy" (PEJ or "J-tube") is a feeding tube placed directly into the small intestine.

"Naso-gastric feeding tube" ("NG tube") is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach.

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"Transgastric jejunal feeding tube" ("G-J tube") is a feeding tube that is placed through the stomach into the jejunum and that has dual ports to access both the stomach and the small intestine.

GUIDANCE §483.25(g)(4)-(5)

A decision to use a feeding tube has a major impact on a resident and his or her quality of life. It is important that any decision regarding the use of a feeding tube be based on the resident's clinical condition and wishes, as well as applicable federal and state laws and regulations for decision making about life-sustaining treatments

#### CONSIDERATIONS REGARDING THE USE OF FEEDING TUBES

The regulations at §483.25(g)(4) require that a feeding tube is not used unless there is a valid, clinical rationale, and the resident or if applicable, his/her representative has consented to its use. Consent implies that a discussion has occurred between the resident or representative and the physician, or other member of the treatment team, explaining the process of receiving the tube, and the risks and benefits.

Several factors may be involved in the decision to use a feeding tube including medical conditions that impair the resident's ability to maintain appropriate nutritional parameters (e.g., cerebrovascular accident, esophageal cancer, delirium, reconstructive facial or oral surgery). The need to improve the resident's nutritional status or level of comfort are also factors that may be involved in the decision to use a feeding tube. The duration of use of a feeding tube may vary, depending on the clinical situation and resident choice.

The interdisciplinary team, with support and guidance from the physician, is responsible for assuring the ongoing review, evaluation and decision-making regarding the continuation or discontinuation of all treatments, devices or approaches implemented to care for the resident. Involving the resident, family, and/or the resident's representative in discussions about the indications, use, potential benefits and risks of tube feeding, types of approaches, and alternatives helps support the resident's right to make an informed decision to use or not use artificial nutrition and hydration.

A clinically pertinent rationale for using a feeding tube includes, but is not limited to:

- An assessment of the resident's nutritional status, which may include usual food and fluid intake, pertinent laboratory values, appetite, and usual weight and weight changes;
- An assessment of the resident's clinical status, which may include the ability to chew, swallow, and digest food and fluid; underlying conditions affecting those abilities (e.g., coma, stroke, esophageal stricture, potentially correctable malnutrition that cannot be improved sufficiently by oral intake alone); factors affecting appetite and intake (e.g., medications known to affect appetite, taste, or nutrition utilization); and prognosis;
- Relevant functional and psychosocial factors (e.g., inability to sufficiently feed self, stroke or neurological injury that results in loss of appetite, psychosis that prevents eating); and
- Interventions attempted prior to the decision to use a feeding tube and the resident's response to them.

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The use of a feeding tube may potentially benefit or may adversely affect a resident's clinical condition and/or psychosocial well-being. Examples of some possible benefits of using a feeding tube may include:

- Addressing malnutrition and dehydration;
- Promoting wound healing; and
- Allowing the resident to gain strength, receive appropriate interventions that may help restore the resident's ability to eat and, perhaps, return to oral feeding.

Examples of some possible adverse effects of using a feeding tube may include:

- Diminishing socialization, including, but not limited to, the close human contact associated with being assisted to eat or being with others at mealtimes;
- Not having the opportunity to experience the taste, texture, and chewing of foods;
- Causing tube-associated complications; and

- Reducing the freedom of movement related to efforts to prevent the resident from pulling on the tube or other requirements related to the tube or the tube feeding.

In order to assure that the resident being fed by a feeding tube maintains the highest degree of quality of life possible, it is important to minimize possible social isolation or negative psychosocial impact to the degree possible (e.g., continuing to engage in appropriate activities, socializing in the dining room). Because of the possible side-effects and discomfort associated with the use of nasogastric tubes, there should be clinically pertinent documentation for extended use of nasogastric tubes (e.g., greater than 30 days).

Nutrition and feeding issues and their underlying causes in the resident with advanced dementia or other chronic neurological disorders such as Parkinson's disease present a particular set of issues and considerations that are discussed in F692. The extended use of enteral feeding tubes in individuals with advanced dementia does not necessarily extend life and remains controversial. The literature regarding enteral feeding of these individuals suggests that there is little evidence that enteral feeding improves clinical outcomes (e.g., prevents aspiration or reduces mortality).

