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IN THIS ISSUE

- Food and Nutritional Services
- Need to Demonstrate Sustained Compliance
- CMS Requirement for Reporting of Acute Respiratory Illness

STEVEN HIRSCH & ASSOCIATES

This issue offers important updates on licensing issues that may impact your successful accreditation.

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FOOD AND NUTRITIONAL SERVICES

by *David R. Woodard, MSc, CIC, FSHEA* and *Amanda D. White-Gann, CEN*

Food and Nutritional (F&N) services is one of the lynchpin departments in the hospital. The Department is responsible for meeting a wide range of dietary needs, balancing flavor and nutrition while accommodating the specific medical restrictions of patients, such as low-sodium, low-sugar, or allergen-free diets.

These responsibilities include the integration of nutrition guidelines and standards, assessment of individual patient nutritional needs, patient-centered care, nutritional education and support, food safety, and quality assurance. The patient menus must be developed according to the specified requirements, while ensuring that food not only aids recovery but also aligns with therapeutic goals.

Meanwhile, the staff and public have an open menu option. Serving these two masters requires the Food and Nutritional Services Department to create versatile menu options for both populations, while maintaining budgetary compliance and the timeliness of service. This then creates the potential for double work, a "public" menu and the "patient care" menu. Remembering that the "patient care" menu requires further manipulation for salt, consistency, and food allergies presents challenges when facilitating compliance with regulatory requirements.

Hospitals are accountable for maintaining compliance with the following CMS standards:

> **§482.28 Condition of participation: Food and Dietetic Services**
>
> The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

The hospital should have written policies and procedures that address at least the following:

- Availability of a diet manual and therapeutic diet menus to meet patients' nutritional needs;
- Frequency of meals served; system for diet ordering and patient tray delivery;

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- Accommodation of non-routine occurrences (e.g., parenteral nutrition (tube feeding), total parenteral nutrition, peripheral parenteral nutrition, change in diet orders, early/late trays, nutritional supplements, etc.);
- Integration of the food and dietetic service into the hospital-wide QAPI and Infection Control programs;
- Guidelines for acceptable hygiene practices of food service personnel; and
- Guidelines for kitchen sanitation.

Critical Access Hospitals too, have similar regulatory requirements.

> **§485.635 Condition of participation: Provision of services.**
>
> (a) ***Standard: Patient care policies.***
>
> ...
>
> (3) The policies include the following:
>
> ...
>
> (vi) Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices. All patient diets, including therapeutic diets, must be ordered by the practitioner responsible for the care of the patients or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff in accordance with State law governing dietitians and nutrition professionals and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care.

More stringent state and local regulations may exist and should be verified when creating policies and procedures specific to your organization.

In a food service facility, particularly in the healthcare setting, kitchen operations are divided into several specialized areas serving specific functions:

1. **Service Area**: This area includes the public-facing elements, such as the Cafeteria serving line and possibly an open grill service where meals are plated or distributed directly to customers.
2. **Food Preparation Area**: Dedicated to preparing raw ingredients, this area includes tasks like chopping, mixing, and marinating before cooking. It involves rigorous hygiene and separation protocols to prevent cross-contamination, especially with raw proteins and fresh produce.
3. **Tray Line**: Separate from the public serving line, both in function and location, this area focuses on preparing and organizing trays for meal delivery to patients or residents. In this area meal components are assembled and packaged or plated according to specific dietary requirements.
4. **Scullery**: This is the cleaning hub of the kitchen. It handles all dishwashing, pot washing, and utensil sanitizing. The scullery has its own set of strict sanitation procedures to avoid contamination.
5. **Storage**: The kitchen has dedicated spaces for dry storage, as well as refrigerated and frozen storage areas. Each area requires temperature regulation and strict product rotation to ensure food remains safe and fresh.

Food safety protocols are essential in each of these areas. Dietary staff are trained in hygiene practices, such as frequent hand washing, using gloves and hair coverings, maintaining correct product temperatures during cooking, cooling, and storage, and following stringent cleaning procedures. These practices ensure that the food served is both nutritious and safe for consumption.

The People

Regulations set forth expectations that all key food service employees have and maintain credentials and where appropriate, academic degrees. The key employees include the Chief Dietitian, the Executive Chef, the sous chefs, and diet aides.

