

List of Policies and Procedures for JCC Review 6-8-26

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
New	LHHPP	28-06	Behavioral Response Team (BRT)/ Therapeutic Care Team (TCT)	A. Michaud	New policy
Revised	LHHPP	24-12	Laguna Premier Club: A Neurobehavioral Day Program	A. Michaud	1. Added section "8. Family Members and Laguna Premier Club Activities"
Revised	Clinical Nutrition Services	Diet Manual	Diet Manual LHH 2026	L. Cecconi	Updated nutritional analysis for all diets Adjusted adequacy language for vegetarian diet Updated prostat flavor to include citrus splash or cherry)
Revised	Clinical Nutrition Services	1.12	Registration of Dietitians	L. Cecconi	Current date reflects Annual 2026 review- minimal grammatical revisions
Revised	Clinical Nutrition Services	1.15	Diet Manual Approved by Medical Staff	L. Cecconi	Current date reflects Annual 2026 review- minimal grammatical revisions
Revised	Clinical Nutrition Services	1.16	Nutrition Screening and Documentation Process	L. Cecconi	Current date reflects Annual 2026 review- one minor grammatical revision
Revised	Clinical Nutrition Services	1.19	Acute Medical/Rehab Admissions/Transfers	L. Cecconi	Current date reflects Annual 2026 review- minimal grammatical revisions
Revised	Clinical Nutrition Services	1.20	Nutrition Screening and Assessment Documentation for Acute Hospital Admissions	L. Cecconi	Current date reflects Annual 2026 review- highlighted text to emphasize protocol
Revised	Clinical Nutrition Services	1.22	Enteral Formulary Availability	L. Cecconi	Current date reflects Annual 2026 review- + designee
Revised	Clinical Nutrition Services	1.23	Discharge Diet Education	L. Cecconi	Current date reflects Annual 2026 review- minor formatting changes
Revised	Clinical Nutrition Services	1.25	NPO or Clear Liquid Diet Orders	L. Cecconi	Current date reflects Annual 2026 review- one minor grammatical revision
Revised	FNS	1.92	Standardized recipes	E. Lavarreda	<ol style="list-style-type: none"> 1. Delete-Established and revised :3/8,1/89, 5/97, 9/06, 7/09,8/13, 8/14 2. Replaced – reviewed to revised. 3. Added-3/26 4. Added- portion control of all. 5. Replaced products with items. 6. Replaced insure with ensure 7. Replaced Chef adapts to chefs convert 8. Included and approved by the RD. 9. Deleted – 11/6/2015
Revised	FNS	1.94	Safety Standards	E. Lavarreda	<ol style="list-style-type: none"> 1. Deleted-Established & 3/26,4/95,9/06,7/09,11/22. Reviewed: 8/13,8/14 2. Added: 3/26 3. Replaced- resident with Residents. 4. Revised Uniform Retail food Facilities Law to Uniform Retail Food code 5. Replaced- Through the use with using. Fourth edition 2006The national Restaurant foundation with Education. 6. Added Food ad Nutrition Service (FNS) staff such as supervisors and designee. 7. Deleted- and, At least three ,(such as egg salad). 8. Added- as. 9. Deleted- 11/292022
Revised	FNS	1.95	Use of Eggs	E. Lavarreda	<ol style="list-style-type: none"> 1. Deleted- Established and 3/89, 5/97, 7/03, 9/06, 5/08, 11/09, 6/10, 6/11. Reviewed - 8/13, 8/14. 2. Replaced – intertidis contaminated with bacteria 3. Capitalized- soft with Soft 4. Added – the sign ° for temperatures. 5. Deleted- 11/6/2015

Revised	Medical Staff Services		LHH Credentialing Policy and Procedures Manual	M. Henry	<p>These updates are being made to ensure compliance with San Francisco Health Plan's credentialing audit corrective action plan (CAP). The additional revision below is a result of SFHP's final audit on the CAP previously submitted based on contracted shared credentialing standards.</p> <ol style="list-style-type: none"> 1. Page 1, 3 – Updated to reflect new NCQA timeframe on primary source verifications on initial appointments and reappointments, from 180 days to 120 days effective July 1, 2025 2. Page 4 – Health Plan requirement, in response to NCQA Health Plan Accreditation standard CR 3, Element C, factor 6 requires non-discrimination statement be included on both the application and policy. Questions on race, ethnicity, and language capabilities are optional and will not be used in credentialing decisions 3. Page 11 – Added to indicate NPDB report is run monthly 4. Page 16 – Revised to meet the new 2025 NCQA requirements on Credentialing System Controls and be able to run reports in 2026. 5. Page 17 – Added to clearly identify the language on Data Deletion Protocol 6. Page 17 – Revised to explicitly name the example 7. Page 17 – Revised to name the example 8. Page 17 – Added example 9. Page 18 – Added copy of the excerpt from the CCSF Employee Handbook 10. Date on document header – changed to 2026 to reflect current revision 11. Approval Dates – Added Joint Commission Committee column to clearly identify approval dates
Revised	Nursing	G 1.0	Vital Signs	C. Figlietti	Revised policy #6 to state "V/S are checked monthly weekly with the weekly summary, at a minimum"

New Hospital-wide Policies and Procedures

BEHAVIORAL [EMERGENCY](#) RESPONSE TEAM (BERT) THERAPEUTIC CARE TEAM (TCT)

POLICY:

The Therapeutic Care Team (TCT) **is a trauma-informed term used to describe the Behavior Emergency Response Team (BERT). This team** is a group of LHH staff who will respond to staff needs for behavior management assistance. Under the supervision of the nurse manager, members of the TCT/[BERT](#) provide guidance and support (including documentation support) to staff working with high need residents and reinforce the treatment/support recommendations from Laguna Honda Hospital [and Rehabilitation Center \(LHH\)](#) Psychiatry Service, Risk Management, and others.

PURPOSE:

1. To help create and maintain a safe and therapeutic environment for all [Laguna Honda LHH](#) residents and staff.
2. To support and empower LHH staff in the process of acquiring and reinforcing behavioral management skills effective with high needs residents.
3. To provide an opportunity for [Laguna Honda Hospital LHH](#) staff to share their concerns and struggles and to help them problem-solve in a productive manner feel to make them feel supported through ~~TCT's~~ use of effective listening skills in interactions with frontline staff
4. To ensure staff consistently employ resident-centered trauma-informed interventions as recommended by the [Laguna Honda Hospital LHH](#) Psychiatric Service, Risk Management and others.
5. To reduce the instances of resident dysregulated behaviors, potential assaults on staff, and resident to resident assaults by instructing neighborhood staff to recognize and intervene early in the cycle of escalation.
6. To audit behavioral documentation in the electronic health record (EHR), track data, and provide staff education regarding behavioral care planning, accessing psychiatry documentation, breaking the glass, and other pertinent information.
7. To increase safe and regulated interactions between staff and residents, as well as among residents with use of Crisis Prevention Institute's Non-violent Crisis Intervention Training.

8. To link hospital staff with additional services such as the Employee Assistance Program (EAP) and recommend residents for beneficial programs within [Laguna Honda Hospital_LHH](#).

PROCEDURE:

1. The Therapeutic Care Team (TCT)/~~Behavior Emergency Response Team (-BERT)~~ members shall:
 - a. Obtain ~~Director of Staff Development (DSD) Certification~~ training and maintain expertise in the following areas:
 - i. Hospital Wide Policy and Procedure
 - ii. Resident Rights
 - iii. Crisis Prevention Institute's Non-Violent Crisis Intervention Training
 - iv. Harm Reduction and Motivational Interviewing
 - v. Suicidal Ideation
 - vi. Trauma Informed Care
 - b. Gather information before daily visit to the unit. Information is available in the following documentation:
 - i. CASPER's Behavior Affecting Others
 - ii. 802/672
 - iii. Nursing Report
 - iv. Safe Report System
 - v. ~~Electronic Health Record (EHR)~~
 - vi. LHH Psychiatric Service Evaluation/Behavior Plan
 - c. Round on the neighborhoods and check-in with the Charge Nurse or any pertinent staff regarding any behavioral health issues from complex residents in the past 24 hours.

- d. Initiate contact with LHH Psychiatric Service and build a strong working relationship in order to clarify and interpret behavioral interventions for nursing staff, as well as reinforce behavioral recommendations as stated in resident behavior plans.
- e. Teach, model, and reinforce new behavior management skills to staff on the neighborhoods.
- f. Provide practical support to staff and listen to their concerns.
- g. Investigate the resident's background through record review and inform staff of environmental and psychosocial factors that may explain resident behaviors.
- h. Educate staff about proper behavioral documentation in electronic health record.
- i. Ensure proper documentation and care planning—for residents with suicidal ideation.
- j. Provide psychological first aid at their discretion in order to achieve the following:
 - i. Mitigate the impact of an event.
 - ii. Accelerate the recovery process.
 - iii. Assess the need for debriefing or other services.
 - iv. Reduce cognitive, emotional, and psychological symptoms of staff stress
 - v. Provide self-care strategies, tools, and recommend public health resources.
- k. Consult on behavioral care plan development as needed.
- l. Attend resident care conferences (RCC).
- m. Provide resident support in the event of a safety search on the neighborhood.
- n. Attend behavioral rounds where applicable.
- o. Track data and audit charting.

2. On the neighborhood, TCT/BERT members will instruct neighborhood staff regarding early recognition and prevention of resident crises based upon Crisis Prevention Institute's Non-Violent Crisis Intervention Training.
 - a. Using the cycle of escalation, TCT/BERT members will educate staff to recognize how and when to effectively interact with residents in crisis.
 - b. TCT/BERT members will support staff in identifying/recognizing underlying causes of threatening behavior. The common underlying causes of threatening behavior are (but not limited to):
 - i. Paranoia
 - ii. Command and/or derogatory auditory hallucinations
 - iii. Frustration
 - iv. Heightened stimulation
 - v. Organic brain disorders and delirium
 - vi. Developmental disorders
 - vii. Intoxication and withdrawal
 - viii. Trauma triggers (Antecedents)
 - c. TCT/BERT members shall observe staff interactions, body language and relationship with the resident that affect their behaviors; as well as observing the escalation cycle for staff, ~~BRT members~~ TCT/BERT will assist staff to identify and utilize a self-control plan. TCT/BERT members will provide constructive feedback following an observation.
 - d. TCT/BERT members will emphasize teamwork, and practice how to intervene when a fellow staff member appears to be inadvertently escalating a resident (fireman's tap).
 - e. TCT/BERT members will help staff to recognize how age, developmental factors, diagnoses, gender, ethnicity, and history of trauma affects the way a resident reacts to behavioral interventions
 - f. Other related variables, TCT/BERT members shall assist staff to recognize when risk is present and how to mitigate risks.

- g. TCT/BERT members will model how to use distractions as a means of deescalating potential violence, such as resident-identified coping skills to assist de-escalation.

4. Attend Resident Care Conferences as needed

- a. TCT/BERT members are required to attend Resident Care Conferences, as availability permits, whenever applicable.
- b. Ensures TCT/BERT members foster a collaborative relationship with Resident Care Team members
- c. Provides an equitable and holistic approach for residents with behavior dysregulation by obtaining health histories, including psychosocial, functional, and developmental background information.

5. Attend Behavioral Management Huddles /Rounds

- a. TCT/BERT members are required to attend Behavior Management Huddles/Rounds whenever applicable. These huddles assist TCT members in the following ways:
 - i. Keep TCT/BERT members up-to-date of any potential changes regarding resident behaviors and /or interventions.
 - ii. Provide a forum for discussion with the entire Resident Care Team (RCT).
 - iii. Give and receive feedback from LHH Psychiatric Service clinicians regarding their consultations to the ~~Resident Care Team (RCT)~~RCT and/or ongoing behavioral health treatment for the resident.
 - iv. Participate in__—huddles regarding screening, evaluation results, and recommendations regarding suicidal ideation with ~~Resident Care Team (RCT)~~RCT members
 - v. Aid RCT in developing and implementing a resident's behavioral management plan.

ATTACHMENT:

None

REFERENCE:

SFDPH Employment Assistance Program sfhss.org/eap

LHHPP 60-04 Safe Report

LHHPP 22-10 Management of Resident Aggression

LHHPP 22-12 Clinical Search Protocol

LHHPP 23-03 Screening and Response to Suicidal Ideation

LHHPP 73-05 Workplace Violence Prevention Program

Revised:

Original adoption 06/15/26

Revised Hospital-wide Policies and Procedures

LAGUNA PREMIER CLUB: A NEUROBEHAVIORAL DAY PROGRAM

POLICY:

Residents of Laguna Honda Hospital and Rehabilitation Center (LHH) with behavioral expressions requiring additional support may be referred by the Resident Care Team (RCT) to the Laguna Premier Club (LPC), a Neurobehavioral Day Program.

PURPOSE:

To provide smaller, therapeutic, nurse-driven groups, including unit visits that are resident-centered and structured to meet our residents' neurobehavioral needs, utilizing evidenced-based approaches and key principles of a trauma-informed system (TIS) with interventions to address trauma's consequences and facilitate healing and well-being.

BACKGROUND:

Long-term care residents with cognitive and behavioral challenges have benefitted from a neurobehavioral day program consisting of smaller groups focused upon residents' individualized programming needs.

PROCEDURE:

1. Laguna Premier Club Referral Process

Resident must:

- a. Express a desire to participate in the program.
- b. Be referred via electronic medical record by the primary care provider and/ or any member of the Resident Care Team (with RCT approval).
- c. Meet the program Referral Criteria as follows: (See Appendix A: LPC Inclusion Criteria for more detail.)
 - i. Evidence of neurobehavioral effects based upon neurological dysfunction. This may include: dementia, traumatic brain injury, stroke, brain tumor, anoxia, hypoxia, electric shock, toxins, neurosurgery, significant impairment due to long term substance use, and/or degenerative conditions, such as Parkinson's disease and Huntington's disease.
 - ii. Presence of behavioral disturbances which are directly associated with brain injury or neurobehavioral deficit, as well as secondary behavioral disturbances that are associated with pain, functional impairment, personal needs, environmental factors, or limited social skills and/or problem solving.
 - iii. Possess sufficient auditory comprehension and attention to follow minimally complex conversations within a small group setting.

- iv. Maintain socially acceptable toileting habits.
- v. Maintain the ability to refrain from tobacco use during program hours.
- d. The RCT shall determine whether the resident would benefit from individualized interventions in smaller groups to address specific targeted behaviors. The resident shall then be referred to the LPC for evaluation.
- e. Pre-screening and intake shall be completed by LPC's licensed nurse on the neighborhood.
- f. The LPC's licensed nurse shall develop a customized schedule with input from the resident as well as neighborhood staff to include:
 - i. Reason for referral
 - ii. Target behavior(s)
 - iii. Qualifying Diagnoses
 - iv. Neighborhood Interventions
 - v. Preferred LPC activities:
 - Social Skills
 - Wellness
 - Thinking
 - vii. Possible activity/time preference for LPC
 - viii. Precautions (for resident aggression/triggers, etc.)

2. Initial Assessment

- a. Initial acceptance into the LPC shall be on a trial basis. Program benefits for each resident shall be determined, and a customized schedule shall be created accordingly within four (4) weeks.
- ~~b.~~ Initially, the trial period may take place on the neighborhood until the resident has demonstrated the ability to success
- ~~e-b.~~ _____ fully participate in groups.
- ~~d-c.~~ _____ Some residents who are not deemed suitable for group participation (i.e.: individuals who are triggered by increased stimuli) may continue to be seen on the neighborhood on a 1:1 basis by LPC staff well past their trial period as staffing permits.

3. Transportation

- a. Once transitioned to groups in the Kanaley Center, neighborhoods must commit to providing reliable transportation arrangements for the resident as LPC staff is limited and must prioritize resident safety.
- b. Reliable transportation to and from the program should be agreed upon between LPC staff and the neighborhood prior to acceptance to the program.

4. Active Program Participation

- a. Participants are provided a schedule at the time of their acceptance. The LPC team shall work to develop a rapport with the resident that is therapeutic and engaging in order to encourage their ongoing participation.
- b. Because target behaviors identified by the RCT may not be exhibited in environments other than their neighborhood, LPC staff may re-evaluate target behaviors during the trial period.
- c. Under the supervision of the LPC Charge Nurse, the LPC LVN may attend the Resident Care Conference (RCC), and shall serve as the primary neighborhood liaison to:
 - i. Coordinate resident schedules with neighborhoods (i.e. transportation to and from neighborhood).
 - ii. Communicate resident progress and share effective interventions while attending the program as well as on the neighborhood.
 - iii. Discuss any unforeseen issues that may have occurred during program time.
 - iv. Document in electronic health record resident participation/progress, and make recommendations, when appropriate, that shall assist the resident in achieving individualized goals.

