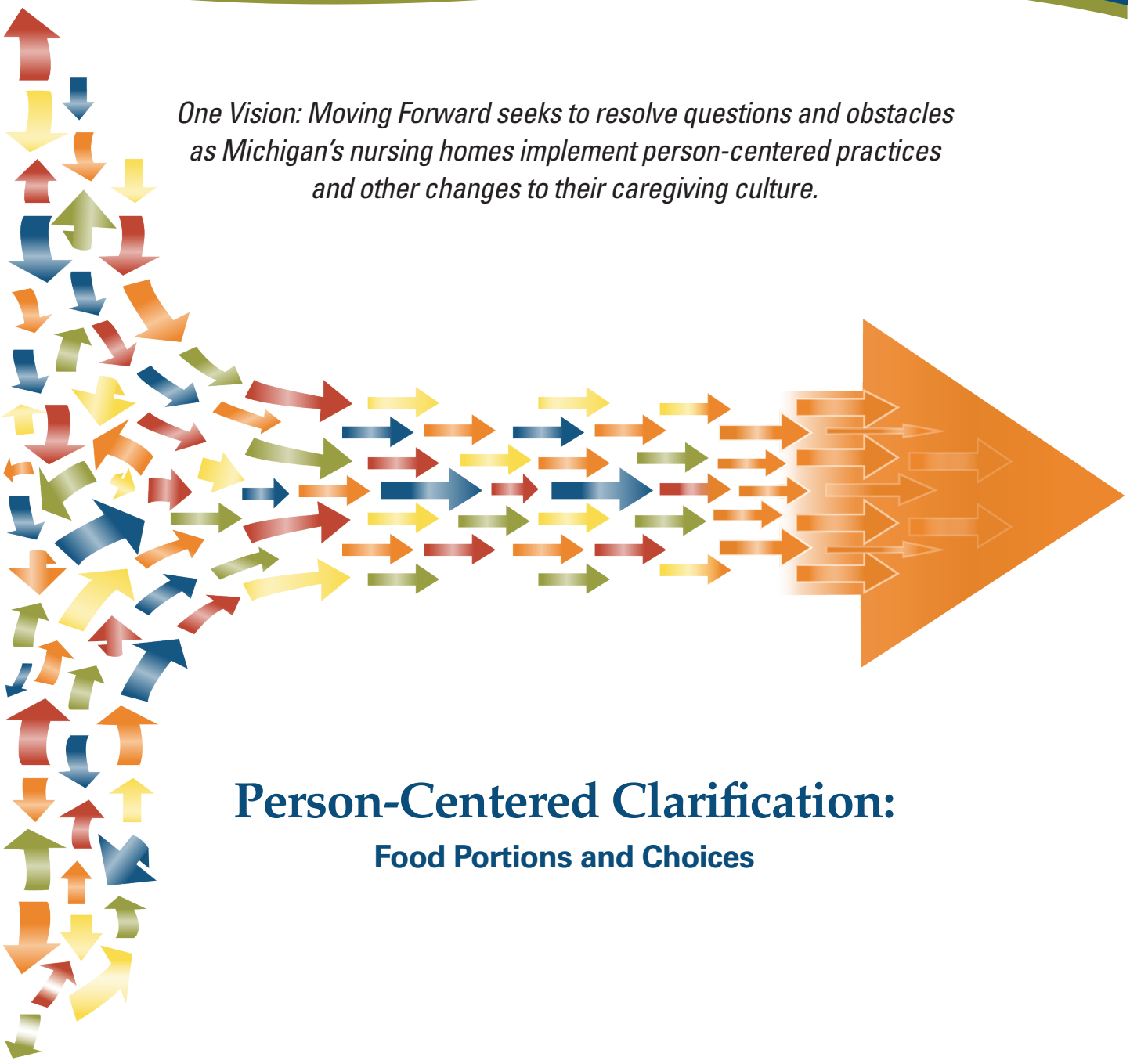
One Vision: Moving Forward

One Vision: Moving Forward seeks to resolve questions and obstacles as Michigan's nursing homes implement person-centered practices and other changes to their caregiving culture.



Person-Centered Clarification:

Food Portions and Choices

This document is part of a series of clarifications available at www.PHInational.org/onevision.