Other employees include cooks, line staff (grill cooks, tray line employees, dishwashers (scullery staff) and housekeepers.

Dietitians should all have a Master's Degree and a post -degree training program in key elements of food service and nutrition; safety; budget; human resources and management, etc. The chefs are generally academically trained in food preparation, food safety, departmental sanitation, and general operations of a kitchen. The diet aides are academically trained as well, generally with an Associate's Degree. However, for the cooks who are critical to the operation of the department, there are generally no academic requirements.

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Equipment and Supplies

The National Sanitation Foundation (NSF) guidelines for food service equipment are designed to ensure safety and hygiene in food preparation, storage, and service. Here is a summary of the main points:

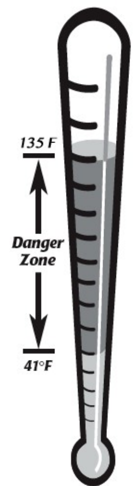
1. **Material Safety**: All equipment must be made from food-safe materials like stainless steel or other non-toxic substances that don't react with food.
2. **Design and Construction**: Equipment should allow for easy cleaning and maintenance, with smooth seams, and proper drainage and ventilation.

3. **Durability and Maintenance**: Equipment should be built to withstand commercial kitchen use. Preventive maintenance is important; integrating it into Facilities Management software helps to ensure timely inspections.
4. **Temperature Management**: Cold foods must be held below 40°F, and hot foods above 140°F. Equipment like refrigerators and ovens must reliably meet these temperature requirements.
5. **Compliance with Regulations**: NSF guidelines generally align with local health department standards and food safety laws. It is important however, to ensure that your facility is compliant with any State or Local guidelines.

For detailed standards, refer to the NSF website or specific publications on different equipment types, as they cover items like cooking appliances, refrigeration units, and preparation tools in depth.

Temperature

It is critical that the food is stored, prepared, and served at temperatures that will prevent or minimize spoilage and contamination. Failure to properly manage temperatures during the continuum of food service can result in food related illness in the Hospital.



According to ServSafe® (an authority on foodservice training material), the danger zone are temperatures between 41°F and 135°F (5 and 57 degrees Celsius). Note that many jurisdictions require refrigerator temperature to be maintained at 40°F or below, freezers below 0°F, and hot food to be held at 140°F or higher. Bacteria thrive and multiply most rapidly at temperatures between 70°F of 125°F. The longer food sits in the temperature danger zone, the greater the risk that bacteria will multiply or produce toxins (e.g. botulism, staphylococcus, streptococcus) that can cause food poisoning. Be sure to check your local requirements for guidelines for safe food holding temperatures. It should be noted that a distinction should be made between cooking temperatures that may vary depending on the food being prepared, and food holding temperature.

The temperatures of the products on the hot serving lines must be taken for each item to ensure that the item is at the correct holding temperature. Similarly, cold foods also must be maintained at the correct temperature.

When evaluating a facility regarding food safety and storage compliance, one might consider asking the following questions to ensure proper logging and monitoring of temperatures across various equipment and storage areas:

1. **Temperature Monitoring Systems**:
   - What type of external thermometer is used for monitoring temperatures in holding boxes, refrigerators, and freezers?
   - How frequently does the thermometer download data to the computer?
   - Are there any alarm features in place for temperature fluctuations? How are these alarms responded to?

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2. **Log Maintenance**:
    - Can staff show the inspector/surveyor the daily logs for temperatures in the walk-in refrigerators, freezers, and holding boxes?
    - How are these logs maintained, and who is responsible for completing them?
    - Are the logs reviewed regularly? If so, who reviews them?

3. **Training and Compliance**:
    - What training do staff receive on temperature monitoring and food safety practices?
    - Are there guidelines or procedures documented for responding to temperature excursions?

4. **Equipment Calibration**:
    - How often is the temperature monitoring equipment calibrated or serviced to ensure accuracy?
    - What steps are taken if a thermometer is found to be out of calibration?

5. **Handling Temperature Deviations**:
    - What protocols are in place if temperatures in the holding boxes or refrigerators fall into the danger zone?
    - How are incidents of temperature deviations logged? Is there a follow-up investigation or corrective action taken?

6. **Food Safety Practices**:
    - Are hot and cold foods stored separately in accordance with food safety guidelines?
    - What measures are taken to ensure that food is not left out at room temperature during service or preparation?