5. Discharged from Program

- a. All residents are encouraged by LPC staff to remain active as participants.
- b. In the event of low or inconsistent attendance (a threshold of less than 65% attendance rate during one quarter), LPC staff shall explore the reasons for any refusal or absences and consult with the RCT as indicated.
 - i. LPC staff including LN's will follow our PDSA by visiting the residents in their units before their scheduled groups and will also discuss with unit staff any interventions they can share to help improve resident's attendance.

- ii. If residents continue to refuse to attend, they risk being discontinued from the program. The RCT shall be notified of the resident's discontinuation from the program by the licensed nurse liaison.
- c. Residents shall be discharged from LPC if transferred and admitted at UCSF, ZSFGH, etc.
 - i. Upon return to LHH, residents shall require a re-referral to verify any change of condition and confirm medical stability before resuming schedule,
 - ii. A re-referral shall be based upon their willingness to participate.

6. Therapeutic Interventions

- a. LPC staff are responsible for conducting smaller, nurse-driven groups including unit visits that are resident-centered and structured to meet our residents' neurobehavioral needs.
- b. Groups are categorized into three general areas of focus; each its own objective as follows:
 - i. Social Skills: To increase resident's awareness of their emotions and how their behaviors affect others.
 - ii. Wellness: To improve resident's health and wellness addressing the challenges of everyday life.
 - iii. Thinking: To strengthen resident's ability to attend, concentrate, problem solve, and remember personally meaningful information.
- c. Groups shall be presented in a therapeutic format which includes Orientation, Introduction, Activity, and Closing. (See Appendix B: Laguna Premier Club Therapeutic Structure)
- d. Evidence-based, Substance Abuse and Mental Health Services Administration (SAMHSA) approved modules involving various life skills are incorporated into the regular programming and presented by the LPC staff regularly.

7. Evaluation

- 1. LPC staff shall be evaluated on their professional presentation skills by LPC administration and be provided with feedback regarding their performance.

8. Family Members and Laguna Premier Club Activities:

- a. As with any therapeutic intervention, it is not recommended that family members attend activities and/or observe their loved one while attending the Laguna Premier Club.

- b. Family and other non-Laguna Honda staff unknowingly pose the risk of a possible HIPAA breach, defined as the unauthorized access, acquisition, use, or disclosure of unsecured Protected Health Information (PHI) which can potentially compromise the security or privacy of our LPC participants.
- c. In addition, residents who attend LPC have a variety of diagnoses and behavioral needs. The presence of family members and/or others may serve as a distraction for program participants or even worse, may represent a trigger for others.
- d. Family members should be respectful of any scheduled appointment for their loved one and make arrangements to plan to visit at a more appropriate time.

ATTACHMENT:

Appendix A: LPC Inclusion Criteria

Appendix B: Laguna Premier Club Therapeutic Structure

REFERENCE:

None.

Revised: 17/11/14, 21/09/14, 25/02/03 (Year/Month/Day)

Original adoption: 16/01/12

Appendix A: Guidelines: LPC Inclusion Criteria

Resident must:

1. Express a desire to participate in the program.
2. Be referred by primary care provider, or any member of the Resident Care Team (with RCT approval).
3. Meet the referral criteria below:

Referral to LPC

Process for referral

RCT shall determine if resident would benefit from more individualized interventions and small group interactions to address specific targeted behaviors. Resident shall then be referred to the LPC for evaluation.

- a. Resident must meet the program Referral Criteria as follows:
 - i. Evidence of neurobehavioral effects based upon neurological dysfunction. This may include: dementia, traumatic brain injury, stroke, brain tumor, anoxia, hypoxia, electric shock, toxins, neurosurgery, significant impairment due to long-term substance use, or degenerative conditions, such as Parkinson's disease and Huntington's disease.
 - ii. Presence of behavioral disturbances which are directly associated with the resident's brain injury or neurobehavioral process, as well as secondary behavioral disturbances that are associated with pain, functional impairment, personal needs, environmental factors, or limited social skills and problem solving.
 - iii. Sufficient auditory comprehension and attention to follow minimally complex conversations in a small group setting.
 - iv. Maintain socially acceptable toileting habits.
 - v. Ability to refrain from tobacco use during program hours.
- b. Initial acceptance into the LPC shall be on a trial basis. Benefits of program for each individual resident shall be determined and schedule shall be modified accordingly within 4 weeks.
- c. Initially, the trial period may take place on the neighborhood until the resident has demonstrated the ability to successfully participate in groups.
- d. Some residents who are not deemed suitable for group participation (for example, individuals who are triggered by increased stimuli) may continue to be seen on the neighborhood on a 1:1 basis by LPC staff well past their trial period as staffing permits.

- i. Pre-screening and Intake on the neighborhood is completed by the LPC licensed nurse and shall focus upon determining target behaviors with RCT.
- e. LPC shall focus on target behaviors resulting from complex neurobehavioral symptoms. These include:
 - i. **Physical Aggression** towards:
 - Others: Hitting; kicking; scratching; pinching; biting; pushing; throwing objects; pulling hair; spitting; head butting; etc.
 - Self: Hitting; scratching; pinching; biting; pica; head banging; etc.
 - Objects: Throwing objects; breaking objects; knocking over furniture.
 - ii. **Verbal Aggression**: Personal attacks on character, competence, or physical appearance; implicit threats; insults; teasing; profanity or inappropriate scolding; etc.
 - iii. **Disruptive Behaviors**: Any behavior that substantially or repeatedly interfere with resident or unit routines, such as irritability or persistent refusals; isolation; noncompliance; etc.
 - iv. **Limited or Altered Interpersonal Skills**: Expressing emotions in socially unacceptable ways; poor social boundaries; inappropriate sexual comments or behaviors; extreme anxiousness or irritability; depressed affect; frequent misperceptions; frequent misunderstandings; etc.
 - v. **Intrusive Tendencies**. Provocative behaviors, such as: grabbing; violating personal space; repetitive questions or statements; inappropriate comments; touching others without permission; loud verbalizations; offensive language; etc.
 - vi. **Impulsive Tendencies**. Wandering; sexual disinhibition; inappropriate comments; taking other people's belongings; persistent pacing; etc.

APPENDIX B:**Guidelines: Laguna Premier Club Therapeutic Structure**

LPC staff are responsible for conducting smaller, nurse-driven groups including unit visits that are resident-centered structured to meet our residents' neurobehavioral needs. Three main categories of LPC groups include:

1. Social Skills
2. Wellness
3. Thinking

Group Set Up:

1. The facilitator of the group shall arrange the participants in a semi-circle seated around a dry erase board or easel for visual cueing.
2. Facilitators shall stand in the center of the circle.
3. The topic shall be written on the dry erase board in order to reinforce its importance.
4. Remember to ask questions of the group in order to encourage participation.
5. Refrain from personal stories and dominating the discussion.

The basic structure of a therapeutic group shall include the following description with examples:

1. Group Orientation to Date, Location, and Name of Group

Today is _____ (day, month, date, year) and we are at Laguna Honda Hospital's Laguna Premier Club (LPC). This is our _____ (Wellness, Social, Thinking) group.

2. Introductions: to encourage turn taking and working memory.

- a. Use the passing of a ball or tossing a balloon to indicate each person's turn when introducing them self and sharing another bit of information about themselves (try to incorporate to relate to the day's topic).

My name is _____ and (add another question to share about themselves) _____ (e.g., My favorite place I have ever lived is _____).

- i. Be patient and allow each person time to remember what was asked of them.
- ii. Repeat any answers aloud for those who cannot or do not speak loud enough for the group to hear.

- iii. Throughout the activity the objective, topic, or group activity is referred to in order to aid memory.
- iv. Facilitator asks participants questions to encourage participation.
- v. Other staff present shall be responsible for monitoring safety (i.e.: seating arrangements to prevent wandering and/or aggressive incidents), addressing issues with residents 1:1, verbal outbursts, redirecting, de-escalation or personal needs).

3. Activity with Group Objective: Goal to be achieved by group intervention.

- a. Social Skills: To increase resident's awareness of their emotions and how their behaviors affect others.
- b. Wellness: To improve resident's health and wellness addressing the challenges of everyday life.
- c. Thinking: To strengthen resident's ability to attend, concentrate, problem solve, and remember personally meaningful information.

LPC Program Highlight Objectives:

- a. Evidence-Based SAMHSA Modules: To strengthen life skills by providing various topics of interest and discussion.
- b. News and Views/Coffee Club: To share information and integrate various opinions regarding current events, social issues and global views.
- c. Traumatic Brain Injury Group: To provide topics and employ strategies that assist memory, enhance recall, and increase retention of information.

4. Closing the Group Activity:

- a. At the close of the activity, the facilitator summarizes the group objective to remind participants of the context.
- b. Each resident is cued regarding their experience while motor skills and coordination are integrated with use of a bouncing ball or balloon toss.
- c. Participants shall be able to respond appropriately to questions based upon cognition and skill level.
- d. A relaxation exercise/deep breathing exercise is recommended to calm residents before transport back to neighborhood.
- e. The next meeting time is discussed.

Revised
Clinical Nutrition Services
Policies and Procedures

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition Department
Diet Manual

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition - Diet Manual

Updated & Revised: ~~October 7, 2025~~ April 23, 2026

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INTRODUCTION

The Laguna Honda Diet Manual serves as a guideline and informational tool for Laguna Honda Hospital (LHH) dietetic personnel and licensed healthcare practitioners acting within the scope of their professional licensure or certification. The LHH Diet Manual is tailored to the therapeutic needs of the population.

Once a diet is ordered, the diet is processed, and a meal tray is prepared for the resident by Food and Nutrition Services. Based on the facility's reasonable efforts, it is the role of the dietitian to accommodate the resident's nutrient needs with appropriate interventions within the patient's personal, cultural, and religious food preferences. All menus are coordinated for color, taste, consistency and texture, appeal, and presentation. Menus are adjusted to include seasonal commodities as available.

Nutritional Adequacy

All LHH Diets shall provide food of the quality and quantity to meet each patient's needs in accordance with the most current Recommended Dietary Allowance (RDA) and Daily Reference Intakes (DRIs) adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. Due to the lack of manufacturer information, not all vitamins and minerals can be reported. Vitamins and Minerals which do not have DRI/RDAs established and are not readily available in the USDA or vendor database cannot be evaluated for complete nutritional adequacy in the patient menu. When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team works to individualize nutritional care of the patient considering their food preferences.

Diet Liberalization

Therapeutic diets are considered both textured modified diets as well as therapeutics diets. The Regular diet is not considered a therapeutic diet. Diet liberalization is a nutritional component that may enhance the quality of life and nutritional status of older adults residing in health care communities. According to Federal Regulations (F692), "diet liberalization could be beneficial to minimize restrictions, such as therapeutic or mechanically altered diet, and provide preferred foods before using supplementation." The registered dietitian will assess, evaluate, and recommend appropriate and individualized nutrition interventions. Collaboration between the interdisciplinary team and the patient and/or decision maker is necessary to assess the risks versus benefits of liberalizing a therapeutic diet. On days when holiday menus are provided, residents quality of life may be prioritized and resident may be allotted foods outside of their therapeutic parameters, per discretion of the registered dietitian and interdisciplinary team.

28-Day Cycle Menu Analysis

The complete 28-Day Laguna Honda Diet cycle was analyzed using the nutrition database CBORD. Each meal, for the 28 days, was analyzed for calories, protein, carbohydrates, fats, minerals, and vitamins. Totals and averages were determined using Excel. Further information or a hardcopy of the nutrient analysis can be found in the Clinical Nutrition Department or by contacting (415) 682-5776.

The Laguna Honda Diet Manual format of each diet is as follows:

- I. Purpose denotes characteristics of each diet as a modification of the diet.
- II. Indications lists specific medical concerns for which the diets can be used.
- III. Adequacy indicates the nutritional adequacy of the diet based on the Dietary Reference Intakes (DRI), and the Recommended Daily Allowance (RDA).
- IV. Approximate Composition lists approximate calories, protein, and carbohydrate, fat and, as needed, specific nutrients provided in each diet.
- V. Suggested Meal Patterns show basic meal-planning guides with approximate amounts of foods specified according to dietary restrictions. The dietitian may adjust meal patterns to meet a resident's cultural, ethnic, food likes and dislikes and meal service preferences.

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition Department
Diet Manual

DIETS AT-A-GLANCE

Diet	Description	Average Calories	Average Protein (g)	Average Carbs (g)	Average Fat (g)
Regular	Designed to achieve or maintain optimal nutritional status in residents who do not require a therapeutic diet.	2300 <u>2350</u>	110	280 <u>285</u>	90
Dental Soft	Includes soft textured foods that are moist, easily crumbled, or served with sauce to increase moisture. For residents with difficulties chewing solid foods.	2250	105	280	80
Mechanical Soft	Designed to minimize the amount of chewing necessary to safely swallow food. For residents who have difficulty chewing or swallowing.	2150 <u>1950</u>	405 <u>100</u>	270 <u>240</u>	75 <u>65</u>
Semi-Puree	Contains food with a smooth consistency to facilitate ease of chewing and swallowing. A more liberal puree diet.	2050 <u>1950</u>	100	260 <u>230</u>	70
Full Puree	Contains food with a smooth consistency to facilitate ease of chewing and swallowing. For residents who are unable to chew or have difficulty swallowing.	1800 <u>1950</u>	100	240	50 <u>65</u>
Clear Liquid	A temporary and transitional diet intended to leave a minimal amount of residue in the gastrointestinal tract. Consists of clear fluids or foods which are fluid at body temperature.	1100	30	260	0
Full Liquid	Consists of a variety of foods that are liquid or very soft in texture. Includes liquid nutritional formula products. For residents who are unable to chew or tolerate solid foods.	2200 <u>2350</u>	125 <u>135</u>	280 <u>300</u>	70
Thickened Liquids	This diet is a modifier to any diet. Honey thick is the thickest consistency. Nectar thick is an upgraded liquid consistency. (Honey < Nectar < Thin)	1900 <u>2000</u>	85	260 <u>270</u>	50 <u>65</u>
Fluid Restriction	This is a diet modifier designed to prevent fluid retention (1000, 1200, 1500 and 1800 mL available). The amount of fluids delivered on the tray will equate to up to half of the daily allowance or as adjusted by RD for quality of life.	2050 <u>1800</u>	95 <u>80</u>	245 <u>230</u>	90 <u>70</u>
Consistent Carbohydrate	Provides consistent levels of carbohydrate at each meal for optimal glycemic control. Three levels available: 60g, 75g and 90g of carbohydrates per meal.	60g: 1600 <u>1750</u> 75g: 2000 90g: 2200	100 105 110	180 225 260 <u>270</u>	60 <u>70</u> 75 90
Renal	60g Protein, 2g Sodium, 2-3g Potassium, 800-1000mg Phosphorous. Designed for impaired renal function.	1600	60	200	60
Potassium Controlled	3g Potassium. Designed to achieve and maintain normal potassium levels.	1750 <u>1800</u>	85	220	60 <u>65</u>
Low Phosphorous	800-1000mg Phosphorous. Designed to achieve and maintain normal phosphorus levels.	1700 <u>2000</u>	70 <u>90</u>	215 <u>245</u>	65 <u>75</u>
Sodium Controlled	Helps to prevent fluid retention, promote the loss of excess fluids, and aid in blood pressure control. <ul style="list-style-type: none">• No Added Salt (3-5g sodium)–mild sodium restriction	NAS: 2250 <u>2300</u> 2g: 2100	110 <u>05</u> 105	275 <u>280</u> 260	80 <u>80</u> 75

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	<ul style="list-style-type: none"> • 2 Gram Sodium–moderate sodium restriction 				
Low Fat/ Low Cholesterol	Restricts intake of cholesterol to a level of approximately 300 milligrams per day. The percentage of fat in the diet is below 30% of the total calories, with the intake of saturated fat about 10%. Indicated for residents with high blood cholesterol levels and at risk for heart disease.	1800 1900	95 105	245 255	45 55
Modified Bland-Low Fiber	Reduce the frequency and volume of stools which lessens irritation to the gastrointestinal tract. Incorporates soft, non-irritating foods. Limits fiber, pepper, citrus fruits, raw fruits (except banana), raw vegetables, fatty foods, sources of caffeine and foods known to be gas-forming.	2000 2050	105 110	225 230	75 80
Vegetarian	Encompass a variety of plant-derived foods and exclude some foods derived from animals. Preferred avoidance of all animal products in the diet except dairy and eggs.	2300	90	310	80 85
Vegan	Encompass a variety of plant-derived foods and exclude all foods derived from animals. Preferred avoidance of all animal products in the diet.	1900	75	280	60
Allergens	To eliminate the eight food allergens, that are regulated by the Food and Drug Administration (FDA), from diets to prevent harmful food reactions to: Egg, fish, peanut, milk/lactose, shellfish, soy, tree nut, wheat/gluten	N/A	N/A	N/A	N/A

REGULAR DIET

I. PURPOSE

The regular diet is designed to achieve or maintain optimal nutritional status in persons who do not require a therapeutic diet. Offers choices that promote intake of whole grains, fresh fruits, and vegetables, soups, fish, and poultry. However, there are no restrictions and individual preferences may necessitate the exclusion of certain food items.