One Vision: Moving Forward

OneVision: Moving Forward Stakeholders:

- Advancing Excellence in America's Nursing Homes, Michigan LANE
- Alzheimer's Association – Greater Michigan Chapter and Michigan Great Lakes Chapter
- Health Care Association of Michigan
- LeadingAge Michigan
- Medical Services Administration Michigan Department of Community Health
- Michigan Department of Licensing and Regulatory Affairs
  - The Bureau of Health Systems
  - The Bureau of Fire Services
- Michigan Alliance for Person Centered Communities
- Michigan Campaign for Quality Care
- Michigan County Medical Care Facilities Council
- Michigan Office on Services to the Aging
- Michigan Star Forum
- Michigan State Long Term Care Ombudsman
- MPRO
- NADONA-Michigan Chapter

"They all wanted to move the field forward, but no one wanted to take the risks of doing it."

– University of Pennsylvania Alzheimer's researcher

One Vision: Moving Forward seeks to resolve questions and obstacles to implementation of person-centered practices and other culture change initiatives in Michigan's nursing homes, and address aspects of the wide array of culture change initiatives that pose challenges to the state's regulatory roles and responsibilities.

With the support of civil monetary penalty funding granted by the Michigan Department of Community Health, PHI[1] has been facilitating a work group of committed stakeholders — representing resident advocates, government agencies, provider associations, employee organizations, and culture change champions.

The stakeholders have, through consensus, developed a framework that is being used to address, clarify, and resolve current and future challenges to a person-centered approach in Michigan's nursing homes. As the results of this effort unfold, the stakeholder group is sharing them with the larger long-term supports and services community in documents such as this.

The ultimate goal of the One Vision: Moving Forward initiative is to make it possible for all Michigan's nursing home residents to experience more person-centered caregiving practices and for homes to improve the quality of care, exceeding the already high regulatory standards established by the State of Michigan.

1 PHI (**www.PHInational.org**) is a national nonprofit working to transform eldercare and disability services. We foster dignity, respect, and independence – for all who receive care, and all who provide it. The nation's leading authority on the direct-care workforce, PHI promotes quality direct-care jobs as the foundation for quality care.

Person-Centered Clarification: Food Portions and Choices

Date of Consensus Agreement: May 1, 2014

This clarification seeks to resolve questions and obstacles to implementation of person-centered practices and other culture change initiatives in Michigan's nursing homes. It was developed through a consensus process involving Michigan state agencies, nursing home organizations, resident advocates, organizations that serve nursing home staff, and organizations promoting person-centered services and culture change. This document is not meant or designed to cover every possible example or scenario. This information is shared with the intent of supporting and promoting high-quality person-centered services reflected in a comprehensive individualized care plan in Michigan's nursing homes.

Food service in nursing facilities has changed a great deal in recent years. The federal Centers for Medicare and Medicaid Services (CMS), which sets the requirements for nursing facilities, made major changes to its guidelines on dining, published in August 2011. These guidelines and the desire of nursing facilities to better serve the needs and wishes of residents have resulted in many innovative practices in food service.

A number of facilities in Michigan have hired trained chefs to lead the food preparation process and in some cases, when qualified, to lead the entire food service department. Others have opened for "24-7" snacking and made available prepared-to-order items; still others have revamped the dining room environment and created a much more inviting and comfortable place for socializing and dining.

Many clinicians have recognized the health and social benefits of supporting the eating style sometimes called "grazing," in which small portions of food are eaten throughout the day, rather than focusing on three larger meals. All of these innovations are geared toward more pleasant, homelike, and healthy dining experiences.

Dietary restrictions related to certain conditions have also long been considered a necessary evil in many facilities. However, as the August 2011 dining standards outlined in some detail, restricted or therapeutic diets actually do more harm than good, especially for older people. Nursing facility requirements allow for "liberalized diets" to serve resident desires.

Topic or question from resident's point of view:

Food is an integral and important part of our cultural and personal identities. Meals are about socialization, friendship, and community as much as nutrition. The experience of a traditional meal in a nursing home can be overwhelming for some people, especially those with sensory impairments, cognitive impairments, or simply small or reduced appetites. The recommended portion or meal size served in many facilities is seen as too large by many residents. And when the portion is overwhelming to individual residents, it is actually counterproductive to the appetite stimulation that would help residents get needed nutrition and prevent weight loss. In other words, too much food on the plate can actually cause a decrease in the amount eaten.