#### CONSENT

A feeding tube should not be placed unless consented to by the resident or if applicable, appropriately authorized resident representative. The resident has the right to make an informed decision about the treatment they receive. If a resident had a feeding tube placed prior to admission or in another care setting the physician and interdisciplinary care team must review the basis (e.g., precipitating illness or condition change) for the initial placement of the feeding tube and the resident's current condition. This is to determine if there is a continued rationale for its use and to ensure that its continued use is consistent with the resident's treatment goals and wishes. Decisions to continue or discontinue the use of a feeding tube are made through collaboration between the resident (or a representative for a resident who lacks capacity to make and communicate such decisions), the physician, and the interdisciplinary care team. This includes a discussion of the relevance of a feeding tube to attaining a resident's goals (e.g., whether the nutritional intervention is likely to have a significant impact on the individual's underlying condition or overall status).

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#### TECHNICAL AND NUTRITIONAL ASPECTS OF FEEDING TUBES

It is important that staff providing care and services to the resident who has a feeding tube are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care. These protocols are required to be developed with the medical director in order to assure staff implement and provide care and services according to resident needs and professional standards of practice.

Facility policies and procedures regarding the technical aspects of feeding tubes must be developed and implemented, which address:

##### Monitoring the feeding tube

How to verify that the tube is functioning before beginning a feeding and before administering medications, which may include:

- Checking gastric residual volume (GRV)
  - o Not recommended for individuals who are alert and able to report symptoms that indicate a feeding is not well tolerated.
  - o May be appropriate when initiating tube feedings or for individuals who are unable to report symptoms such as bloating, nausea, or abdominal pain.
  - o Actions to take based upon the amount of GRV vary depending on the individual and the clinical condition.

o pH of GRV may indicate correct placement i.e. pH < 5 generally indicates gastric contents versus intestinal contents but medications and feeding formulas can alter pH levels.

o Changes in GRV appearance may also be helpful in confirming placement but should not be used in isolation.

- Observing changes in external length of tubing may indicate a change in position but can only be used if the exit site was marked upon initial placement; this method does not apply to low profile G tubes (tube that sits at skin level).

NOTE: Auscultation is no longer recommended for checking placement of the feeding tube.

Movement of air would likely be heard whether the tube was in the correct or incorrect location.

X-ray confirmation is the most accurate method for verification of tube placement when concerns arise regarding dislodgement or placement. Additional information regarding monitoring of feeding tubes may be found at, <https://www.ismp.org/tools/articles/ASPEN.pdf>

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Care of the feeding tube

- Securing a feeding tube externally;
- Providing needed personal, skin, oral, and nasal care to the resident;
- Examining and cleaning the insertion site in order to identify, lessen or resolve possible skin irritation and local infection;

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- Using infection control precautions and related techniques to minimize the risk of contamination; for example, in connecting the tube and the tube feeding; and
- Defining the frequency of and volume used for flushing, including flushing for medication administration, and when a prescriber's order does not specify.

Feeding tube replacement. Direction for staff regarding the conditions and circumstances under which a tube is to be changed, such as:

- When to replace and/or change a feeding tube (generally replaced either as planned/scheduled or as needed such as when a long-term feeding tube comes out unexpectedly or a tube is worn or clogged);
- How and when to examine a feeding tube and the infusion plug to identify splits or cracks that could produce leakage;
- Instances when a tube can be replaced within the facility and by whom;
- Instances when a tube must be replaced in another setting (e.g., hospital, ambulatory surgery center); and
- Notification of the practitioner when the need for a tube change arises unexpectedly.

Nutritional Aspects of Feeding Tubes

When a resident is receiving nutrition via a feeding tube, the practitioner and the interdisciplinary team identify the resident's nutritional needs and facility procedures that direct staff in providing care and services to the resident. The practitioner's orders related to tube feeding typically include the following components: kind of feeding and its caloric value; volume, duration, and mechanism of administration (e.g., gravity or pump); and frequency of flush.

Facility procedures regarding the nutritional aspects of feeding tubes include, but are not limited to:

Enteral nutrition. Direction to staff regarding the nutritional product and meeting the resident's nutritional needs such as:

- Types of enteral nutrition formulas available for use;
- How to determine whether the tube feedings meet the resident's nutritional needs and when to adjust them accordingly;
- How to balance essential nutritional support with efforts to minimize complications related to the feeding tube;
- Ensuring that the selection and use of enteral nutrition is consistent with manufacturer's recommendations;
- Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders; and
- Ensuring that the product has not exceeded the expiration date;
- Ensuring that additional water ordered for flushes or for additional hydration is administered per orders.