II. INDICATIONS

The regular diet is used to promote health and reduce the risks for the development of major, chronic, and nutrition-related diseases.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	23 50 0	110	28 50	90

V. SUGGESTED MEAL PATTERN:

BREAKFAST

- 4 oz. Fruit or Juice
- 1 Serving Cereal
- 1 Egg or Alternate
- 1 Slice Toast or Alternate
- 1 Pat Butter
- 8 oz. Low Fat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

LUNCH & DINNER

- 6 oz. Soup or Salad w/ Dressing
- 3 oz. Meat or Alternate
- 2 oz. Gravy
- 3 oz. Starch
- 3 oz. Cooked Vegetable
- 1 Serving Dessert
- 1 Slice Bread, 1 Pat Butter
- 8 oz. Low Fat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. General, Healthful Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=6. Accessed July 6, 2023.

TEXTURE MODIFIED DIETS

Dysphagia is the impaired ability to swallow. Diagnoses that may be indicative of potential swallowing problems include any resulting in neurological impairment, head and neck cancer or surgery, patients with tracheostomy, vocal cord dysfunction, aspiration pneumonia, and dementia.

A dysphagia diet or diet texture modification may reduce the risk of aspiration. Speech Language Pathologists (SLP) evaluate for swallowing deficits and recommend the least restrictive diet. The SLP works with the dietitian to optimize food variety while meeting the resident's nutritional and safety needs.

Signs to look for which may indicate possible dysphagia include:

- Coughing
- Choking
- Holding food in mouth
- Significant pocketing of food
- Significantly delayed swallow
- Significant leakage of food or liquid from the mouth
- Food or liquid coming from a tracheostomy (Serious sign of aspiration!)
- Excessive drooling
- Recurrent pneumonias

Note: Some persons with dysphagia can aspirate silently without exhibiting any of the above signs.

Dietary considerations for dysphagia:

1. Avoid small pieces of food for residents with reduced sensations as they can become lost in the mouth and increase the chance of choking.
2. Select foods that form a bolus within the mouth and do not break apart (e.g., bananas, mashed potatoes, macaroni, and cheese).
3. Avoid sticky foods that adhere to the roof of the mouth. These can cause fatigue in residents with muscle weakness and risk of airway obstruction.
4. Thickening of thin liquids may be tried with select pureed foods.
5. Residents with decreased salivation need moist foods. Gravies, extra margarine, sauces, salad dressing may be used. Dry foods may be dunked in soup or beverage.
6. Avoid milk products if excess mucus formation is a problem as they increase salivation.
7. Individualize diets for consistency.
8. High calorie, high protein foods should be emphasized for dysphagia residents managing limited intakes at a time.
9. Offer small frequent meals when minimizing fatigue and optimizing food temperature and total nutrient intake is desirable.
10. Residents requiring thickened liquids are at increased risk for dehydration. Thickened water and thickened juice should be offered several times a day between meals.

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The texture modified diets at Laguna Honda Hospital are modeled after the International Dysphagia Diet Standardization Initiative (IDDSI) guidelines. This is a globally recognized framework for describing and classifying texture-modified foods. It aims to improve the safety and care of individuals with swallowing difficulties. See below for a crosswalk of the IDDSI diet levels to those at Laguna Honda Hospital.

Regular (Level 7) includes normal, everyday foods of various textures. Regular Easy to Chew (Level 7) includes normal, everyday foods of soft/tender texture. Soft & Bite Sized (Level 6) includes soft, tender and moist foods. Minced & Moist (Level 5) includes very soft and moist food that can be easily mashed. Puree (Level 4) includes foods with a smooth texture with no lumps.

Moderately Thick (Level 3) can be eaten with a spoon and requires moderate effort to drink through a straw. Mildly Thick (Level 2) flows off a spoon, but slower than thin liquids and requires mild effort to drink through a straw.

Crosswalk of Laguna Honda Hospital Diets to IDDSI Diet Levels

Foods

LHH Diets	IDDSI Diets
Regular	Regular (Level 7)
Dental Soft	Regular Easy to Chew (Level 7)
Mechanical Soft	Soft & Bite Sized (Level 6)
Semi Puree	Minced & Moist (Level 5)
Full Puree	Puree (Level 4)

Liquids

LHH Diets	IDDSI Diets
Honey Thick	Moderately Thick (Level 3)
Nectar Thick	Mildly Thick (Level 2)
Thin	Thin (Level 0)

Reference

International Dysphagia Diet Standardization Initiative. Complete IDDSI Framework Detailed Definitions. <https://www.iddsi.org/resources/framework-documents>. Accessed April 28, 2025

DENTAL SOFT DIET

I. PURPOSE

This diet provides soft-textured foods that can be easily chewed, requiring minimal biting. Foods are moist, easily crumbled, or served with sauce or gravy to increase moisture. This diet follows the principles of the IDDSI Level 7 Easy to Chew diet.

II. INDICATIONS

This diet may be ordered for residents who have difficulty chewing solid foods because of missing teeth, poorly fitting dentures, and mouth pain.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2250	105	280	80

V. SUGGESTED MEAL PATTERN:

BREAKFAST

- 4 oz. Fruit or Juice
- 1 Serving Cereal
- 1 Egg or Alternate
- 1 Slice Toast or Alternate
- 1 Pat Butter
- 8 oz. Low Fat Milk
- 1 Serving Dessert
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

LUNCH & DINNER

- 6 oz. Soup or 6 oz. Soft Salad
- 3 oz. Meat or Chopped Alternate
- 2 oz. Gravy
- 3 oz. Starch
- 3 oz. Cooked Vegetable
- 1 Slice White or Wheat Bread
- 1 Pat Butter
- 8 oz. Low Fat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

DENTAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Milk	Milk, buttermilk, milkshakes, Plain or fruited yogurt.	Yogurt with nuts.
Meats, Fish, Poultry	Tender or chopped meats, diced chicken. Thinly sliced deli meats. Soft sandwich mixes. Baked, steamed or sauté fish.	Crispy fried or breaded meats, fish, and poultry. Hot dog. Thick sliced roasts or ham. Bone-in meats. Dry salami.
Cheese	Cottage cheese, soft cheeses.	Hard cheese.
Eggs	Soft scrambled eggs, soft cooked egg, fried egg, hard cooked egg, plain egg salad.	None.
Vegetables	Soft, cooked vegetables. Tomato juice.	Kernel corn. Other raw vegetables. Crunchy vegetables.
Fruits	Canned fruit. Soft fresh fruit: melon, strawberries, ripe banana. Fruit juices.	All other raw fruit, fruit that contains. pits, seeds, and skin. Other dried fruit.
Starches	Soft potatoes or yams, Rice, noodles.	Whole kernel corn. Crunchy noodles. French fries.
Cereals	Hot cereals. Cold flaked cereal.	All coarse cold cereals And those with nuts or dried fruits.
Breads	White, wheat, or rye bread. Pancakes, waffles, French toast. Cornbread, soft rolls, muffins.	All breads that Contain nuts.
Fats and Oils	Margarine, butter, strained Gravy, creamers, sour cream, mayonnaise, salad dressings. Sausage links.	Crisp bacon.

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DENTAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Soups	Soups made with allowed foods.	All other soups.
Beverages	Coffee, tea, sodas, milk. Liquid nourishment supplements.	None.
Desserts	Ice cream, sherbet, smooth puddings, gelatin, custard. Soft pies, cakes, cookies.	All desserts which Contain fibrous fruits And nuts.
Miscellaneous	Sugar, jelly, syrup, honey. Salt, spices.	Hard to chew snacks. Chewy candy. Hard candy. Pretzels

MECHANICAL SOFT DIET

I. PURPOSE

This diet is designed to minimize the amount of chewing necessary to safely swallow food by residents. This diet follows the principles of the IDDSI Level 6 Soft & Bite Sized diet.

II. INDICATIONS

This diet may be ordered for residents who have difficulty chewing or swallowing solid foods because of facial paralysis, poor or broken teeth, missing or poorly fitting dentures.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2150 1950	100 5	2470	675

V. SUGGESTED MEAL PATTERN:

BREAKFAST

4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Yogurt
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER

6 oz. Soup or 6 oz. Soft Salad
3 oz. Chopped Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Pat Butter
1 Serving Dessert
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain cereals and starches are served daily.

The mechanical soft diet can be reduced in texture as necessary to meet the resident's needs. These adjustments may include: *mechanical soft with puree vegetables and mechanical soft with puree fruits and vegetables*. This provides the resident with soft foods without all foods having to be pureed. The diet may also be partially upgraded in texture to regular with mechanical soft entrée.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 5 Minced and Moist (Orange) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=420. Accessed July 6, 2023.

MECHANICAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Milk	All milk: buttermilk, milkshakes, Plain or fruited yogurt. Ice cream.	Yogurt with nuts. Ice cream with nuts.
Meats, Fish, Poultry	Chopped meats and poultry. Chopped tender fish.	All whole meats, poultry, Fried fish, stringy meats. Hot dogs, hamburgers. Crunchy fried foods. Luncheon meats.
Cheese	Cottage cheese, soft cheese.	Hard or strong cheeses. Peanut butter.
Eggs	Soft scrambled eggs, soft cooked egg, fried egg. Plain egg salad.	Hard cooked egg.
Vegetables	Diced tender cooked or pureed vegetables. Tomato Juice.	Cut green beans, peas, corn, leafy greens. Fibrous, tough vegetables, Brussel sprouts, broccoli, raw vegetables.
Fruits	Soft canned, diced fruit, ripe banana. Fruit juices.	All other raw fruit or fruit Containing pits, seeds, skin.
Starches	Diced soft potatoes or yams, Juk. Rice, small or chopped spaghetti, macaroni, other pastas/noodles.	Kernel corn. Snack chips. Crunchy fried foods. Snack crackers.
Cereals and Breads	Hot cooked cereals. Cold flaked or puffed cereal. Chopped pancakes, waffles, French toast.	All coarse cold cereals. All breads, muffins, rolls. Crisp snacks, pretzels. Popcorn.
Fats and Oils	Margarine, butter, strained gravy, sauces, sour cream, cream, mayonnaise, salad dressings.	Crisp bacon, ham patty, sausage links and Other breakfast meats.
Soups	Soups made with allowed foods and Salt, herbs, spices, and seasonings.	All other soups.
Beverages	Coffee, tea, sodas, milk. Liquid nourishment supplements.	None.
Desserts	Ice cream, sherbet, gelatin, smooth Puddings. Sugar, jelly, syrup.	Pie, cakes. All desserts containing nuts and fibrous fruits. Hard to chew snacks, chewy candy. Dried fruit. Cookies.

SEMI-PUREE DIET

I. PURPOSE

The Semi-Puree Diet contains food which has a smooth consistency to facilitate ease of chewing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs.

The Semi-Puree diet is a more liberal puree diet in several ways and when tolerated is well accepted by the resident. This diet follows the principles of the IDDSI Level 5 Minced & Moist diet.

II. INDICATIONS

This diet is designed for residents who are unable to chew or swallow solid foods due to: poor or broken teeth, missing or poorly fitting dentures, sore gums, or decreased mentation that interferes with eating. Food consistency is based on resident clinical condition and individual tolerance.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1920 50	100	236 0	70

V. SUGGESTED MEAL PATTERN:

BREAKFAST

4 oz. Fruit or Juice
1 Serving Cooked Cereal
1 Egg or Alternate
1 Yogurt
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER

6 oz. Strained Soup
4 oz. Pureed Meat or Alternate w/Gravy.
3 oz. Mashed Potato or Alternate
3 oz. Pureed Vegetable
1 Serving Dessert
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain cereals and starches are served as tolerated.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 4 Pureed (Green) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July 6, 2023.

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SEMI-PUREE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>DO NOT SERVE</u>
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream With seeds, nuts, fruit Pulp or fruit skin.
Meats, Fish, Poultry	Meat, poultry, and fish which are smooth pureed consistency. Soft sandwich mixes made from tuna, egg, chicken with mayonnaise.	All regular meats, Fish and poultry if not pureed. Casseroles made w/ whole meats or vegetables. Lunchmeats.
Cheese	Cottage cheese.	Hard cheeses, soft cheeses.
Eggs	Scrambled eggs. Plain egg salad with mayonnaise.	All other eggs.
Vegetables	Pureed vegetable consistency, tomato juice.	Whole or fresh vegetables Unless blended until smooth.
Fruits	All fruit that is finely pureed. Applesauce, fruit juices, nectar Thickened juices.	All other whole, canned or fresh fruit. Coconut.
Starches	Smooth mashed potatoes or yams, Smooth polenta, cream of rice, corn puree, pasta puree. Juk.	All other potatoes, rice or noodles. Kernel corn, French fries.
Breads, Cereals, Grains	Hot smooth cooked cereals, e.g. cream of wheat, farina, malt-o-meal. Plain Rice Porridge, Oatmeal Minced pancakes.	All breads and crackers. Waffles, French toast. Cold cereal, pizza, tortillas. Cake, muffins.
Fats and Oils	Margarine, sour cream, mayonnaise, Strained gravies.	All fried foods. Avocado. Chunky sauces, tartar sauce.
Soups	Thickened strained cream soups, Strained broth soups.	Chunky soups containing Foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements	None.
Desserts	Custard, smooth puddings, gelatin Ice cream and sherbet.	Cookies, candy, jam, peanut butter. Baked products and cake. Doughnuts and pastries.
Miscellaneous	Sugar, salt, mild seasonings	Sticky /chewy food. Snack chips, pretzels, popcorn.

FULL PUREE DIET

I. PURPOSE

The Full Puree Diet contains food that has a smooth consistency to facilitate ease of swallowing and swallowing. Food choices are based on resident tolerance and the resident’s individualized needs.

II. INDICATIONS

The Full Puree diet is designed to facilitate eating for residents who are unable to chew, have difficulty swallowing or who may have other problems identified with feeding.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1958 0	100	240	655 0

V. SUGGESTED MEAL PATTERN:

BREAKFAST

- 4 oz. Fruit Juice
- 6 oz. Refined Hot Cereal
- 1 Serving Pureed Eggs
- 1 Serving Custard
- 1 Pat Butter
- 8 oz. Low Fat Milk
- Coffee, Tea, Decaf
- Half & Half
- Sugar, Salt, Pepper

LUNCH & DINNER

- 6 oz. Strained Soup/4 oz. Juice
- 4 oz. Puree Meat/Alternate
- 3 oz. Puree Starch/Gravy
- 3 oz. Puree Vegetable
- 1 Pat Butter
- 4 oz. Puree Fruit/Dessert
- 8 oz. Low Fat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 4 Pureed (Green) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July 6, 2023.

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FULL PUREE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>DO NOT SERVE</u>
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream With seeds, nuts, fruit Pulp or fruit skin.
Meats, Fish, Poultry, Cheese	Meat, poultry, and fish which are smooth pureed consistency	All regular meats, fish and poultry if not pureed. Lunchmeats. Cheese.
Eggs	Custard. Pureed scrambled eggs.	All regular eggs (boiled, scrambled, fried.)
Vegetables	Vegetables which are pureed Consistency, tomato juice	Whole or fresh vegetables.
Fruits	All fruit that is finely pureed. Applesauce, fruit nectars, Thickened juices.	All other whole, canned or fresh fruit and juices. Banana. Coconut.
Starches	Smooth mashed potatoes or yams, smooth polenta, cream of rice.	All other potatoes, Rice or noodles.
Breads, Cereals, Grains	Hot smooth cooked cereals, cream of wheat, farina, malt-o-meal, cream of rice, Plain Rice Porridge, Oatmeal	All breads , coarse grains, oatmeal, cornmeal, rolled wheat. All crackers. Pancakes, waffles, tortillas. Cold cereal.
Fats and Oils	Margarine, sour cream, Mayonnaise, strained gravies.	All fried foods. Avocado. Chunky sauces.
Soup	Thickened strained cream soups. Strained broth soups.	Chunky soups containing Foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements.	None.
Desserts	Smooth puddings, custard, plain ice cream, gelatin, sherbet.	All baked products, Cookies, pastry, nuts, dried fruit, jam.
Miscellaneous	Sugar, clear jelly, salt, Mild spices.	Candy, peanut butter. Pizza, popcorn, chips. Sticky or chewy food.