7. **Record-Keeping**:
    - How long are temperature logs and incident reports retained?
    - Is there a backup system in place for electronic logs?

8. **Visual Checks**:
    - Are visual checks performed in addition to thermometer readings? How often are these checks done?
    - Are holding boxes, refrigerators, and freezers clearly labeled with temperature ranges for safe food storage?

9. **Monitoring Procedures**:
    - Is there a standard operating procedure (SOP) for temperature monitoring and record-keeping? Can the procedure be readily produced for review?
    - How does the facility ensure that all meals meet required temperature standards throughout the entire service process?

10. **Emergency Planning**:
    - What procedures do you have in place in case of power outages or equipment failures that could affect food safety?
    - Are there emergency contacts identified for dealing with temperature-related emergencies?

Asking these questions helps ensure compliance with food safety standards and can identify areas for improvement in handling and monitoring food safely.

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Cutting Boards

Guidelines for color-coordinating cutting boards for different food types are great for promoting food safety and preventing cross-contamination! Here is a more detailed breakdown, along with additional tips for cleaning, storing, and using cutting boards effectively:

Cutting Board Color Coordination

- **Red**: Use exclusively for raw red meat (e.g., beef and lamb).
- **Brown**: Designated for raw pork products (e.g., pork chops, sausage).
- **Yellow**: For raw poultry (e.g., chicken, turkey).
- **Blue**: Reserved for raw fish and shellfish (e.g., salmon, shrimp).

- **Green**: For fresh produce (e.g., fruits and vegetables).
- **White**: For ready-to-eat foods such as cooked items, breads, cheeses, and others. Cutting boards can also be labeled for specific types of foods to avoid confusion.

Cleaning and Maintenance

1. **Regular Cleaning**: Rinse cutting boards with hot, soapy water immediately after use. For wood boards, if permitted, avoid soaking them to prevent warping.
2. **Sanitizing**: After washing, sanitize the cutting board with a solution of one tablespoon of unscented liquid chlorine bleach mixed with one gallon of water. Allow it to sit for a few minutes before rinsing and drying.
3. **Drying**: Always allow cutting boards to air dry completely before storing. This helps prevent bacterial growth.
4. **Oiling (for wood boards)**: Regularly oil wooden cutting boards with food-safe mineral oil to prevent them from cracking and to maintain their surface.

Storage

- **Hanging Hooks**: Utilize hooks for hanging cutting boards to ensure they can air dry properly and are easy to access. This reduces the risk of moisture build-up.
- **Rubber Feet**: Cutting boards with rubber feet provide stability during use, preventing sliding and enhancing safety.

Additional Safety Tips

- **Labeling**: Consider labeling cutting boards with their designated use, especially in busy kitchens, to reduce the risk of accidental cross-contamination.
- **Inspection**: Regularly inspect cutting boards for deep cuts, grooves, or damage. Replace any cutting boards that have become excessively worn or damaged, as these can harbor bacteria.
- **Separate Equipment**: Use separate knives and utensils for each cutting board type to further prevent cross-contamination.

By following these guidelines, you can ensure a safer kitchen environment and avoid foodborne illnesses.

References:

Code of Federal Regulations.
42 CFR § 482.28; 42 CFR § 485.635(a)(3)(vi)

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USDA Food and Safety Inspection Service. (January 5, 2024). *Keep Food Safe! Food Safety Basics.* U.S. Department of Agriculture. https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/steps-keep-food-safe#:~:text=Always%20wash%20hands%20with%20soap,tops%20with%20hot%2C%20soapy%20water

CMS REQUIREMENT FOR REPORTING OF ACUTE RESPIRATORY ILLNESSES

by Steven Hirsch, MPA, FACHE

The Centers for Medicare and Medicaid Services (CMS) issued QSO-25-05 for Hospitals and Critical Access Hospitals on October 22, 2024 in which the Conditions of Participation were updated for Hospitals and Critical Access Hospitals relating to the requirement to report acute respiratory illnesses, inclusive of SARS-COV2/Covid-19, influenza, and RSV. Confirmed infections of respiratory illnesses among hospitalized patients, hospital bed census and capacity, and limited geographic demographic information including age, must be reported through the CDC's National Healthcare Safety Network (NHSN) or other CDC owned or supported system.