Flow of feeding. Direction for staff regarding how to manage and monitor the rate of flow, such as:

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- Use of gravity flow;
- Use of a pump;
- Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders;
- Calibration of enteral feeding pumps to ensure that pump settings accurately provide the rate and volume consistent with the resident's care plan; and
- Periodic maintenance of feeding pumps consistent with manufacturer's instructions to ensure proper mechanical functioning.

#### Complications Related to the Feeding Tube

An enteral feeding tube may be associated with significant complications, including aspiration, leaking around the insertion site, abdominal wall abscess, or erosion at the insertion site including the nasal areas. Feeding tubes can perforate the stomach or small intestine, with resultant peritonitis. Esophageal complications of feeding tubes may also occur including esophagitis, ulcerations, strictures, and tracheoesophageal fistulas. The use of tubes not designed or intended for enteral feeding may increase the risk of complications.<sup>16, 17</sup>

Tubes may clog for various reasons, including plugging by formula, pill fragments, or the precipitation of medications incompatible with the formula.<sup>18</sup> Flushing feeding tubes regularly and in association with medication administration, as indicated by current professional standards of practice and provided in the resident care policies, can help reduce the risk of clogging.

#### Complications Related to the Administration of the Enteral Nutrition Product

The administration of an enteral nutrition product may be associated with other complications including, but not limited to, nausea, vomiting, diarrhea, abdominal cramping, inadequate nutrition and aspiration. Additionally, interactions between the formula and various medications can affect the absorption and/or effectiveness of the medication. For example, the effectiveness of phenytoin sodium (Dilantin, Phenytek) may be reduced by the drug binding with the enteral feeding's protein component, leading to less free drug availability and possibly inadequate therapeutic levels.

Metabolic complications related to tube feeding may include inadequate calorie or protein intake, altered hydration, hypo- or hyperglycemia, and altered electrolyte and nutrient levels.

These risks may be reduced by calculating the nutritional needs of the resident, taking into ac-

count comorbid conditions and medications that affect these balances, monitoring for adequate nutritional status and complications, and adjusting the tube feeding accordingly.

While a feeding tube may be initiated with the intent to address certain medical conditions, the use of a feeding tube does not necessarily decrease the risk of aspiration for individuals with other risk factors, such as moderate or less severe swallowing abnormalities. Aspiration risk may potentially be affected by factors such as diminished level of consciousness, improper positioning of the resident during administration of the feeding, and failure to assure the feeding tube is correctly positioned within the stomach or intestine. The evidence is inconsistent and conflicting regarding any connection between gastric residual volume (GRV) and the risk or occurrence of aspiration.<sup>19</sup>

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Risk of aspiration should be assessed individually and appropriate interventions (e.g., proper positioning, rate of flow) implemented accordingly. There may be situations where other coexisting factors influence decisions about elevating the head of the bed; for example, a resident being fed by a tube who may be at risk for shearing by sliding down the sheets when the head of the bed is elevated to a recommended angle.

Complications Management

The facility is expected to identify and address actual or potential complications related to the feeding tube or tube feeding and to notify and involve the practitioner in evaluating and managing care to address these complications and risk factors.

PROCEDURES §483.25(g)(4)-(5)

Use the Tube Feeding Critical Element (CE) Pathway along with the above guidance when determining if the facility utilized a feeding tube only after adequate assessment of the resident's clinical condition to ensure this intervention is medically necessary and with the resident's consent.

The surveyor(s) should use the following: observations, interviews and record reviews to determine if a feeding tube is utilized only if the resident's clinical condition makes this intervention medically necessary and with the resident's consent. The surveyor must determine if a feeding tube is utilized in accordance with current professional standards of practice and if services are provided to prevent complications to the extent possible. Additionally, for a resident whose goal is to restore normal eating skills to the extent possible, the surveyor must determine if the necessary care and services were provided to reach this goal. If there are concerns regarding the facility's use and care of feeding tubes, review facility policies and practices with regard to the use and care of feeding tubes.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F693, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- Ensure enteral feeding was clinically indicated; or
- Ensure enteral feeding was consented to by the resident; or
- Ensure a resident receiving enteral feeding received appropriate care and services to restore oral eating skills, if possible, or
- Ensure a resident receiving enteral feeding received appropriate care and services to prevent complications of enteral feeding.