There is a perception that federal and state requirements are what cause residents to be faced with unwanted foods or overly large and, therefore, unappetizing portions.

The following clarification is sought:

- **How do Michigan nursing homes assure flexible and individualized meal portions and food choices?**
- **How do nursing homes promote resident choice in the types and amounts of food served within the context of the various dietary requirements generally associated with certain physical conditions and illnesses (such as diabetes, high cholesterol, or congestive heart failure)?**
- **Who needs to be involved in creating a plan for flexible/individualized meal portions and food choices? Who can be involved in preparing food?**

Clarifications of person-centered practices and approaches:

1. **How do Michigan nursing homes assure flexible and individualized meal portions?**

   This topic can and should be addressed in the assessment and care-planning process. In the section of F325 that discusses assessment of the resident's nutritional status and needs, facilities and residents should discuss "dislikes, and preferences (including ethnic foods and form of foods such as finger foods); meal/snack patterns, and **preferred portion sizes.**"[1]

   Nursing homes offer and honor resident choices in many areas of life, including food preferences. One factor the federal surveyor guidelines for F325 look for is "Whether the facility accommodated resident choice, individual food preferences, allergies, food intolerances, and fluid restrictions and if the resident was encouraged to make choices."[2]

   Residents, their friends and family, and nursing facility staff can even enjoy "potluck" dining in nursing facilities. See the One Vision: Moving Forward Clarification on "Potlucks" dated July 16, 2012, at **www.PHInational.org/OneVision**.

2. **How do nursing homes promote resident choice in the types and amounts of food individuals are served within the context of the various dietary requirements generally associated with certain physical conditions and illnesses (such as diabetes or congestive heart failure)?**

   Facilities should distinguish between those residents who do not benefit from a restricted diet and those who would through the process of assessment. In a facility that has a population of younger residents who would benefit from more restricted diets (for example, in short-term rehab, "younger" residents with good appetites, dialysis patients with good appetites), residents should be presented with appropriate food choices that support a healthy diet: i.e, a diet high in fruits and vegetables, low-fat dairy, whole grains, and lean protein sources, and low in fat, cholesterol, salt, and added sugars. See **http://www.health.gov/dietaryguidelines/2010.asp**.

   Resident choice is the most important element in decisions like food preferences and portions. Facilities can and must discuss food choices with residents and help them to create individualized care plans that address the benefits and risks of the choices they make. The key to promoting choice and staying in compliance with requirements is having the conversation, informing residents of risks and benefits, and documenting these events thoroughly in the plan of care.

[1] CMS Pub. 100-07 State Operations Provider certification, Transmittal 36, August 1, 2008, page 5

[2] CMS Pub. 100-07 State Operations Provider certification, Transmittal 36, August 1, 2008, page 23

Facilities can "bend" dietary requirements in the service of resident choice and preference. In fact, research shows, "One of the frequent causes of weight loss in the long-term care setting is therapeutic diets. Therapeutic diets are often unpalatable and poorly tolerated by older persons and may lead to weight loss. The use of therapeutic diets, including low-salt, low-fat, and sugar-restricted diets, should be minimized in the LTC settings."[3]

Liberalized diets can enhance residents' quality of life and improve health outcomes. Many older adults realize more benefits from diets of their own choosing than from more strict therapeutic diets. Pleasure, appetite, and ultimately food intake are all improved in many older people on liberalized diets. The benefits of a low-sugar, restricted diet for a younger person with diabetes, for example, are far bigger than the benefits realized by older people with diabetes.[4] Low-sodium diets, likewise, have shown only very minimal improvement in blood pressures of nursing home residents and may actually risk unintended weight loss because of lower intake amounts when food is not seasoned to the resident's liking: "More lenient blood pressure and blood sugars in the frail elderly may be desirable rather than weight loss due to unpalatable food."[5]

3. **Who needs to be involved in creating a plan for flexible/ individualized meal portions and food choices? Who can be involved in preparing food?**

The resident and any other people the resident chooses (family, friends, allies) along with the interdisciplinary team — which may include the Dietetic Professional in the facility (Registered Dietitian, Dietetic Technician, Certified Dietary Manager), nurses, physical therapists, speech therapists, occupational therapists, physicians, dietary aides, CNAs, and other staff who have a role in the resident's dining experience — should all be included in creating the care plan. Residents have the right to be informed of the risks and likely outcomes of decisions they make, including decisions about what and how much to eat.