CLEAR LIQUID DIET

I. PURPOSE

This temporary, transitional diet intended to leave a minimal amount of residue in the gastrointestinal tract. It supplies fluid, electrolytes and energy in a form that requires minimal digestion. This diet consists of clear fluid or foods which are fluid at body temperature.

II. INDICATIONS

This diet is designed to provide fluids and calories to prevent dehydration in residents who have diarrhea and or vomiting. This diet is also used for test diets requiring a clear G.I. tract.

III. ADEQUACY

This diet does not meet the Recommended Daily Allowances for most nutrients. If residents are on this diet for more than three days, the rationale for the diet should be reviewed and revised, if necessary.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1100	30	260	0

V. SUGGESTED MEAL PATTERN:

BREAKFAST, LUNCH & DINNER

- 8 oz. Juice
- Coffee/Tea/Decaf
- Chicken or Beef Broth
- 4 oz. Fruit Gelatin
- Ensure Clear 8 oz.

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>DO NOT SERVE</u>
Clear Liquid Foods		
Soups	Clear broth or bouillon	All Others
Sweets and Desserts	Clear, flavored gelatin, Clear fruit ices/popsicles, sugar, honey, hard candy, sugar substitutes.	All Others
Beverages	Clear fruit juices, such as apple, cranberry, or grape juice. Clear coffee or tea and carbonated beverages, as allowed and tolerated.	All Others including Nectars, milk, cream, juices with pulp.
Miscellaneous	High caloric clear supplement beverages	All Others

FULL LIQUID DIET

I. PURPOSE

This diet consists of a variety of foods that are liquid or very soft in texture. In addition, supplements such as liquid nutritional formula products are served. The primary foods allowed on this diet are strained soup, custard, gelatin, juice, milk, pudding, and ice cream.

II. INDICATIONS

This diet is designed for residents who are unable to chew due to recent dental surgery or are unable to tolerate solid foods due to cancer of the mouth, throat, stomach, or G.I. tract. This diet may be used as the interim diet in weaning residents from enteral diets, when swallowing semi-soft solid foods is a problem. This diet should be advanced as tolerated. However, long term use of this diet may be warranted for quality of life and pleasure.

III. ADEQUACY

The Full Liquid Diet is not nutritionally adequate and therefore should not be used for extended periods of time without consultation with the dietitian.

IV. APPROXIMATE COMPOSITION: (includes the use of supplements)

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	220 <u>350</u>	12 <u>35</u>	280 <u>300</u>	70

V. SUGGESTED MEAL PATTERNS:

BREAKFAST

- Refined Cereal
- Custard
- Low Fat Milk
- 8 oz. Juice
- Coffee/Tea/Decaf
- 8 oz. Nx Liquid

LUNCH & DINNER

- Strained Cream Soup
- Custard
- Yogurt
- Low Fat Milk
- 8 oz. Juice
- Coffee, Tea, Decaf
- 8 oz. Nx Liquid

THICKENED LIQUIDS

I. PURPOSE

Thickened liquids are recommended for people with swallowing difficulty. Consuming thickened liquids will decrease aspiration risk. Laguna Honda Hospital currently supplies thin, nectar, and honey thick liquids. Honey thick is the thickest consistency << Nectar thick is an upgraded liquid consistency << thin liquids (no diet order required, automatically supplied on tray with any diet order without liquid consistency specially ordered by MD). Liquid consistency may be ordered with a swallow evaluation recommendation, MD/RD/Nursing observation or resident preference for quality of life.

II. INDICATIONS

Dysphagia, difficulty swallowing, head/throat/esophageal cancer, radiation therapy, cognitive impairment, thin liquids are observed not to be tolerated by speech therapist, RD, nursing staff, MD, resident, or family member.

III. ADEQUACY

This diet is a modifier to any diet.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1900 <u>2000</u>	85	2760	5065

V. SUGGESTED MEAL PATTERN:

BREAKFAST

- 4 oz. Honey or Nectar Fruit or Juice
- 1 Serving Cereal
- 1 Egg or Alternate
- 1 Slice Toast or Alternate
- 1 Pat Butter
- 8 oz. Honey or Nectar Low Fat Milk
- Sugar, Salt, Pepper

LUNCH & DINNER

- 6 oz. Nectar Thick Soup or Salad w/ Dressing
- 3 oz. Meat or Alternate
- 2 oz. Gravy
- 3 oz. Starch
- 3 oz. Cooked Vegetable
- 1 Serving Dessert
- 1 Slice Bread, 1 Pat Butter
- 8 oz. Honey or Nectar Low Fat Milk
- Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

VI. LIQUID FOOD GUIDE

All puree and strain soups may be ordered w/specialized feeding plan and/or MD order for quality of life and can be thickened with honey or nectar thick packets using manufacturer's instructions.

Beverages such as milk, juices without pulp, coffee, tea, soda, carbonated beverages, alcoholic beverages, eggnog, and nutritional supplements should be thickened to the right thickness as ordered by MD.

Frozen beverages such as malts and milk shakes should be avoided.

THICKENED LIQUIDS

VI. LIQUID FOOD GUIDE

Sherbet, frozen yogurt, and ice cream should be avoided.

Gelatin should also be avoided.

Yogurt is acceptable for honey and nectar thick liquid consistency.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Thickened Liquid Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=424. Accessed July 6, 2023.

FLUID RESTRICTION

I. PURPOSE

This is a diet modifier designed to prevent fluid retention. It can be added to any diet order and specifies the daily fluid allowance in milliliters (mL) as 1000 mL, 1200 mL, 1500mL and 1800 mL. The amount of fluids delivered on the tray will equate to up to half of the daily allowance or as adjusted by RD for quality life. The quantity of fluids provided may have slight variations due to resident preferences and/or menu offerings available. This allows the remaining fluids to be administered by nursing for medication administration and floor stock fluid requests.

II. INDICATIONS

Residents with the following diagnosis may have a fluid restriction ordered by the MD: heart failure, renal dialysis disease, hepatic disease, hypervolemia; hyponatremia.

III. ADEQUACY

Fluid adequacy is based on the physician order.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	<u>1800</u> 2050	<u>95</u> 80	<u>230</u> 45	<u>79</u> 0

V. FLUID RESTRICTON MEAL PATTERN:

BREAKFAST

- 1 Serving Cereal
- 1 Egg or Alternate
- 1 Slice Toast or Alternate
- 1 Pat Butter
- 8 oz. Low Fat Milk
- Sugar, Salt, Pepper
- 4 oz. fruit juice, 8 oz. Milk and/or 8 oz. Coffee

LUNCH & DINNER

- 3 oz. Meat Alternate
- 2 oz. Gravy
- 3 oz. Starch
- 3 oz. Cooked Vegetable
- 1 Serving Dessert
- 1 Slice Bread
- Sugar, Salt, Pepper

<u>Restriction</u>	<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Total Dietary</u>
1800 mL	300 mL	300 mL	300 mL	900 mL
1500 mL	240 mL	240 mL	240 mL	720 mL
1200 mL	240 mL	120 mL	240 mL	600 mL
1000 mL	240 mL	120 mL	120 mL	480 mL

*Fluids provided may vary due to resident preferences and/or menu offerings available

FLUID RESTRICTION

VI. FLUID AND CONTENT OF SELECTED FOODS

Food Item	Fluid (mL)	Food Item	Fluid (mL)
Broth (6 oz.)	180	Ice Cream	120
Hot Cocoa (8 oz.)	240	Gelatin	120
Coffee/Tea (8 oz.)	240	Milk (8 oz.)	240
Creamer	15	Soup (6 oz.)	180
Fruit Ice (4 oz.)	120	Ensure Clear (8 oz.)	240
Fruit Juice (4 oz.)	120	Ensure Van, Choc, Straw (8 oz.)	240
Sherbet (4 oz.)	120	Ensure Enlive (8 oz.)	240

Supplements:

Fluids provided from supplements should be accounted for in the fluid restriction.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Fluid-Restricted Nutrition Therapy.
https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=413. Accessed July 6, 2023.

CONSISTENT CARBOHYDRATE DIETS

I. PURPOSE

The goals of nutritional therapy and diabetes management for all people are:

- to improve blood glucose and lipid levels
- to promote consistent day-to-day intake for people with insulin-dependent diabetes
- weight management for people with non-insulin-dependent diabetes
- to encourage healthy eating habits for residents during their stay at LHH, for residents with diabetes and for those with coexisting medical conditions.

The consistent carbohydrate diets are based on recommendations from the Academy of Nutrition and Dietetics, which recommends consistent carbohydrate intake at snacks and meal on a day-to-day basis for improved glycemic control. The diet provides consistent levels of carbohydrate at each meal. There are three levels available: 60g, 75g and 90g of carbohydrates per meal.

Consistency in meal schedules and portion sizes assist in normalizing blood sugar. Protein, fat, and carbohydrate are divided throughout the day; foods high in added sugars are avoided.

Institutional menus are carefully planned and served to accommodate a resident's preferences. The dietitian adjusts dietary patterns for individual preferences and tolerances, to maximize compliance with dietary restrictions and consistency in carbohydrates. A variance of +/- 15g of carbohydrate is allotted per meal to allow for variety and adequacy in the diet.

Morning, afternoon, or evening nourishments, composed of both protein and carbohydrate, may be planned when necessary or by request.

II. INDICATIONS:

Diabetes mellitus or altered glucose tolerance.

III. ADEQUACY

Diets are nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION

See individual dietary patterns by carbohydrate level in section VII.

CONSISTENT CARBOHYDRATE DIETS

V. FOODS TO AVOID:

Condiments: Sugar, honey, jam, jelly, molasses, maple syrup, corn syrup

Breakfast Foods: Sweetened or sugar-coated cereals, doughnuts, sweet rolls.

Fruits: Dried fruit, frozen or canned fruit with added sugar or syrup.

Beverages: Sweetened sodas or other beverages containing sugar.

Desserts: Cakes, pies, cookies, ice cream, gelatin, pudding.

Snacks: Candy, milkshakes, snack chips and snack crackers.

VI. FOODS CONSIDERED ACCEPTABLE IN UNLIMITED AMOUNTS

Sugar substitutes	Fat Free broth
Coffee, tea, Decaf	Bouillon
Unsweetened Gelatin	Consommé
Vinegar	Unsweetened Cranberries
Spices and Herbs	Unsweetened Lemons and Limes
Mustard	Unsweetened Pickles
Raw Vegetables	Horseradish
Lettuce	Sugar Free Beverages
Cucumber	Radish
Parsley	

CONSISTENT CARBOHYDRATE DIETS

VII. MEAL PATTERN BY CARBOHYDRATE LEVEL

Carbohydrate Level	60g	75g	90g
Calories:	1675 00	- 2000	2200

Protein (g):	100	105	110
Carbohydrate (g):	180	225	276 0
Fat (g):	76 0	75	90

Diabetic Exchange Groups (Approximate) Served at Meals for Each Carbohydrate Level

	60g (4 CHO/meal)	75g (5 CHO/meal)	90g (6 CHO/meal)
Breakfast:			
Fruit	1 (15 g CHO)	1 (15 g CHO)	1 (15 g CHO)
Bread/Starch	2 (15 g CHO)	3 (15 g CHO)	4 (15 g CHO)
Egg/Protein	1	1	2
Fat	1	1	1
Milk	1 (12 g CHO)	1 (12 g CHO)	1 (12 g CHO)
Lunch/Dinner:			
Meat/Protein	2	3	3
Bread/Starch	2 (15 g CHO)	3 (15 g CHO)	4 (15 g CHO)
Vegetable	1	1	1
Fruit	1 (15 g CHO)	1 (15 g CHO)	1 (15 g CHO)
Fat	1	1	1
Milk	1 (12 g CHO)	1 (12 g CHO)	1 (12 g CHO)

*1 Exchange Group = 15 grams Carbohydrate

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Carbohydrate Counting for People with Diabetes.

https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=123. Accessed July 6, 2023

<https://diabetes.org/healthy-living/recipes-nutrition/understanding-carbs/carb-counting-and-diabetes>. Accessed July 6, 2023.

RENAL DIET

I. PURPOSE

The protein (60 gm.), sodium (2.0 gm.), potassium (2-3 gm.) and phosphorus (800-1000 mg.) controlled diet is designed to provide adequate amounts of essential nutrients and sufficient calories to maintain optimal nutritional status in those residents with impaired renal function. Modifications in the diet may be moderate or may require complex modification depending on the stage of kidney disease. Refer to individual sodium, potassium, phosphorus restricted diets for comprehensive information on food recommendations.

II. INDICATIONS

This diet provides a guide for planning diets for persons with acute or chronic renal failure, and for residents on hemodialysis and peritoneal dialysis. The cause and the degree of kidney dysfunction should determine the level of protein, sodium, and potassium restriction in the diet.

Protein intake needs to be controlled to avoid excessive amounts of nitrogenous waste products in the blood and to prevent negative nitrogen balance.

Sodium content of the diet is controlled to help maintain normal hydration status, to avoid fluid retention, hypertension, and to help prevent congestive heart failure. Pyelonephritis and polycystic kidney diseases tend to be salt wasting conditions that require increased sodium.

Potassium content of the diet is controlled to prevent hyperkalemia, as well as hypokalemia in some instances. Consideration for the level of potassium in the diet includes checking serum potassium levels, urinary potassium level, and drug therapy (such as digoxin, furosemide, etc.). Stress, catabolism, and diabetic ketoacidosis can increase potassium levels.

III. ADEQUACY

This diet is potentially low in calories, minerals, and vitamins. A nutrition supplement with low protein, high calories may be recommended to bring the calories, minerals, and vitamins up to optimal. Calcium-based phosphate binders are often used with this patient population and should be taken into consideration when analyzing overall calcium intake.

IV. APPROXIMATE COMPOSITION:

RENAL - 60 gm Protein, 2 gm Sodium, 2 – 3 gm Potassium, 800-1000 mg Phosphorus

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1600	60	200	60

V. SUGGESTED MEAL PATTERN:

RENAL - 60 Gram Protein, 2 Gram Sodium, 2 – 3 Gram Potassium, 800-1000 mg Phosphorus

BREAKFAST

- 4 oz. Fruit Juice (low potassium)
- 1 Serving Cereal – Half & Half
- 1 Slice Toast
- 1 Pat Butter
- 1 Egg
- 8 oz. Low Fat Milk
- Coffee, Tea, Decaf
- Sugar, Pepper

LUNCH & DINNER

- Salad w/Diet Dressing (Lunch)
- ½ Portion LS entrée (limited beans and processed meat)
- ½ Portion LS Starch
- ½ Portion LS Vegetable (low potassium)
- 1 Slice –read - 1 Pat Butter
- 1 Serving Fruit (low potassium)
- 4 oz. Nondairy Substitute (Lunch or Dinner)
- Sugar, Pepper, Half & Half

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RENAL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Milk and Milk Products	All in limited quantities within 8 fl. oz. restriction per day	Soy milk, malted milk. Excess of 8 fl. oz./ day of milk, chocolate milk, buttermilk, puddings, cream soups, light cheese, soy milk
Meats, Fish, Poultry	All except those excluded, tofu ok	Canned, cured, smoked, pickled, spiced or Processed meats, such as bacon, Sausage, luncheon meats, frozen dinner, Canned meats, dried peas, limit beans and lentils, avoid salted nuts.
Meat Alternates	1 egg daily, tofu ok	Beans
Vegetables	All those not high in potassium Vegetables included but not limited To green and wax beans, beets, Cabbage, carrots, cauliflower, celery Corn, cucumber, green peas, summer squash, turnips, peppers, onions, asparagus, zucchini, greens (mustard, collard)	All those high in potassium Canned vegetables, vegetables in brine, artichoke, potato, sweet potato, spinach, Brussel sprouts, chard, pumpkin, yams, okra tomato and tomato sauce
Fruits	All those not high in potassium Fruits included but not limited to apple, Blueberry, cranberry, fruit cocktail, grape Juice, grapes, peaches, pears, pineapple, Strawberry, watermelon	All those high in potassium Dried fruits, bananas, orange and juice, raisins, prunes, and juice, avocado, apricots, Limit: cherries, cantaloupe, grapefruit, mango
Breads, Cereals	Most bread, cereals (1 cup), pasta, rice	Whole wheat breads, croissants, Sweet potatoes, potato chips, bran Avoid potatoes.
Fats and Oils	Butter or margarine. All fats and oils, low salt gravy, mayo, Salad dressings	Bacon, cream sauces, sour cream
Soups	All except those not recommended	Meat bouillon, broth, consommé. Soups made with meat stock. base or with tomatoes. Butternut.
Beverages	Carbonated beverages other than cola, Coffee, tea, milk limited to 1 cup/day	Cola, cocoa, tomato/veg juice, canned soup, coconut water.
Desserts	All except foods not recommended	Chocolate, nuts, cream/pumpkin pies,
Miscellaneous	Herbs and spices without added salt, all Except those listed in foods not Recommended	Salt, monosodium glutamate, olives, soy sauce, teriyaki sauce, barbeque. sauce, ketchup, phosphorus. containing ingredients (e.g., calcium phosphate, disodium phosphate, phosphoric acid, etc.)