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

An example of Severity Level 4 Noncompliance : Immediate Jeopardy to Resident Health or Safety, includes but is not limited to:

- The facility failed to properly set up the tube feeding pump and to monitor a cognitively impaired resident receiving the tube feeding, resulting in the resident receiving too much

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liquid nourishment at a rate too fast to be absorbed. The resident was found to be unresponsive with excess liquid nourishment coming from his or her nose and mouth.

An example of Severity Level 3 Considerations: Actual Harm that is Not Immediate Jeopardy includes, but is not limited to:

- The facility failed to monitor for complications related to a resident's feeding tube and tube feeding. As a result, the resident experienced significant but not serious tube feeding-related complications; or

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

- As a result of staff failure to anchor a feeding tube properly, the resident had leakage and irritation around the tube insertion site that required topical treatment and resolved without complications;
- As a result of staff failure to manage a tube feeding pump properly, the resident did not receive the calculated amount of tube feeding, without resulting in significant weight loss or other GI complications; or
- As a result of staff failure to consistently flush a resident's feeding tube as ordered, the tube clogged and had to be replaced, but there were no other complications.

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

The failure of the facility to provide appropriate care and services for feeding tubes, places the resident at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

#### POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

If there are concerns identified regarding the resident receiving adequate nutrition/hydration when receiving tube feeding, review F692, Assisted Nutrition and Hydration, for further investigation.

If there is lack of consent related to the placement of a feeding tube, cite those deficiencies here instead of the Resident Rights since this regulatory language is specific to consent for a feeding tube.

### **F694 § 483.25(h) Parenteral Fluids.**

Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

#### INTENT §483.25 (h)

The intent of this requirement is that the facility assures that each resident receives care and services for the provision of parenteral fluids consistent with professional standards of practice in order to provide:

- Safe administration of parenteral fluids by qualified, competent and trained staff in accord with State laws/practice acts;

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- Care consistent with the resident's input, goals and preferences, as delineated in the care plan; and

- Ongoing support of the resident, during intravenous fluid (IV) treatments, including monitoring the resident's status, monitoring for complications and assuring the provision of appropriate infection control practices.

DEFINITION §483.25 (h)

Parenteral fluid is defined as an IV infusion of various solutions to maintain adequate hydration, restore and/or maintain fluid volume, reestablish lost electrolytes, or provide partial nutrition which includes Total Parenteral Nutrition (TPN). Taken from <http://medical.dictionary.thefreedictionary.com/administration+of+parenteral+fluids>

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GUIDANCE §483.25 (h)

There is no requirement that a facility must offer IV treatments/services. If the facility has an arrangement with an outside contractor for the provision of IV services, the facility must inform each resident before or at the time of admission, and periodically during the resident's stay, of IV services, if available in the facility.

Residents of a facility may receive IV services through options such as:

- The facility provides the IV services either directly or contracting for individuals to provide the services; however, these individuals must be qualified, trained and competent in accordance with professional standards of practice, licensure and State practice acts/laws; or
- If a current resident chooses to receive IV services, and the facility does not allow for these onsite services, the facility must assist the resident with the transfer to another facility or in the relocation to a setting (e.g. private home, or residential/assisted living facility) of his/her choice that provides IV services.

The facility must develop and implement resident care policies, based upon current professional standards of practice for the preparation, insertion, administration, maintenance and discontinuance of the IV as well as prevention of infection at the site to the extent possible. The procedures must include the care and use of all equipment, such as pumps, tubing, syringes, fluids, etc.

The facility minimizes risks to a resident receiving IV therapy by developing and implementing policies that adhere to professional standards of practice, which may include, but are not limited to:

- Use of appropriate hand hygiene during all aspects of IV services;
- Use of aseptic technique when placing a venous access device;

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- Use of personal protective equipment (PPE) (based on potential for exposure to blood, bodily fluids, and infectious agents);
- Competency of staff to:
  - o Use infusion equipment;
  - o Accurately perform IV insertion, and maintain vascular access; and
  - o Assess for complications.
- Administration of solutions according to orders [correct solution, administration route (central/peripheral line), duration, frequency, and infusion rate]; and
- Labeling and dating, as appropriate, infusion fluids and lines.