Various nursing facility staff can be involved in preparing and cooking food. Cross training in proper food handling is essential when staff will be preparing or cooking food in the facility. In some culture change models, staff take a holistic approach to all the tasks that support a resident's highest practicable well-being. In the Green House Project® model, the Shahbaz is trained to work with residents on areas of personal care, food preparation and cooking, laundry, housekeeping, and all the tasks needed in any home. Some residents, too, enjoy cooking and should be supported in preparing food and cooking, when desired.

Resources and tools to better actualize resident preferences or needs within the intent of the regulatory standards:

1. "New Dining Practice Standards: Pioneer Network Food and Dining Clinical Standards Task Force." August 2011. Found at: **http://www.pioneernetwork.net/Data/Documents/NewDiningPracticeStandards.pdf**.

2. CMS Publication 100-07 State Operations Provider certification, Transmittal 36. August 1, 2008. Found at: **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R36SOMA.pdf**.

3. American Medical Directors Association Clinical Practice Guideline: Altered Nutritional Status. 2009. Found at: **http://www.amda.com/tools/cpg/nutritionalstatus.cfm**.

[3] American Medical Directors Association Clinical Practice Guideline: Altered Nutritional Status, 2009. Quote from: "New Dining Practice Standards: Pioneer Network Food and Dining Clinical Standards Task Force," August 2011, page 9.
[4] "New Dining Practice Standards…: August 2011, page 14.
[5] "New Dining Practice Standards…: August 2011, page 16.

Definition of Person-Centered Planning

"'Person-centered planning' means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities." MCL 330.1700(g)

The Michigan Department of Community Health (MDCH) and the Department of Licensing and Regulatory Affairs (LARA) hope to facilitate innovation that will increase individual quality of life and satisfaction with service delivery by implementing person-centered planning across all long-term care supports and services. The elements of Person-Centered Planning (PCP) as adopted by the departments are:

- **Person-Directed** – The individual controls the planning process.
- **Capacity Building** – Planning focuses on an individual's gifts, abilities, talents, and skills rather than deficits.
- **Person-Centered** – The focus is continually on the individual's life with whom the plan is being developed and not on fitting the person into available services and supports in a standard program.
- **Outcome-Based** – The planning process focuses on increasing the experiences identified as valuable by the individual during the planning process..
- **Presumed Competence** – All individuals are presumed to have the capacity to actively participate in the planning process (even individuals with cognitive and/or mental disabilities are presumed to have capacity to participate).
- **Information** – A PCP approach must address the individual's need for information, guidance, and support.
- **Facilitation** – Individuals may choose to have an independent advocate/champion to act as facilitator. Facilitation may include pre-planning and conducting the planning meetings. This may be done more effectively by someone outside of the provider organization.
- **Participation of Allies** – For most individuals, person-centered planning relies on the participation of allies chosen by the individual, based on who they feel is important to be there to support them.
- **Health and Welfare** – The needs of the individual must be addressed in a person-centered manner; strategies to address identified health and welfare needs must be supported to allow the individual to maintain his/her life in the setting of his/her choice.
- **Documentation** – The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan.

More clarifications about residents' right to participate in meaningful activities and maintain control are available to assist residents, their families and advocates, facilities and others are available. Go to: **www.phinational.org/onevision**.

Related Federal and State provisions:

F326
§483.25(i)(2) Receives a therapeutic diet when there is a nutritional problem
Intent §483.25(i)
The intent of this regulation is to assure that the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate intervention, when there is a nutritional problem.

Interpretive Guidelines §483.25(i)
This corresponds to MDS 2.0 sections G, I, J, K and L when specified for use by the State. Parameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels).

Weight
Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide in determining nutritional status. An analysis of weight loss or gain should be examined in light of the individual's former lifestyle as well as the current diagnosis. Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

The following formula determines percentage of loss:
% of body weight loss= (usual weight - actual weight) / (usual weight) x 100

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

Suggested laboratory values are:

- Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion)
- Plasma Transferrin >60 yr.:180-380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.)
- Hemoglobin Males: 14-17 g/dl; Females: 12-15 g/dl
- Hematocrit Males: 41 – 53; Females: 36 – 46
- Potassium 3.5 - 5.0 mEq/L
- Magnesium 1.3 - 2.0 mEg/L

Some laboratories may have different "normals." Determine the range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident's clinical condition and baseline normal values.