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RENAL DIET

Reference

Nutrition Care Manual. Chronic Kidney Disease Stage 3-5 Nutrition Therapy

https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157. Accessed July 6, 2023.

Nutrition Care Manual. Chronic Kidney Disease Stage 5 Tips for People Not on Dialysis Receiving Conservative, Supportive or Medical Care Nutrition Therapy

https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=160. Accessed July 6, 2023.

POTASSIUM CONTROLLED DIET

2-3 gram Potassium

I. PURPOSE

The diet is designed to achieve and maintain normal potassium levels in individuals at risk for hyperkalemia. This diet also allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

II. INDICATIONS

Elevated serum potassium and resident medical condition determine level of potassium restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are receiving Renal Dialysis, hyperkalemia, receiving potassium sparing medications and extensive tissue damage.

III. ADEQUACY

This diet may not meet all the Recommended Dietary Allowances; therefore, supplements may be required. The 2-3 gram potassium level is recommended where moderate control is desired.

IV. APPROXIMATE COMPOSITION:

	Potassium (g)	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2.5	1750 1800	85	220	65 0

V. SAMPLE MEAL PATTERN: 2-3 Gram Potassium

BREAKFAST

- 4 oz. Juice (low potassium)
- 1 Serving Cereal
- 1 Egg
- 1 Slice Toast
- 1 Pat Butter
- 8 oz. Low Fat Milk
- Coffee, Tea
- Sugar, Pepper

LUNCH & DINNER

- 6 oz. Salad/Soup - Lunch **or** Dinner
- 3 oz. Meat or Alternate (limit intake of fish/bean/turkey)
- 3 oz. Rice or Noodles (avoid potatoes)
- 3 oz. Vegetable (low potassium)
- 1 Serving Fruit Dessert (low potassium)
- 1 Slice Bread
- 1 Pat Butter
- Coffee, Tea
- Sugar, Pepper

Snacks included per patient preference and/or to meet nutrient needs.

Reference

Academy of Nutrition Dietetics. Nutrition Care Manual. Chronic Kidney Disease Stages 3-5 Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157. Accessed July 6, 2023.

Academy of Nutrition and Dietetics. Nutrition Care Manual. Potassium Content of Foods. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=478. Accessed July 6, 2023.

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POTASSIUM CONTROLLED DIET

2-3 gram Potassium

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Milk and Milk Products	All in limited quantities within 8 fl. oz. restriction per day	Soy milk, malted milk. Excess of 8 fl. oz. per day of milk, chocolate milk, buttermilk, yogurt, puddings, cream soups, Cheese, cottage cheese, custard, ice cream
Meats, Fish, Poultry	Meats; Fish except those not Recommended	Fish-halibut, tuna, cod, snapper, Turkey
Meat Alternates	1 egg daily.	Beans
Vegetables	Beets (canned), Broccoli, Cabbage, Carrots, Cauliflower, Corn, Cucumber, Eggplant, Green Beans, Kale, Lettuce (1 cup), Mushrooms, Onions, Radishes, Snow Peas, Summer Squash, Turnips	Artichokes, Avocado, Brussel Sprouts, Butternut Squash, Greens (Mustard /Collard), Okra, Parsnips, Potato, Pumpkin Spinach, Sweet potatoes, Swiss Chard Tomatoes, Tomato Sauce/Puree/ Juice, Wax Beans, Winter Squash, Yam
Fruits	Apples, Applesauce, Blueberries Cranberry Fruit/Juice, Fruit Cocktail Grape Juice, Grapes, Lemon, Lemon Juice, Limes, Lime Juice, Peaches (canned), Pineapples, Plums (1), Strawberries, Tangerines (1), Watermelon	Pomegranate, Prune Juice, Prunes, Raisins
Breads, Cereals	White and Brown Rice, Tortilla, flour Or corn, Waffles, Bagels, English Muffin, Oatmeal, White Bread/Pasta	Bran Muffins, dark rye bread, gingerbread, granola, Avoid potatoes.
Fats and Oils (Limit meat gravies)	Butter or margarine. All fats and oils.	Limit intake of nuts/seeds
Soups	All except those not recommended	Meat bouillon, broth, consommé. Soups made with meat stock. base or with tomatoes. Butternut.
Beverages	Cranberry juice, tea	Limit dairy intake, fruit/veg juices. high in Potassium, soy milk
Desserts	Marshmallows, gelatin, ice pops	Desserts made with high amounts of dairy or high potassium veg/fruits.
Miscellaneous	All except foods not recommended	Salt-Substitutes, chocolate, maple syrup, barbeque sauce, soy sauce, steak sauce, Worcestershire sauce

LOW PHOSPHORUS DIET

800-1000 mg Phosphorus

I. PURPOSE

This diet is to achieve and maintain normal phosphorus levels in individuals at risk for elevated phosphorus levels in the blood. It is a modifier of the regular diet that excludes/limit foods high in phosphorus and limit phosphorus intake from meals to less than 1000 mg per day. This allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

II. INDICATIONS:

Elevated serum phosphorus and resident medical condition determine level of phosphorus restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are: Renal Dialysis disease, autoimmune activating mutations of the calcium-sensing receptor, parathyroid disease, Vitamin D or Vitamin A intoxication, granulomatous disease, immobilization, osteolytic metastases, milk-alkali syndrome and severe hypermagnesemia or hypomagnesemia.

III. ADEQUACY:

This diet may not meet all the Recommended Dietary Allowances; therefore, supplements may be required. The 800–1000-gram phosphorus level is recommended where moderate control is desired.

V. APPROXIMATE COMPOSITION:

	Phosphorus (mg)	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1000	1700 <u>2000</u>	7 <u>90</u>	24 <u>15</u>	7 <u>65</u>

V. SAMPLE MEAL PATTERN: 800-1000 mg Phosphorus

BREAKFAST

- 4 oz. Juice
- 1 Serving Cereal
- 1 Egg
- 1 Slice Toast
- 1 Pat Butter
- Coffee, Tea (non-dairy creamer)
- Sugar, Pepper

LUNCH & DINNER

- 6 oz. Soup - Lunch or Dinner
- 3 oz. Meat or Alternate (limit meat and legume)
- 3 oz. Rice or Noodles (avoid whole grains)
- 3 oz. Bland Vegetable
- 1 Serving Fruit Dessert
- 1 Slice Bread
- 1 Pat Butter
- 8 oz. Low Fat Milk (limited quantity, no more than 1 cup/day)
- Coffee, Tea
- Sugar, Pepper

Additional snacks may be added based on individual patient needs if total phosphorus intake within limit.

LOW PHOSPHORUS DIET

800-1000 grams Phosphorus

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Milk and Milk Products	Whole, low fat or nonfat milk Cheese. Ice cream, sherbet. (8 oz. milk/day)	Commercial milk drinks, milkshakes. Cocoa, cream soups, cottage cheese, yogurt, puddings, custard, ice cream, buttermilk
Meats, Fish, Poultry	Limit meats	Organ meats (1 oz.), nuts (1/4 cup),
Meat Alternates	1 egg daily	Tofu (1/4 cup), Vegetarian meat replacements
Vegetables	All, except peas	Peas
Fruits	All fresh or canned fruits and fruit juices	None
Breads, Cereals and Starches	Refined white grains, bread, pasta bagel (1/2 small); bread, all kinds (1 slice); dinner roll (1 ea.); English Muffin (1/2)	Biscuits, muffin (1 small); granola/oatmeal (1/2 cup); pancakes/waffles (1 ea.); whole wheat cereal, bran cereal (1/2 cup). tortillas, corn (2 ea.); whole grain bread; brown rice
Fats and Oils	All fats and oils.	Limit intake of nut and nut butters
Soups	None.	Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes.
Beverages	All, except those not recommended	Chocolate drinks, cocoa, drinks made w/milk, canned iced teas, dark colas.
Desserts	All, except those excluded.	Chocolate, caramels, desserts made primarily from dairy products (cheesecake)
Miscellaneous	All, except those not recommended	Phosphorus-containing ingredients (e.g. calcium phosphate, disodium phosphate, Phosphoric acid, etc.)

Reference

Nutrition Care Manual. Chronic Kidney Disease Stage 3-5 Nutrition Therapy.

https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157 . Accessed July 6, 2023

Nutrition Care Manual. Phosphorus Content of Foods.

https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=477 . Accessed July 6, 2023

SODIUM CONTROLLED DIETS

I. **PURPOSE**

The goal of sodium restriction is to help prevent fluid retention, promote the loss of excess fluids, and aid in blood pressure control.

II. **INDICATIONS:**

Restriction of dietary sodium may decrease body fluid volume and relieve symptoms of diseases, e.g., congestive heart failure or other cardiovascular diseases, cirrhosis, hypertension, ascites, SIADH, other conditions that may cause fluid retention, hypernatremia, or renal diseases where the kidneys cannot get rid of excess sodium and water. The physician should specify the level of sodium restriction desired using the following guide:

No Added Salt (3-5 grams sodium - 130-217 mEq)--mild sodium restriction

2 Gram Sodium (87 mEq)--moderate sodium restriction

For greater flexibility and resident compliance, it is preferred that the No Added Salt diet be ordered for

III. **ADEQUACY**

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. **APPROXIMATE COMPOSITION:**

2 gm Sodium (87 mEq), moderate sodium restriction

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2100	105	260	75

No Added Salt Diet (3–5-gram sodium - 130-217 mEq)--mild sodium restriction

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2250 2300	110 95	275 80	80

SODIUM CONTROLLED DIETS

SUGGESTED MEAL PATTERN:

2 Gram Sodium

BREAKFAST

4 oz. Fruit or Juice
1 Serving Low Sodium Cereal
1 Serving Low Sodium Egg
1 Slice Toast
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Pepper
Coffee, Tea, Decaf

LUNCH & DINNER

6 oz. Low Sodium Soup or Salad w/Diet Dressing
3 oz. Low Sodium Meat or Alternate
2 oz. Low Sodium Gravy
3 oz. Low Sodium Starch
3 oz. Low Sodium Vegetable
1 Serving Dessert
1 Sl. Bread - 1 Pat Butter
8 oz. Low Fat Milk LS herbs and spices
Sugar, Pepper, LS herbs and spices

No Added Salt

BREAKFAST

4 oz. Fruit or Juice
1 Serving Cereal
1 Serving Egg or Alternate
1 Slice Toast
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Pepper
LS herbs and spices

LUNCH & DINNER

6 oz. Low Sodium Soup or Salad w/Diet Dressing
3 oz. Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Sl. Bread - 1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Pepper, LS herbs and spices

Whole grain breads, cereals and starches are served daily.

SODIUM CONTROLLED DIETS

VI. FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>2 Gram Sodium</u>	<u>No Added Salt</u>
Milk	More than 3 cups/ day Buttermilk, milkshake.	More than 3 cups per day, Buttermilk
Meat, Fish, Poultry/ Eggs/ Cheese	Same, including commercially packaged foods and instant mixes.	Highly salted meats as listed. Processed foods (except low sodium products). Limit cheese and salted peanut butter.
Vegetables (Limit to 4 serv./ day with no added salt)	Canned vegetables. Sauerkraut. Tomato juice	Limit use of drained canned vegetables. Tomato juice with salt added.
Fruits (all ok)	---	---
Breads and Cereals	Same, except: 3 slices of regular bread allowed per day.	Salted crackers, Potato chips. Bread with salted tops. Snack foods. Instant commercially prepared mixes.
Fat and Oils	Same except 3 pats of regular margarine per day	Salt pork, bacon, bacon bits, salted nuts and seeds
Soups (Limit to 1 svg. per day)	Bouillon cubes and canned/dehydrated soup or broth; all soups prepared with added salt or highly salted ingredients. Canned soups.	Same
Beverages	Bottled, powdered, frozen or canned beverages containing salt or sodium preservatives.	None
Desserts (Limit to 2 svgs per day)	Commercial bakery products	None

SODIUM CONTROLLED DIETS

VI. FOODS TO BE AVOIDED

<u>FOOD GROUP</u>	<u>2 Gram Sodium</u>	<u>No Added Salt</u>
Miscellaneous	Salt. Seasoned salts such as garlic salt, onion salt, celery salt variety salt mixtures and packaged seasoning mixes, MSG. Olives, pickles, relish. Soy, barbecue, and prepared sauces, ketchup, prepared mustard, pickles, salted popcorn. Snack dips.	Limit all items on this list. Any Salt added in cooking. Limit salted peanut butter.

Supplements: All nutrition supplements are permitted with order.

Read product labels when purchasing commercially packaged foods. Choose low sodium foods with no added salt or sodium compounds.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Low-Sodium Nutrition Therapy http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=121. Accessed July 6, 2023.

LOW FAT/ LOW CHOLESTEROL DIET

I. PURPOSE

This diet restricts intake of cholesterol to a level of approximately 300 milligrams per day. The percentage of fat in the diet is below 30% of the total calories, with the intake of saturated fat about 10%.

II. INDICATIONS

This diet is indicated for the residents who have high blood cholesterol levels and are at risk for heart disease. This diet may be useful in weight loss programs.

III. ADEQUACY:

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	18900	1095	2545	545

V. SUGGESTED MEAL PATTERN:

BREAKFAST

4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate (* 3/week)
1 Slice Toast
1 Pat Butter
1 Pkt Jelly
8 oz. Non-Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER

Green Salad/Diet Dressing or
6 oz. Calculated Soup/Crackers
3 oz. Calculated Meat or Alternate
3 oz. Calculated Starch
3 oz. Calculated Vegetable
1 Serving Fruit
1 Slice Bread/1 Pat Butter
8 oz. Non-Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

Reference

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. LDL Cholesterol-Lowering Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=466. Accessed July 6, 2023

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. Heart-Healthy Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=107. Accessed July 6, 2023

LOW FAT/ LOW CHOLESTEROL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS AVOIDED</u>
Milk	Nonfat milk, 0% fat milk, drinks made with nonfat milk, fruit drinks except those listed to avoid.	All beverages made with cream, whole milk, 2% low-fat milk ice cream or egg yolk.
Meat, Fish, Poultry, Cheese (Use alternates to red meat at least 5 times a week)	Lean meat, fish, poultry, without skin. Low-fat cottage cheese, low-fat yogurt. cheese made with nonfat milk. Dry beans and peas.	Fatty or heavily marbled meats and luncheon meats, frankfurters, bacon, sausages. Cheese made with milk or cream.
Eggs (Limit 3 per week)	Any prepared without added fat. Egg substitutes. Egg whites.	Fried eggs.
Vegetables	All prepared without added fat, 3-5 servings each day.	Any prepared with added fat, sauces or cheese.
Breads, Grains, Cereals	Enriched breads, whole grain cereals graham crackers, low fat crackers.	Any made with butter, cream, egg yolk, whole milk.
Fruits	All fruits and juices, 2-4 servings/day.	Smoothies made with milk.
Potatoes or Starches	Plain rice, low fat noodles and pasta, white and sweet potatoes and yams. Grits.	Fried potatoes, potato chips, snack chips. Any prepared with fat, milk, butter, or cream.
Desserts	Fruits, gelatin desserts, Fruit ices, angel food cake.	any made with butter, chocolate, egg yolks, milk.
Sugar, Sweets	Sugar, honey, jam, jelly, syrup, molasses, plain sugar	Candy containing nuts, chocolate, milk, or cream. Most commercial desserts.
Fats, Vegetable Oils (Limit to no more than 5 teaspoons per day)	Margarine, vegetable oil and soft tub low-fat spreads.	Gravy, fatty sauces, butter, lard, any deep-fried foods. No palm & coconut oils.
Soups	Fat-free, broth-base soups; soups made with nonfat milk.	Commercial soups; soups prepared with cream, fat, or milk.
Beverages	Coffee, tea, decaf. Sodas.	See Milk and Fruits sections.
Miscellaneous	Salt, flavorings, spices. Cocoa powder.	Butter, nuts, olives, cream. Sauces, peanut butter, popcorn.