Effective November 1, 2024, Hospitals and Critical Access Hospitals are required to electronically report data on acute respiratory illnesses as noted above. All Hospitals and Critical Access Hospitals, with the exception of acute psychiatric hospitals, rehabilitation hospitals, and distinct part psychiatric hospital units or rehabilitation units, must submit daily data values on a weekly basis to NHSN. There are additional provisions specific to new admissions of patients with confirmed respiratory illnesses, including Covid-19, influenza, and RSV by age group, in which hospitals are required to report such data aggregated on a weekly basis rather than daily.

It should be noted that psychiatric hospitals, rehabilitation hospitals, and distinct part psychiatric units and rehabilitation units are required to report once annually, beginning in January of 2025 and include only the data for the previous week.

This new respiratory illness reporting requirement comes with an enforcement structure for incomplete reporting or for non-compliance. CMS has established an approach for notification and enforcement for incomplete reporting of specified data elements on a weekly basis, and non-compliance with the Hospital and Critical Access Hospital reporting requirements that have become effective during the 2025 fiscal year, which began October 1. Facilities that fail to report the specified data elements on a weekly basis will receive initially an incomplete reporting notification letter from CMS. Should compliance not be achieved with reporting requirements, future enforcement action may be implemented, including CMS determining that the provider is non-compliant with the Hospital or Critical Access Hospital Conditions of Participation. According to the CMS letter, non-compliance with the above-mentioned reporting requirements will be determined independently from health and safety surveys for all other Conditions of Participation performed by state agencies or accrediting organizations on behalf of CMS.

Should you have any questions regarding the above, please do not hesitate to contact us at (714) 965-2800. For a copy of the CMS letter, QSO-25-05-Hospitals/CAHs, please utilize the hyperlink below.

https://www.cms.gov/files/document/QSO-25-05-hospitals-cahs.pdf

NEED TO DEMONSTRATE SUSTAINED COMPLIANCE

by Steven Hirsch, MPA, FACHE

During the triennial surveys in the calendar year 2024, it was observed that a number of accrediting organizations are citing healthcare facilities for not maintaining compliance with accreditation standards that had been cited during previous accreditation surveys. It is imperative that organizations, whether accredited or not, maintain compliance with Plans of Correction submitted to the state licensing agency, CMS, or to their accreditation organization following survey.

Plans of Correction submitted to any of the above agencies represent the organization's commitment to addressing identified deficiencies including actions taken to make corrections, accountability for oversight of the corrections, as well as ***ongoing monitoring*** to assure implementation of effective corrective actions.

A significant observation during recent accreditation surveys revealed that, rather than identifying lack of sustained compliance with individual standards or Elements of Performance cited during a previous accreditation survey under the specific non-compliant standard, the accreditation organization cited the organization under Leadership standard LD.04.01.01 EP3, "Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies." The new finding issued, to reflect lack of accountability of the organization's leaders, is that "The organization did not demonstrate a sustained level of compliance from the previous triennial survey, as evidenced by repeat deficiencies identified at the following standards…," which were listed out.

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Need to Demonstrate Sustained Compliance

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The healthcare organization, when preparing for any regulatory survey, should look back to its previous survey reports relating to accreditation, licensing, or Medicare Certification, to assure that any Plans of Correction have continued to be addressed, ensuring that the organization can demonstrate sustained compliance with the standard or regulation previously cited and for which a Plan of Correction had been submitted. It is recommended that within the Quality Management Plan, a monthly review of compliance with Plans of Correction be conducted and the results of the review provided to leadership.

A Plan of Correction is the organization's commitment to implement appropriate corrective or remedial actions to achieve ongoing compliance. Failure to do so can adversely impact your organization's accreditation decision and status, and potentially, your Medicare certification.

References:

Centers for Medicare and Medicaid Services. (October 22, 2024). *Updates to the Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report Acute Respiratory Illnesses.* Department of Health and Human Services. https://www.cms.gov/files/document/QSO-25-05-hospitals-cahs.pdf

The Joint Commission. Critical Access Hospital. California 2024 | Leadership, LD.04.01.01 EP3.

Wishing You and Your Family a Happy Holiday Season and Healthy New Year!

For more information on how to
keep your facility compliant with current Regulations and Standards,
contact Steven Hirsch, MPA, FACHE at

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