NOTE: There is no requirement that facilities order the tests referenced above. It is prudent to integrate and consider lab values and tests in the overall assessment of the resident's nutritional status and meeting the required body weight.

Clinical Observations
Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting.

Risk factors for malnutrition are:

1. Drug therapy that may contribute to nutritional deficiencies such as:
    a. Cardiac glycosides
    b. Diuretics
    c. Anti-inflammatory drugs
    d. Antacids (antacid overuse)
    e. Laxatives (laxative overuse)
    f. Psychotropic drug overuse
    g. Anticonvulsants
    h. Antineoplastic drugs
    i. Phenothiazines
    j. Oral hypoglycemic
2. Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations
3. Depression or dementia
4. Therapeutic or mechanically altered diet
5. Lack of access to culturally acceptable foods
6. Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating
7. Cancer

Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not be possible include, but are not limited to:

- Refusal to eat and refusal of other methods of nourishment;
- Advanced disease (i.e., cancer, malabsorption syndrome);
- Increased nutritional/caloric needs associated with pressure sores and wound healing (e.g., fractures, burns);
- Radiation or chemotherapy;
- Kidney disease, alcohol/drug abuse, chronic blood loss, hyperthyroidism;
- Gastrointestinal surgery; and
- Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice.

"Therapeutic diet" means a diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium), or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).

Procedures §483.25(i)
Determine if residents selected for a comprehensive review or focused review as appropriate, have maintained acceptable parameters of nutritional status. Where indicated by the resident's medical status, have clinically appropriate therapeutic diets been prescribed?

Probes §483.25(i)
For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable:

- Did the facility identify factors that put the resident at risk for malnutrition?
- Identify if resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration/fluid balance. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement.
- What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)?
- Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes?
- Was this care provided consistently?
- Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?

F363
(Rev. 5, Issued: 11-19-04, Effective: 11-19-04, Implementation: 11-19-04)
§483.35(c) Standard Menus and Nutritional Adequacy

Menus must:
(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

Intent §483.35(c)(1)(2)(3)
The intent of this regulation is to assure that the meals served meet the nutritional needs of the resident in accordance with the recommended dietary allowances (RDAs) of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. This regulation also assures that there is a prepared menu by which nutritionally adequate meals have been planned for the resident and followed.

Procedures §483.35(c)(1)
For sampled residents who have a comprehensive review or a focused review, as appropriate, observe if meals served are consistent with the planned menu and care plan in the amounts, types and consistency of foods served. If the survey team observes deviation from the planned menu, review appropriate documentation from diet card, record review, and interviews with food service manager or dietitian to support reason(s) for deviation from the written menu.

Probes: §483.35(c)(1)

- Are residents receiving food in the amount, type, consistency and frequency to maintain normal body weight and acceptable nutritional values?
- If food intake appears inadequate based on meal observations, or resident's nutritional status is poor based on resident review, determine if menus have been adjusted to meet the caloric and nutrient-intake needs of each resident. If a food group is missing from the resident's daily diet, does the facility have an alternative means of satisfying the resident's nutrient needs? If so, does the facility perform a follow-up?

Menu adequately provides the daily basic food groups:

- Does the menu meet basic nutritional needs by providing daily food in the groups of the food pyramid system and based on individual nutritional assessment taking into account current nutritional recommendations?

NOTE: A standard meal planning guide (e.g., food pyramid) is used primarily for menu planning and food purchasing. It is not intended to meet the nutritional needs of all residents. This guide must be adjusted to consider individual differences. Some residents will need more due to age, size, gender, physical activity, and state of health. There are many meal planning guides from reputable sources—e.g., American Diabetes Association, American Dietetic Association, American Medical Association, or U.S. Department of Agriculture that are available and appropriate for use when adjusted to meet each resident's needs.

§483.35(c)(2) and (3) Menus and Nutritional Adequacy
§483.35(c)(2) Be prepared in advance; and §483.35(c)(3) Be followed.