MODIFIED BLAND - LOW FIBER DIET

I. PURPOSE

The modified bland-low fiber diet is used to reduce the frequency and volume of stools which lessens irritation to the gastrointestinal tract. It incorporates soft, non-irritating foods. This diet limits fiber, pepper, citrus fruits, raw fruits (except banana) and raw vegetables. It limits fatty foods, sources of caffeine and foods known to be gas-forming. Dairy products are used. Adjustments are made for individual preferences and tolerances.

II. INDICATIONS

The intended use of this diet is for people with stated sensitivity to gas-forming foods, "sensitive stomach", a history of peptic ulcer disease, hiatal hernia or reflux, recent GI surgery, radiation therapy to the pelvis and lower bowel. It is not intended for those individuals with a history of diverticulosis unless specifically requested by the resident.

III. ADEQUACY

This diet may be inadequate in fiber.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2050	105 <u>10</u>	225 <u>230</u>	80 <u>75</u>

V. SUGGESTED MEAL PATTERN

BREAKFAST

- 4 oz. Fruit or Juice
- 1 Serving Hot Cereal
- 1 Egg or Alternate
- 1 Sl. White Toast
- 1 Pat Butter
- 8 oz. Low Fat Milk
- Decaf, Sugar, Salt

LUNCH & DINNER

- 6 oz. Soup (Lunch or Dinner)
- 3 oz. Meat or Alternate
- 2 oz. Cream Gravy
- 3 oz. Potato or Alternate
- 3 oz. Cooked Bland Vegetable
- 1 Serving Dessert
- 1 Sl. Bread, 1 Pat Butter
- 8 oz. Low Fat Milk
- Decaf, Sugar, Salt

MODIFIED BLAND – LOW FIBER DIET

VI. FOODS ALLOWED AND FOODS TO AVOID:

<u>FOOD GROUP</u>	<u>FOODS ALLOWED</u>	<u>FOODS ALLOWED AS TOLERATED</u>	<u>FOODS TO AVOID</u>
Milk	All		None
Meats, Fish, Poultry, Cheese	All eggs, meats poultry, fish, cheese, except as noted.	Fried foods.	Highly spiced or cured meats.
Vegetables	All cooked vegetables, except those to avoid.	Gas producing or irritating vegetables onions, peppers, corn, broccoli, Brussel sprouts, celery, cabbage, lima beans. cauliflower. Tomato products.	Raw vegetables. Legumes.
Fruits and Juices	All as tolerated.	Raw fruits and citrus.	None.
Breads, Cereals, starches	All refined breads, cereals, Pancake, waffle, French toast, potatoes, rice.	All whole grain breads. All coarse cereals. Potato chips French fried potatoes.	None.
Fats and Oils	All fats in moderation.	All as tolerated.	Highly spiced salad dressings, sauces, gravies.
Soups	Cream soups made with allowed vegetables.		Soups made with foods to avoid.
Beverages	All fruit juices.	Caffeinated and decaffeinated coffee and soft drinks.	Alcoholic beverages.
Desserts	All as tolerated.		
Miscellaneous	Salt in moderation. Coconut, catsup, mustard, vinegar.	Popcorn, nuts. Strong spices, and seasoning. Chocolate.	Black pepper. Red Pepper Chili powder. Pickles.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Heart-Healthy Fiber Tips. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=101. Accessed July 6, 2023.

VEGETARIAN DIET

I. PURPOSE

Vegetarian meal plans encompass a variety of plant-derived foods and exclude some foods derived from animals.

II. INDICATIONS

Preferred avoidance of all animal products in the diet except dairy and eggs.

III. ADEQUACY

~~This diet may not meet all the recommended Dietary Allowances; therefore, supplements may be required.~~

~~This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).~~

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2300	90	310	85 0

V. SUGGESTED MEAL PATTERN:

BREAKFAST

4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER

6 oz. Soup or Salad w/ Dressing
3 oz. Meat Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Supplements: Supplements are permitted with order.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. General, Healthful Vegetarian Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=7 . Accessed July 6, 2023.

American Heart Association. Vegetarian, Vegan and Meals without Meat. <http://www.heart.org/en/healthy-living/healthy-eating/eat-smart/nutrition-basics/vegetarian-vegan-and-meals-without-meat>. Accessed July 6, 2023.

VEGAN DIET

PURPOSE

Vegan meal plans encompass a variety of plant-derived foods and exclude all foods derived from animals.

II. INDICATIONS

Preferred avoidance of all animal products in the diet.

III. ADEQUACY

This diet may not meet all-of-all the recommended Dietary Allowances; therefore, supplements may be required.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1900	75	280	60

V. SUGGESTED MEAL PATTERN:

BREAKFAST

4 oz. Fruit or Juice
1 Serving Cereal
1 Egg Alternate
1 Slice Toast or Alternate
8 oz. Soy Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER

6 oz. Soup or Salad w/ Dressing
3 oz. Meat Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread or Alternate
8 oz. Soy Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Supplements: Supplements are permitted with order.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. General, Healthful Vegetarian Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=7 . Accessed July 29, 2024.

American Heart Association. Vegetarian, Vegan and Meals without Meat. <http://www.heart.org/en/healthy-living/healthy-eating/eat-smart/nutrition-basics/vegetarian-vegan-and-meals-without-meat>. Accessed July 29, 2024.

ALLERGENS

I. PURPOSE

To eliminate the eight food allergens, that are regulated by the Food and Drug Administration (FDA), from diets to prevent harmful food reactions.

II. INDICATIONS

Harmful food reactions to:

1. Egg
2. Fish
3. Peanut
4. Milk/Lactose
5. Shellfish
6. Soy
7. Tree Nut
8. Wheat/Gluten

All manufactured food products regulated by the Food and Drug Administration (FDA) that contain food allergens as an ingredient must list the “food allergy” on the product label. Food allergens are identified using the USDA or vendor database, when available.

Other food allergens may include beef, citrus, hot dog, mushroom, pork, red meat, and tuna. To accommodate food allergens/intolerances outside the FDA regulated food allergens, the Clinical Nutrition and Food Service Department can modify any diet to eliminate specific foods in food preferences.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. Multiple Food Allergies Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=29. Accessed July 6, 2023.

ENTERAL NUTRITION

Physicians must order a tube feeding according to the product desired, volume required to meet caloric and nutritional needs, the amount of water to assure adequate hydration and the frequency and mode of feeding. The dietitian will provide specific information and calculations for the formula order. However, the MD may order less than the dietitians' estimated nutrition support needs due to medical indications or for quality of life.

The following diet orders are available for physicians to order.

1. **Tube Feeding, NPO (TF-NPO):** residents who require total nutrition support via enteral nutrition.
2. **Tube Feeding W Food (TF-FOOD):** residents who require supplemental nutrition via enteral nutrition in addition to an oral diet. This order must be accompanied by a diet order specifying texture, therapeutics, etc.

Appendix Table 3 provides Laguna Honda's nutrition support formulary.

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APPENDIX TABLE 1: DIETARY REFERENCES BASED ON AGE-SEX

	Source of Goal	Female, 19-30	Female, 31-50	Female, 51-70	Female, >70	Male, 19-30	Male, 31-50	Male, 51-70	Male, >70
Calorie Level Assessed		2000	1800	1600	1600	2400	2200	2000	2000
Macronutrients									
Protein (% kcal)	AMDR	10-35%	10-35%	10-35%	10-35%	10-35%	10-35%	10-35%	10-35%
Protein (g)	RDA	46	46	46	56	56	56	56	46
Carbohydrate (% kcal)	AMDR	45-65	45-65	45-65	45-65	45-65	45-65	45-65	45-65
Carbohydrate (g)	RDA	130	130	130	130	130	130	130	130
Fiber (g)	14g/1000 kcal	25	25	21	21	38	38	30	30
Added Sugars (% kcal)	DGA	<10	<10	<10	<10	<10	<10	<10	<10
Total Lipid (% kcal)	AMDR	20-35	20-35	20-35	20-35	20-35	20-35	20-35	20-35
Saturated Fatty Acids (% kcal)	DGA	<10	<10	<10	<10	<10	<10	<10	<10
18:2 Linoleic Acid (g)	AI	12	12	11	11	17	17	14	14
18:3 Linoleic Acid (g)	AI	1.1	1.1	1.1	1.1	1.6	1.6	1.6	1.6

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	Source of Goal	Female, 19-30	Female, 31-50	Female, 51-70	Female, >70	Male, 19-30	Male, 31-50	Male, 51-70	Male, >70
Minerals									
Calcium (mg/d)	RDA	1000	1000	1200	1200	1000	1000	1000	1200
Chromium (mcg/d)	AI	25	25	20	20	35	35	30	30
Fluoride (mg/d)	AI	3	3	3	3	3	4	4	4
Copper (mcg/d)	RDA	900	900	900	900	900	900	900	900
Iodine (mg/d)	RDA	150	150	150	150	150	150	150	150
Manganese (mg/d)	AI	1.8	1.8	1.8	1.8	2.3	2.3	2.3	2.3
Selenium (mcg/d)	RDA	55	55	55	55	55	55	55	55
Chloride (g/d)	AI	2.3	2.3	2	1.8	2.3	2.3	2	1.8
Molybdenum (mcg/d)	RDA	45	45	45	45	45	45	45	45
Iron (mg/d)	RDA	18	18	8	8	8	8	8	8
Magnesium (mg/d)	RDA	310	320	320	320	400	420	420	420
Phosphorus (mg/d)	RDA	700	700	700	700	700	700	700	700
Potassium (mg/d)	AI	2600	2600	2600	2600	3400	3400	3400	3400
Sodium (mg/d)	AI	1500	1500	1500	1500	1500	1500	1500	1500
Zinc (mg/d)	RDA	8	8	8	8	11	11	11	11

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	Source of Goal	Female, 19-30	Female, 31-50	Female, 51-70	Female, >70	Male, 19-30	Male, 31-50	Male, 51-70	Male, >70
Vitamins									
Vitamin A (mcg/d)	RDA	700	700	700	700	900	900	900	900
Vitamin E (mg/d)	RDA	15	15	15	15	15	15	15	15
Vitamin D (mcg/d)	RDA	15	15	15	20	15	15	15	20
Vitamin K (mcg/d)	AI	90	90	90	90	120	120	120	120
Vitamin C (mg/d)	RDA	75	75	75	75	90	90	90	90
Thiamin (mg/d)	RDA	1.1	1.1	1.1	1.1	1.2	1.2	1.2	1.2
Riboflavin (mg/d)	RDA	1.1	1.1	1.1	1.1	1.3	1.3	1.3	1.3
Niacin (mg/d)	RDA	14	14	14	14	16	16	16	16
Vitamin B-6 (mg/d)	RDA	1.3	1.3	1.5	1.5	1.3	1.3	1.7	1.7
Vitamin B-12 (mg/d)	RDA	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
Choline (mg/d)	AI	425	425	425	425	550	550	550	550
Pantothenic Acid (mg/d)	AI	5	5	5	5	5	5	5	5
Biotin (mcg/d)	AI	30	30	30	30	30	30	30	30
Folate (mcg/d)	RDA	400	400	400	400	400	400	400	400

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APPENDIX TABLE 2: LAGUNA HONDA HOSPITAL ORAL SUPPLEMENT FORMULARY

Oral Supplements									
Formula	KCAL	CHO (g)	PRO (g)	FAT (g)	Gluten Free	Suitable for Lactose Intolerance	Kosher	Halal	Notes
Ensure Original 237 mL/8 oz. (Vanilla, Chocolate)	250	41 (42, choc)	9	6	Yes	Yes	Yes	Yes	<i>Standard formula</i>
Ensure Enlive *Ensure Plus High Protein 237 mL/8 oz. (Vanilla) *substitute	350	44 (40 *)	20	11 (13*)	Yes	Yes	Yes	N/A	<i>Concentrated, high protein formula</i>
LHH Fortified Pudding 118.3 mL/4 oz. (Vanilla, Chocolate)	246 (243, choc)	42 (40, choc)	8	5	Yes	No	Yes	N/A	<i>Pudding Thick</i>
Ensure Clear 237 mL/8 oz. (Apple, Mixed Berry)	240	52	8	0	Yes	Yes	Yes	Apple Only	<i>Clear Liquid</i>
Glucerna Shake 237 mL/ 8oz. (Vanilla)	220	26	10	9	Yes	Yes	Yes	Yes	<i>Diabetes</i>
Nepro w/ Carb Steady 237 mL/ 8oz. (Vanilla)	425	38	19	23	Yes	Yes	Yes	Yes	<i>Dialysis; low in phosphorus, potassium, and sodium</i>
Suplena w/ Carb Steady 237 mL/ 8oz. (Vanilla)	425	46.4	10.6	23	Yes	Yes	Yes	Yes	<i>Chronic Kidney Disease, not on dialysis</i>

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Protein Modulars									
Formula	KCAL	CHO (g)	PRO (g)	FAT (g)	Gluten Free	Suitable for Lactose Intolerance	Kosher	Halal	Notes
Beneprotein 1 scoop/7 g (unflavored)	25	0	6	0	Yes	Yes	Yes	N/A	<i>Elevated protein requirements</i>
Juven 24g packet (orange)	80	8.4	7g L-Arg./ 7g L-Glu	0	Yes	Yes	Yes	N/A	<i>Elevated protein requirements. Contains Phenylalanine.</i>
Prostat 30 mL/1 oz. (Citrus splash <u>or cherry</u>)	100	10	15	0	Yes	Yes	Yes	N/A	<i>Elevated protein requirements</i>

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APPENDIX TABLE 3: LAGUNA HONDA HOSPITAL ENTERAL NUTRITION FORMULARY

Formula	KCAL	CHO (g)	PRO (g)	FAT (g)	Fiber (g)	Osmolality (mOsm/kg H₂O)	Na (mg)	K (mg)	P (mg)	Mg (mg)	Water (mL)	mL to meet 100% RDI	Notes
Jevity 1.2 1000 mL	1200	169.4	55.5	39.3	17	450	1067	2390	1200	370	807	1250	<i>Standard formula</i>
Jevity 1.5 1000 mL	1500	215.7	63.8	49.8	21	525	1330	2180	1250	420	760	1000	<i>Standard formula</i>
Osmolite 1.0 1000 mL	1060	143.9	44.3	34.7	0	300	930	1570	835	290	835	1500	<i>Low-Residue formula</i>
Osmolite 1.2 1000 mL	1200	157.5	55.5	39.3	0	360	1067	2274	1200	370	820	1250	<i>Low-Residue formula</i>
Osmolite 1.5 1000 mL	1500	203.6	62.7	49.1	0	525	1330	2180	1250	420	762	1000	<i>Low-Residue formula</i>
Glucerna 1.2 1000 mL	1200	114.5	60	60	16.1	720	1110	2020	1200	320	805	1250	<i>Diabetic formula</i>
Glucerna 1.5 1000 mL	1500	133.1	82.5	75	16.1	875	1380	2520	1000	400	759	1000	<i>Diabetic formula</i>
Nepro with Carb Steady 1000 mL	1800	160	81	96	25	745	1050	949	717	169	727	944	<i>Dialysis formula</i>
Pivot 1000 mL	1500	172.4	93.8	51	7.5	660	1475	1983	969	421	750	1300	<i>Peptide-based. High protein</i>
TwoCal HN 1000 mL	2000	218.6	83.5	90.5	5	710	844	2110	1321	414	700	948	<i>Calorie and protein dense</i>
Vital 1.5 1000 mL	1500	187	67.5	57.1	6	671	1139	2194	1251	422	764	1000	<i>Elemental, Calorically Dense</i>
Vital AF 1.2 1000 mL	1200	110.6	75	53.9	5.1	459	1266	1645	1004	337	811	1250	<i>Elemental</i>

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APPENDIX TABLE 4: DIET RESTRICTION CODE AND DESCRIPTION

BLND	Bland/Low Fiber
CARB60G	Carb Control 60g
CARB75G	Carb Control 75g
CARB90G	Carb Control 90g
CLIQ	Clear Liquid
DS	Dental Soft
FLD10	Fluid Restricted 1000 cc
FLD12	Fluid Restricted 1200 cc
FLD15	Fluid Restricted 1500 cc
FLD18	Fluid Restricted 1800 cc
FLDNO	Fluid Restricted - No fluid
FLIQ	Full Liquid
HONEY	Thick Liquid Honey
LFATLCHOL	Low Fat/ Low Cholesterol
LOK	Low Potassium
LOPHOS	Low Phosphorus
MS	Mechanical Soft
MSPV	Mechanical Soft Puree Vegetables
MSPFV	Mechanical Soft Puree Fruits and Vegetables
NA2	Sodium 2 Gram
NAS	No Added Salt
NECT	Thick Liquid Nectar
NKA	No Known Allergy
NKFA	No Known Food Allergy
NOBEEF	No Beef
NOCITRS	No Citrus
NOEGG	No Egg
NOFISH	No Fish
NOGLUTWHEAT	No Gluten/Wheat
NOHOTDOG	No Hot Dog
NOLACT	No Lactose
NOMILKPROD	No Milk Products
NOMUSH	No Mushrooms
NOPNUT	No Peanut
NOPORK	No Pork
NORDMT	No Red Meat
NOSHELLFISH	No Shellfish
NOSOY	No Soy
NOTREENUT	No Tree Nuts
NO TUNA	No Tuna
NPO	Nothing By Mouth
PUR-FULL	Puree-Full
PUR-SEMI	Puree-Semi
REG	Regular
REN60	Renal Diet, 60 g protein
RMSE	Regular with Mechanical Entree
TF-FOOD	Tube Feeding with Food
TF-NPO	Tube Feeding, NPO
TFPR	Tube Feeding with Puree
VEG	Vegetarian
VEGAN	Vegan

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Institute of Medicine. 2006. *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/11537>.