According to the CDC, the following terminology has been used to describe IV catheters: "Terminology and Estimates of Risk - The terminology used to identify different types of catheters is

confusing, because many clinicians and researchers use different aspects of the catheter for informal reference. A catheter can be designated by:

- The type of vessel it occupies (e.g., peripheral venous, central venous, or arterial);
- Its intended life span (e.g., temporary or short-term versus permanent or long-term);
- Its site of insertion (e.g., subclavian, femoral, internal jugular, peripheral, and peripherally inserted central catheter [PICC]);
- Its pathway from skin to vessel (e.g., tunneled versus nontunneled);
- Its physical length (e.g., long versus short); or
- Some special characteristic of the catheter (e.g., presence or absence of a cuff, impregnation with heparin, antibiotics or antiseptics, and the number of lumens).

To accurately define a specific type of catheter, all of these aspects should be described (Table 1).” - <https://www.cdc.gov/hicpac/BSI/bsi-table-1-2011.html>

#### Complications/Risks of Intravenous Fluid Administration

Administration of IV fluids may be required to restore or maintain adequate hydration, replace electrolytes, or provide partial nutrition. However, because it is invasive, administration of IV fluids has associated risks such as:

- Infiltration;
- Bruising;
- Embolism (Air or Blood);
- Phlebitis;
- Fluid overload;
- Electrolyte imbalance; and
- Infections (Cellulitis, Septicemia).

NOTE: Refer to Centers for Disease Control (CDC) guidelines for the prevention of intravascular catheter related infections found at: <https://www.cdc.gov/hai/pdfs/bsi-guidelines-2011.pdf>

In addition to adhering to professional standards of practice, facilities are responsible to administer IV therapy according to the resident-centered care plan and in accordance with the resident’s goals, preferences, and advance directives, as applicable and according to State law.

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#### INVESTIGATIVE PROCEDURES

Observations: Observe the resident to determine:

- Are there signs of inflammation or infiltration at the insertion site and has site been changed according to current, professional standards of practice?
- If the rate of parenteral fluid being administered reflects that which was ordered by the physician.
- If 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)?

Observe staff changing the IV site, tubing, or bottle/bag, if possible. Determine whether aseptic technique is maintained in accordance with current, professional standards of practice.

Record Review:

Review the medical record and comprehensive care plan (or baseline if the resident’s admission was within 14 days of the review) to determine:

- If the resident has a diagnosis warranting the administration of parenteral fluids;
- If the resident has orders for parenteral fluid;
- o If yes, note the solution type, administration route, frequency, and infusion rate to compare to observations.
- How frequently staff are to change IV tubing.

Review facility policies and procedures related to parenteral therapy to determine if policies and/or procedures address:

- Aseptic technique for IV insertion;
- Maintenance of IV site;
- Frequency of IV site, tubing, and bag changes, and do they reflect current, professional standards of practice?

Interviews:

Interview the resident or if applicable, the representative to determine:

- If they understand why the resident is receiving parenteral fluid;
- If the resident has had any complications or concerns related to the IV.

Interview staff to determine if there are specific qualifications and/or competencies required for staff who perform IV insertion, IV maintenance, and parenteral fluid administration.

DEFICIENCY CATEGORIZATION §483.25 (h)

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

- Facility's failure to adhere to sterile technique during maintenance of parenteral therapy that lead to sepsis and resulted in the resident's hospitalization or death.
- Facility's failure to monitor administration in fluid that resulted in overload of cardiovascular system, resulting in hospitalization or death.

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

- Facility's failure to monitor for complications related to parenteral therapy, resulting in infiltration of the IV, causing the resident to experience pain and swelling.
- Facility's failure to ensure a resident received fluids as ordered, resulting in dehydration, which was later reversed after staff became aware.

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:

- Facility's failure to consistently flush a resident's IV site, resulting in the IV becoming clogged and requiring replacement.
- Facility's failure to anchor the IV needle and tubing, resulting in leakage around the IV site that required topical treatment and resolved without complications.

Severity Level 1 Noncompliance No Actual Harm with Potential for Minimal Harm The failures of the facility to provide appropriate care and services related to parenteral fluids places the resident at risk for more than minimal harm. Therefore Severity 1 does not apply for this regulatory requirement.

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION:

- If noncompliance with parenteral therapy is related to staff competency issues, also consider F725, §483.35(a)(3), Nursing Services
- If noncompliance with parenteral therapy is related to accuracy of fluid type, or amount, also consider F755, §483.45 Pharmacy Services.
- If noncompliance with parenteral therapy is related to lack of equipment such as IV tubing, pumps, etc., also consider F907 §483.90(c)(1) Space and equipment.

If noncompliance with parenteral therapy is related to the provision of adequate nutrition/hydration, also consider F692 §483.25(g), Assisted Nutrition and Hydration.