Probes: §483.35(c)(2)
Menu prepared in advance:

- Are there preplanned menus for both regular and therapeutic diets?

Probes: §483.35(c)(3)
Menu followed:

- Is food served as planned? If not, why?

There may be legitimate and extenuating circumstances why food may not be available on the day of the survey and must be considered before a concern is noted.

F364
§483.35(d) Food

Each resident receives and the facility provides:
(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;
(2) Food that is palatable, attractive, and at the proper temperature;

Intent §483.35(d)(1)(2)
The intent of this regulation is to assure that the nutritive value of food is not compromised and destroyed because of prolonged food storage, light, and air exposure; prolonged cooking of foods in a large volume of water and prolonged holding on steam table, and the addition of baking soda. Food should be palatable, attractive, and at the proper temperature as determined by the type of food to ensure resident's satisfaction. Refer to §483.15(e) and/or §483.15(a).

Interpretive Guidelines §483.35(d)(1)
"Food-palatability" refers to the taste and/or flavor of the food.
"Food attractiveness" refers to the appearance of the food when **served** to residents.

Procedures §483.35(d)(1)
Evidence for palatability and attractiveness of food, from day to day and meal to meal, may be strengthened through sources such as: additional observation, resident and staff interviews, and review of resident council minutes. Review nutritional adequacy in §483.25(i)(l).

Probes: §483.35(d)(1)(2)

- Does food have a distinctly appetizing aroma and appearance, which is varied in color and texture?
- Is food generally well-seasoned (use of spices, herbs, etc.) and acceptable to residents?

Conserves nutritive value:

- Is food prepared in a way to preserve vitamins? Method of storage and preparation should cause minimum loss of nutrients.

Food temperature:

- Is food served at preferable temperature (hot foods are served hot and cold foods are served cold) as discerned by the resident and customary practice?

Not to be confused with the proper holding temperature.

F365
§483.35(d)(3) Food prepared in a form designed to meet individual needs; and

F366
§483.35(d)(4) Substitutes offered of similar nutritive value to residents who refuse food served
Therapeutic diets must be prescribed by the attending physician.

Procedures §483.35(d)(3)(4)
Observe trays to assure that food is appropriate to resident according to assessment and care plan. Ask the resident how well the food meets their taste needs. Ask if the resident is offered or is given the opportunity to receive substitutes when refusing food on the original menu.

Probes: §483.35(d)(3)(4)

- Is food cut, chopped, or ground for individual resident's needs?
- Are residents who refuse food offered substitutes of similar nutritive value?

Interpretive Guidelines §483.35(d)(4)
A food substitute should be consistent with the usual and ordinary food items provided by the facility. For example, if a facility never serves smoked salmon, they would not be required to serve this as a food substitute; or the facility may, instead of grapefruit juice, substitute another citrus juice or vitamin C rich juice that the resident likes.

F367
§483.35(e) Therapeutic Diets

Intent §483.35(e)
The intent of this regulation is to assure that the resident receives and consumes foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the treatment and plan of care.

Interpretive Guidelines §483.35(e)

"Mechanically altered diet" is one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' order.

Procedures §483.35(e)
If the resident has inadequate nutrition or nutritional deficits that manifests into and/or are a product of weight loss or other medical problems, determine if there is a therapeutic diet [see definition above] that is medically prescribed.

Probes: §483.35(e)

- Is the therapeutic diet that the resident receives prescribed by the physician?

Also, see §483.25(i), Nutritional Status

F368
§483.35(f) Frequency of Meals
(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.
(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.
(3) The facility must offer snacks at bedtime daily.
(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

Intent §483.35(f)(1-4)
The intent of this regulation is to assure that the resident receives his/her meals at times most accepted by the community and that there are not extensive time lapses between meals. This assures that the resident receives adequate and frequent meals.

Interpretive Guidelines §483.35(f)(1-4)
A "substantial evening meal" is defined as an offering of three or more menu items at one time, one of which includes a high-quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements.

"Nourishing snack" is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the "nourishing snack" will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility (e.g., Is the offered snack usually satisfying?).

Procedures §483.35(f)(1-4)
Observe meal times and schedules and determine if there is a lapse in time between meals. Ask for resident input on meal service schedules, to verify if there are extensive lapses in time between meals.