IOM (Institute of Medicine). 2011. *Dietary Reference Intakes for Calcium and Vitamin D*. Washington, DC: The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. 2019. *Dietary Reference Intakes for sodium and potassium*. Washington, DC: The National Academies Press. doi: <https://doi.org/10.17226/25353>.

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State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Facilities. 2023, Rev 211: 375. Accessed 7/5/2023, <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

1.12 Registration of Dietitians

Revised: [7/25/26](#)

Policy: All Clinical Dietitians, Dietetic Technicians and the Chief Dietitian are required to maintain registration with the Academy of Nutrition and Dietetics through the Commission on Dietetic Registration.

Purpose: To keep apprised of ~~developments~~ [best practices](#) in nutrition science and Medical Nutrition Therapy. To ensure that all nutrition professionals maintain current clinical knowledge and expertise in their field.

Procedure:

The Chief Dietitian will [maintain a record of clinical dietetic staff dietetic Registration](#) and maintain current copies of the Academy of Nutrition and Dietetics registration cards for each individual. The Chief Dietitian [or designee](#) will ~~routinely notify~~ [provide](#) Human Resources ~~with a copy of~~ [current registration, by sending copies to human resources](#) for inclusion in the employees' file [annually with the Performance Plan and Appraisal Report \(PPAR\) or as requested.](#)

Note:

Headquarters

Academy of Nutrition and Dietetics
120 South Riverside Plaza, Suite 2000
Chicago, Illinois 60606-6995
Phone: 800/877-1600

Washington, D.C. Office

Academy of Nutrition and Dietetics
1120 Connecticut Avenue NW, Suite 480
Washington, D.C. 20036
Phone: 800/877-0877

Phone: Chicago: 800/877-1600 and one of the extensions below
Washington, D.C.: 800/877-0877

1.15 Diet Manual Approved by Medical Staff

Revised: [8/25-4/26](#)

Policy: The Laguna Honda Hospital Diet Manual has been written by the staff of Dietitians in the Clinical Nutrition Department and is available to Medical, Nursing and Dietetic personnel for reference. It is reviewed annually and revised at least every five years to ensure that it remains current.

Purpose: To standardize the principles of dietary treatment and practical applications of current practice. To serve as a method of communication among physicians, nurses and dietitians, [or other ancillary departments](#), as a guide to kinds and amounts of foods served to residents.

Procedure:

1. The Manual is reviewed annually and revised as necessary to incorporate the best practices and latest trends in clinical nutrition. The recommended revisions are submitted to the Medical Executive Committee and Nursing Executive Quality ~~and Safety Committee~~ as applicable for review.
2. Once approved by the Medical and Nursing Staff the revised manual is sent to through the Annual Quality Management and Executive Committee review process before final approval through the Joint Commission Committee.
3. A written cover sheet noting the acceptance of the revision, or the review must be signed by the Medical Director and the Chief Dietitian. This cover sheet precedes the opening page of the diet manual. The approved revised version is uploaded to the Laguna Honda Intranet web page.

1.16 Nutrition Screening and Documentation Process

Revised: [8/254/26](#)

Policy: All residents admitted shall receive a nutrition and hydration screening. A complete comprehensive assessment, quarterly review and reassessment shall be documented in the EHR according to the guidelines mandated by California Code of Regulations- Title 22, Center for Medicare and Medicaid Services (CMS) guidelines, and the OBRA Federal Statute.

Purpose: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT) and comply with the State and Federal guidelines.

Procedure:

1. The dietetic technician (DTR) or Registered Dietitian (RD) shall complete the initial screening for nutrition risk within 48 hours for newly admitted/readmitted residents to identify immediate nutrition needs and documented in the EHR. A baseline care plan must be developed by the RD within 48 hours of a resident's admission.
2. Within 7 days of admission, the K section of the MDS is completed by the DTR/RD and any other associated CAA section that is identified that needs to be ~~filled out~~[completed](#) by the RD/DTR. The CAA summary is formulated by the RD.
3. Newly admitted or readmitted residents shall have a comprehensive assessment written by an RD within 14 days of admission. Residents admitted to the medical or rehabilitation acute unit shall be assessed, and a nutritional assessment completed within 3 working days (day of admission day zero) or as needed by nursing risk assessment/MD consult.
4. The Nutrition Care Process (NCP) is used to provide a standardized language using terminology organized by each NCP step, which include Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD and DTR, in providing individualized high-quality nutrition care. The RD or DTR documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical staff and ancillary departments. The ADIME guidelines are below:
 - i. ADIME:
 - a. ASSESSMENT Nutrition assessment is a systematic method for obtaining, verifying and interpreting data needed to identify nutrition-related problems, their causes and their significance. Data is obtained in the review of clinical history, laboratory indices, discussions with the resident and the health care team. Current food intake from daily meals and supplemental foods are determined through meal observations, contacts with nursing staff and review of the chart notes. When the primary source of nutrition is from enteral feedings, a nutrition professional evaluates the adequacy and suitability of the formula for the resident. It consists of the following elements:
 - i. Food/Nutrition related history
 - ii. Anthropometric measurements
 - iii. Biochemical data, medical tests, and procedures

- iv. Nutrition-focused physical findings
 - v. Client history
- b. **DIAGNOSIS:** The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
- i. Intake
 - ii. Clinical
 - iii. Behavioral-Environment
- c. **INTERVENTION:** Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. The RD calculates the resident's individual nutrient needs for calories, protein, fluid and other nutrients. Therapeutic restrictions in the diet, the resident's personal food and ethnic preferences and other meal requests are used to develop the meal pattern and immediate goals of nutrition therapy. The RD considers the expected degree of dietary compliance for the resident. Diets are liberalized when appropriate.
- d. Four domains of nutrition intervention have been identified:
- i. Food and/or Nutrition Delivery
 - ii. Nutrition Education
 - iii. Nutrition Counseling
 - iv. Coordination of Nutrition Care
- e. **MONITORING/EVALUATION:** The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
- i. Food/Nutrition-Related History
 - ii. Anthropometric Measurements
 - iii. Biochemical Data, Medical Tests, and Procedures
 - iv. Nutrition-Focused Physical Findings
5. Clinical nutrition protocol and guidelines as outlined in Standards of Practice for Clinical Nutrition: Laguna Honda Hospital are used by the RD to assess the resident's current nutritional status. The RD shall complete a review of the resident's nutritional status and the care plan at least quarterly in the EHR, or more frequently as nutritional risk warrants. A comprehensive annual assessment shall be completed based on the MDS schedule.
6. The RD is a member of the RCT and attends weekly or as scheduled RCT meetings to discuss nutritional status. The plan for the resident's nutritional care is based on goals and interventions discussed in the resident care conference.
7. The care plan for nutrition is coordinated with the resident/caregiver, the core RCT and other ancillary team members, such as speech therapy and occupational therapy. The RD provides expertise in nutritional interventions in acute and chronic diseases, resident nutrition needs, techniques for maximizing independent feeding, food and eating safety, socialization at meals, dietary restrictions in nutrition therapy, individualized meal patterns, food preferences and available menu substitutions. The care plan for nutritional care is documented in the Care Plan section of the EHR along with the initial assessment & the associated CAA. In

cooperation with the RCT, the nutrition goals and interventions are developed for nutrition problems triggered in the assessment.

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics
<https://www.ncpro.org/nutrition-care-process>

CMS guidelines

F692 §483.25 (g)(1)(2)(3)

F693 §483.25 (g)(4)-(5)

F636 §483.20 (b)

F655, F656, F657§483.21 (a)

1.19 Acute Medical/Rehab Admissions/Transfers

Revised: [8/25/26](#)

Policy: When Residents are diagnosed with an acute medical problem requiring a transfer to an acute nursing unit, diet orders for meals and supplements will be cancelled. Meals and other scheduled food orders will be held until a new diet order is received from the attending physician.

Purpose: To assure that residents receive the appropriate diet for their current medical condition.

Procedure:

1. ~~Communications:~~ The Diet Clerks run the daily admission/discharge/transfer ([ADT](#)) report prior to each meal. The diet clerk communicates via EPIC secure chat to the assigned Registered Dietitian (RD) and Dietetic Technician (DTR) and informs them of the admission, discharge, or transfer to an acute unit.
2. ~~Once the resident is transferred, the receiving acute unit orders the new diet order via EPIC and diet order interfaces with the CBORD system to update the individual residents' card file. The same process of notification occurs when the resident leaves the acute unit to return to SNF unit.~~
3. ~~The SNF diet and All food items~~ are discontinued for the resident ~~if on an NPO order~~. No meals or supplements or other foods will be sent to the resident until a diet is ordered by the Physician. All nourishment bag meals shall be removed from the tray line set up and nourishment delivery cart.

1.20 Nutrition Screening and Assessment Documentation for Acute Hospital Admissions

Revised ~~0/26~~04/26

Policy: All residents admitted to the medical or rehabilitation hospital acute unit shall receive a Nursing nutrition screen within 24 hours of admission. A complete comprehensive assessment and follow up shall be documented by the RD in the EHR according to the guidelines established and outlined for determination of priority level.

Purpose: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT).

Procedure:

Residents admitted to the medical or rehabilitation hospital acute unit shall have a nutritional assessment completed within the guidelines established for low, medium, and high risk.

1. Newly admitted residents shall have a Nursing Nutrition Screen completed in the EHR to identify nutrition needs. The RD follows the established guidelines (see table below) for identifying risk level and completes the nutrition assessment.
2. The Nutrition Care Process (NCP) is used to provide a standardized language using terminology organized by each NCP step, which include Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD in providing individualized high-quality nutrition care. The RD documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical staff, and ancillary departments. The ADIME guidelines are below:
 - i. ADIME:
 - a. ASSESSMENT: Nutrition assessment is a systematic method for obtaining, verifying, and interpreting data needed to identify nutrition-related problems, their causes and their significance. It consists of the following elements:
 - i. Food/Nutrition related history
 - ii. Anthropometric measurements
 - iii. Biochemical data, medical tests, and procedures
 - iv. Nutrition-focused physical findings
 - v. Client history
 - b. DIAGNOSIS: The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
 - i. Intake
 - ii. Clinical
 - iii. Behavioral-Environment
 - c. INTERVENTION: Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. Four domains of nutrition intervention have been identified:
 - i. Food and/or Nutrition Delivery
 - ii. Nutrition Education
 - iii. Nutrition Counseling
 - iv. Coordination of Nutrition Care

- d. **MONITORING/EVALUATION:** The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
- i. Food/Nutrition-Related History
 - ii. Anthropometric Measurements
 - iii. Biochemical Data, Medical Tests, and Procedures
 - iv. Nutrition-Focused Physical Findings
3. Clinical nutrition protocol and guidelines are used by the RD to determine level of nutrition risk for each resident. RD shall document any nutritional recommendations and notify provider through the EHR.
4. The nutrition follow-up schedule is determined by the RD using the Clinical Nutrition guidelines below or shall be adjusted on an individual basis when:
- a. Resident is stable on current nutrition regimen.
 - b. Nutrition problems have resolved.
 - c. Resident transfers to a higher or lower level of care

Nutrition Risk Level Guidelines for Clinical Nutrition: LHH Food and Nutrition Services

Admission Day = Day Zero*

Category*	High (1 or more from below) (within 24hours)	Moderate (within 72 hours)	Low (within 72 hours)
Nutrition History	<ul style="list-style-type: none"> • < 50% of goal nutrition intake \geq 5 days 	<ul style="list-style-type: none"> • <50-75% of goal nutrition intake > 7 days • Food Allergies/intolerances • Food insecurity not addressed. • Complicated food preferences 	<ul style="list-style-type: none"> • No significant change in recent intake • >50-75% goal nutrition intake • Food insecurity addressed. <p>Routine food preferences</p>
Diet Order	<p>New TPN: Assess within 24 hours.</p> <p>New Tube Feed: Assess within 24 hours.</p>	<p>NPO/Liquid diet <u>(48-72 hours)**</u></p> <p>All other diet orders not listed as high/low (ex. GI related diet, Aspiration risk diet, Liquid diets)</p> <p>Evolving TF/TPN +/-PO plan</p> <p>Stable TF/TPN plan</p>	<p>Regular</p> <p>Mechanical Soft</p> <p>Consistent CHO</p> <p>Renal</p> <p>Cardiac or Low Sodium</p> <p>Fluid Restricted</p> <p>Vegetarian/Vegan</p>
Weight History and Nutrition Focused Physical Exam	<ul style="list-style-type: none"> • Weight loss (unintentional) <ul style="list-style-type: none"> ○ > 2% one week ○ > 5% one month ○ > 7.5% 3 months • >10% 6 months 	<ul style="list-style-type: none"> • Weight loss (unintentional) <ul style="list-style-type: none"> ○ \leq 1-2% one week ○ \leq 5% one month ○ \leq 7.5% 3 months ○ \leq 10% 6 months 	<ul style="list-style-type: none"> • No weight change or otherwise planned intentional weight loss
Nutrition Diagnosis	<ul style="list-style-type: none"> • -Inadequate enteral/parenteral infusion 	<ul style="list-style-type: none"> • -Non healing wound • -Altered labs r/t nutrition 	<ul style="list-style-type: none"> • -Stable or healing wound

	<ul style="list-style-type: none"> -Malnutrition (acute) 	<ul style="list-style-type: none"> - No prior knowledge of therapeutic diet, drug-nutrient interaction or reinforce new diet education 	<ul style="list-style-type: none"> -Reinforce existing therapeutic diet or drug-nutrient interaction
Other Clinical Indicator	<ul style="list-style-type: none"> -Medical dx: malnutrition, failure to thrive, refeeding syndrome, burn, SBO or GI injury -Unstable outputs (ostomy, emesis, large GI drain output) 	<ul style="list-style-type: none"> -Medical dx: new nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia) pressure ulcers all stages Change in acuity increasing AMS) -Need to monitor output management (emesis, -ostomy, GI drain) - Unstable labs warrants nutrition change (i.e. lytes, glucose, triglycerides, renal) 	<ul style="list-style-type: none"> -Medical dx: stable nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia) -Stable clinical course -No persistent GI complaints -Labs stable or addressed with medication or diet prescription
Reassessment/ Follow Up	<ul style="list-style-type: none"> Within 3 days <u>**including NPO status</u> 	<ul style="list-style-type: none"> Within 5 days 	<ul style="list-style-type: none"> Within 7 days
Responsible Party	RD	RD	RD

*Per RD clinical judgement to assign nutrition risk w/ categories and examples to provide general framework.

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics
<https://www.ncpro.org/nutrition-care-process>

CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 5 CHAPTER 1, ACUTE HOSPITAL - 70273 Dietetic Service General Requirements

1.22 Enteral Formulary Availability

Revised ~~08/25~~04/26

Policy: All tube feeding formulas should be chosen from the LHH enteral feeding formulary.

Purpose: To provide control of the number and types of enteral formulas used in the hospital.

Procedure:

1. A list of enteral formulas is provided in the diet office and can be found as an appendix in the Diet Manual. Selections for enteral feeding orders should be made from this list. Nutritional Composition of Formulas may be obtained from the dietitian.
2. If it is necessary to order a product that is not in the formulary, the clinical dietitian and the physician will decide on an appropriate temporary substitute until the product can be acquired. The Chief Dietitian or designee should be consulted to assure that the product is available.
3. Once the formula has been received, it will be entered into the Diet Office System. On a daily basis, the diet clerk will print a delivery sheet with the correct amount of formulary to be delivered to each unit to cover a 24-hour time period.

1.23 Discharge Diet Education

Revised: ~~08/25~~04/26

Policy: Residents requiring discharge diet education will receive instructions from a dietitian prior to discharge.

Purpose: To ensure that residents leaving the hospital on therapeutic diets receive education on the essentials of that diet.

Procedure:

1. The Registered Dietitian will provide nutritional counseling for those residents being discharged on a therapeutic diet restriction at least 24 hours prior to discharge.
2. Consideration shall be made of resident's diet history, dietary knowledge, primary language, religious and cultural beliefs.
3. The Dietitian will gather the necessary materials and information for the resident's diet. Source resident education material from the Academy of Nutrition and Dietetics Nutrition Care Manual, or other sources as required per clinician's judgement. Bilingual education materials in Spanish, Chinese, and other languages are available for several diets.
4. The dietitian will instruct ~~resident~~resident, a designated ~~and~~ family member(s) or other caregiver on the essentials of the diet.
5. The dietitian will document that a diet instruction was given and an assessment of the ability of the resident to understand and comply with the diet in the integrated charting notes.

1.25 NPO or Clear Liquid Diet Orders

Revised: ~~8/25~~04/26

Policy: A Clinical Dietitian is notified when a resident's diet order changes to NPO or clear liquid diet.

Purpose: To assure adequate nutrition intervention.

Procedure:

1. Residents who receive a diet order for NPO or clear liquid are noted by the diet clerk and communicated to the unit Dietitian and Dietetic Technician via secure message communication in the EPIC chart. The Diet Clerk runs the admission/discharge/transfer (ADT) report daily and prior to each meal that includes any change in diet.
2. The diet order for the individual resident is discontinued in EPIC and CBORD. The new diet order for NPO is made in EPIC.
3. If the order for NPO or clear liquid diet continues for three days, the Dietitian confers with the nursing staff and the physician. The Dietitian documents in a nutrition note to assess the nutritional adequacy of the diet.

Revised Food and Nutrition Policies and Procedures

1.92 Standardize Recipes

~~Established and Revised: 3/81, 1/89, 5/97, 9/06, 7/09~~

~~Revised/ed: 3/8/26/13, 8/14~~

Policy: To ensure consistent quality and portion control of all food items-products, Standardized Recipes are to be used in food production. No deviations are permitted without prior approval from Food and Nutrition Services (FNS) leadership and a Registered Dietitian (RD).

Purpose:

- To maintain the consistency and quality of food products.
- To maintain controls on food during inventory, ordering, and production.
- To provide guidelines of how a food product should be prepared.
- To assure proper utilization of CBORD printed reports.

Procedure:

1. The key to proper food preparation techniques is the accurate use of Standardized Recipes. When the Standard Recipe is used correctly a predetermined result will be achieved each time the item is produced. The need for uniformity must be related to the patient as well as the avoidance of waste through improper preparation of food products.

2. Once a week, Standard Recipes are generated from the CBORD system. It is compiled into a binder for the Week's cycle. The Standard Recipes include the following information:

Recipe name and number Recipe; Yield in number of pounds or pans; Description of ingredients (cooked, raw); its weight Form of ingredients (chopped, grated); advance prep days Method of combining ingredients; Cooking Time; and Cooking Temperature for product; Volume in weight or count to be placed in serving pans; Total number of portions; Recipe Distribution of when, where, and amounts Subassembly recipes to follow.

~~2.3.~~ Each cook is responsible for using the appropriate recipe and returning it to the proper location. The cook must follow the recipe completely and use proper weights in recipes to insureensure that the desired results will be achieved.

~~3.4.~~ The Chefs converts~~adapts~~ recipes from standard quantities to amount needed.

~~4.5.~~ Changes in Standardized Recipes may be made through the chefs if it proves to improve the quality of a food product and approved by the RD. Changes are then made on CBORD system.

1.94 Safety Standards

~~Established and r~~Revised: 3/26-4/95, 9/06, 7/09, 11/22
Reviewed: 8/13, 8/14

Policy:

1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the ~~resident~~residents.
2. Procurement (obtaining) of food will occur through sources approved or considered satisfactory by federal, state, and local authorities.
 - a) This provision does not prohibit the facility from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices, and the facility's policy for food grown in facility gardens.
 - ~~b)~~
 - b) This provision does not preclude residents from consuming foods not procured by the facility. Staff and residents shall follow facility policy regarding personal foods.
3. All Food will be received, stored, and processed in accordance with Safety Guidelines as set forth in California ~~Uniform~~ Retail Food ~~Code~~Facilities Law.

Procedure:

1. ~~1.~~ The Director of Food and Nutrition Services shall order food from approved sources and maintain invoices from food vendors that show the source of food acquisition and the date of delivery.
2. ~~2.~~ When food is brought in from an off-site kitchen, the Director shall maintain records that the kitchen has been approved and inspected by the appropriate federal, state, or local authorities.
3. Food production standards are maintained ~~through the use of~~using ServSafe Course Education. — Fourth Edition, 2006 The National Restaurant Foundation
4. Many HACCP checks are performed daily through temperature monitoring by Food and Nutrition Service (FNS) staff such as Cooks, and Chefs, Supervisors or designee.
- ~~1.5.~~ At least three HACCP CQI Activities are scheduled annually to verify production safety of potentially harmful foods ~~(such as egg salad).~~
- ~~2.~~ These standards are ~~made~~made as a part of every sanitation and food production ~~in~~services in-service.
- ~~3-6.~~

1.95 Use of Eggs

~~Established and Revised: 3/26, 3/89, 5/97, 7/03, 9/06, 5/08, 11/09, 6/10, 6/11~~
~~Reviewed: 8/13, 8/14~~

Policy: The Department will use safe handling techniques for use of pasteurized and unpasteurized eggs in the food service, as recommended by the Food and Drug Administration (FDA) and others.

Purpose: To reduce the effect of Salmonella ~~bacteria, enteritidis-contaminated~~ eggs on our elderly and/or immuno-compromised residents.

Procedure:

1. Fresh shell eggs will only be prepared as described below:

- a. Raw eggs will be cooked immediately after being cracked; they shall not be pooled or held in cups or bowls before use.
- b. Eggs shall be cooked in the following manner:
- c. Scrambling on 375° F grill for four minutes (only pasteurized bulk liquid eggs used)
- d. Hard cooked egg – boil or steam for twelve minutes (shell eggs)
- e. ~~soft cooked~~ Soft, cooked egg – boil or steam under 7 minutes (shell *pasteurized* eggs)
- f. Fried cooked egg – fried in pan over medium (shell *pasteurized* eggs)

2. General precautions:

- ~~g.a.~~ Eggs will be held at below 41±° F at all times, except in the cooking process.
- ~~h.b.~~ Eggs will be rotated, First-In, First-Out (FIFO), as all stock on hand.
- ~~i.c.~~ Eggs will be ordered in the most efficient manner to allow for the freshest product.
- ~~j.d.~~ Pasteurized shell eggs will be stored separately from the other unpasteurized eggs. They are easily identified by a “P” on each shell egg.

~~2.3.~~ No raw eggs, soft, cooked eggs or fried eggs will be served unless by a physician’s order.

Revised Medical Services Policies and Procedures

CREDENTIALING POLICY AND PROCEDURES MANUAL

PURPOSE:

Laguna Honda Hospital (LHH) ensures that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership.

REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

DEFINITIONS:

Practitioner: A physician (M.D. or D.O.), dentist (D.D.S. or D.M.D.), clinical psychologist (Ph.D. or Psy.D.), or podiatrist (D.P.M.) licensed to practice in the State of California.

Affiliated Health Practitioners: Affiliated Health Practitioners are individuals who perform functions that would otherwise be considered the practice of medicine. They (1) are employees or contractors of the City and County of San Francisco; (2) provide health services requiring them to exercise independent judgment within the area of their professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable practice laws; (3) do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists, and (4) belong to a professional category that has been accepted for practice at the Hospital by the Governing Body after appropriate consultation. At present, Affiliated Health Practitioners are practitioners from the following categories who meet the above requirements:

- Nurse Practitioners
- Clinical Nurse Specialists
- Physician Assistants
- Clinical Pharmacists
- Optometrists
- Certified Body Work Practitioners, i.e. certified massage therapists
- Acupuncturists

Complete Application: A complete application, at the point that verifications are finished, means the following:

- all information is verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by LHH have been resolved.

POLICY:

- A. The Medical Staff Office conducts credentialing for all clinical venues within LHH. Credentialing is performed prior to appointment and reappointment to the LHH Medical Staff.
- B. Each provider has a confidential credentials file, which contains verification documents (see **Appendix A**). These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than 120 days old at the time of Governing Body review.

- C. Credential files are treated as confidential and are kept electronically and within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

Medical Staff Members shall be granted access to their own credentials file, subject to the following provisions:

1. Timely notice of a request for access shall be made by the member to the Chief of Staff or designee;
 2. The Member may review and receive a copy of only those documents provided by or addressed personally to the member.
 3. A summary of all other information, including but not limited to National Practitioner Databank Reports, peer review findings, letters of reference, and proctoring reports and complaints, shall be provided to the Member, in writing, by the Chief of Staff, at the time the Member reviews the credentials file or within a reasonable period of time after receipt of a request for such summary, as determined by the MEC. Such summary shall disclose the substance, but not the source, of the information summarized; and
 4. The review by the Member shall take place in the Medical Staff Office, during regular working hours, with the Chief of Staff or designee present.
- D. Provider Rights to obtain Status of Application
Upon request, providers will be notified of the status of their application during the credentialing process.

E. Rights to Request Corrections/Additions

Medical Staff Members may exercise the right to request the corrections or appropriate additions to credentials file information following the below listed protocol.

- A. After reviewing the file, a Member may address a written request to the Chief of Staff asking for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
- B. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the MEC, after such review, whether or not to make the correction or deletion requested. The MEC, when so informed, shall either ratify or initiate action contrary to this recommendation.
- C. The Member shall be notified promptly, in writing, of the decision of the MEC.
- D. Members shall have the right to add to their own credentials file, upon written request to the MEC, a statement responding to any information contained in the file.

PROCEDURE:

Initiation of Credentialing Process: Upon receipt of a written request from the Chief Medical Officer or designee, and a copy of the applicant's CV, an application packet will be forwarded to the applicant.

- A. Providers must complete the following items:
- Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges or Standardized Procedures
 - Agreement to abide by the Medical Staff Bylaws, Rules and Regulations

- Health Plan Attestation form (as applicable)
- B. In addition to returning a completed application packet, providers also must submit any relevant licensure/certificates, documents, as applicable to the requested privileges or clinical activity, including but not limited to:
- Copy of California License(s)
 - Copy of DEA Certificate and/or Furnishing certificate as appropriate
 - Copy of other certificates, licenses as necessary for clinical practice at LHH
 - Evidence of Current Malpractice Coverage, if applicable
 - Fluoroscopy Certificate, as appropriate to clinical practice
 - Current Photo
 - **CPR Certificate (BLS/ACLS), if applicable**
 - Current Curriculum Vitae (CV)
 - Continuing Medical Education (CME) or CE
- C. The Medical Staff Services Office reviews the application packet for completeness as follows:
1. All items on the application form, including answers to all questions on the application; copies of requested licenses, certifications, documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status;
 2. Applicant's signature or electronic signature is present and dated on the application, privilege request, and all other forms;
 3. Complete and accurate addresses, phone and fax numbers for:
 - Medical school, Internships, Residencies, Fellowships, and other clinical training;
 - Hospitals and affiliations, past and present;
 - Peer references; and
 - Malpractice insurance, past and present
 4. Privileging forms or Standardized Procedures are completed, signed, dated, as appropriate.
 5. Attest to completion of Continuing Medical Education (CME or CE).
 6. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.
 7. Completion of Medi-Cal related acknowledgements for health plan specific provider trainings. These acknowledgements are required to begin within 10 working days of a new provider becoming active and are completed within 30 days of active credentialing. The attestations of training may be completed up to 120 days prior to a new provider becoming active.
- D. Verification of information begins as soon as the application appears complete and is conducted as specified in **Appendix B - Verification Methods**. Online, written, or verbal verification must be obtained from primary sources.
- Online and written verifications require the date a document was queried and the name of the person performing the verification.
- Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date, and time of verification.
- E. File Triaging:
Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.
- F. Credentials Committee Meeting:
Files are reviewed in accordance with the File Triaging categories (See Appendix C). All files (initial and reappointment applications) will be reviewed irrespective of triage category. Yellow and Red applications (flagged files) are discussed in detail by the Credentials Committee. All

files presented will entertain recommendations from the Credentials Committee.

G. Temporary Privileges for Initial Appointments:

Temporary clinical privileges may be granted by the Chief of Staff with the written concurrence of the appropriate Chiefs of the Clinical Service to a practitioner following licensure verification and provision of evidence of malpractice coverage (if applicable). Prior to the granting of any temporary privileges, the credentialing office shall query the appropriate professional board and the National Practitioner Data Bank for information regarding the practitioner. The Chief of Staff shall review the information obtained. In exercising temporary privileges, the practitioner shall act under the supervision of the Chief of Staff and the appropriate Chief of Clinical Service.

H. Non-Discriminatory Credentialing and Recredentialing

The San Francisco Department of Public Health (SFDPH), including SFHN and LHH, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California. (§1375.61, SB-487)

Reappointment Process:

A. Reappointment Application Packet

Providers are emailed an application for reappointment at least five (5) months prior to the end of the two (2) year appointment period. The reappointment packet includes:

- Pre-populated Reappointment Application
- Copy of current clinical privileges

B. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:

- Copy of current DEA Certificate, as appropriate;
- Fluoroscopy Certificate, as appropriate;
- **BLS/ACLS**, if applicable;
- Current CV

C. If the application is not returned within the designated time period, the provider and Service Chief will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned" to the Credentials Committee.

Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires. Reinstatement shall follow the same process as reappointments.

All Practitioners/Affiliates whose membership has expired longer than one (1) month shall be required to complete the initial appointment process.

D. The Medical Staff Office reviews the documents as follows:

1. Application form includes all questions answered, copies of requested documentation enclosed, and attachments or explanations for any irregularities regarding practice issues, legal matters and health status are provided.

2. Applicant's electronic signature is present and dated on all forms.
 3. Privileging forms and Standardized Procedures are completed, as appropriate.
 4. Clinical venues are specified, as appropriate.
 5. Completed addresses, phone and fax numbers as listed for:
 - Hospitals and affiliations;
 - Peer references; and
 - Malpractice insurance company(ies)
 6. Attest to completion of Continuing Medical Education (CME or CE).
 7. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.
- E. Verification of Information:
Verification of information begins as soon as the application appears complete, and is conducted as specified in **Appendix B - Verification Methods**. Verification for some items must be obtained from primary sources online, in writing, or oral verification. Online and written verifications require the date a document was queried and the name of the person performing the verification. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date, and time of verification.
- F. Reappointment Performance Improvement:
The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.
- G. Credentials Committee Meeting: Files are reviewed in accordance with the File Triaging categories (See **Appendix C**). All files (initial and reappointment applications) will be reviewed irrespective of triage category. Yellow and Red applications (flagged files) are discussed in detail by the Credentials Committee. All files presented will entertain recommendations from the Credentials Committee.

Evaluation and Approval Process:

- A. Clinical Services Evaluation Process:
If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file (including application, supportive documents, and privileges request form) is sent to the appropriate Service Chief for review and recommendation to the Credentials Committee. If the applicant's file was flagged, the reviewer must document sufficient review to support making a recommendation for appointment/reappointment.

The Service Chief will draft a report to the Credentials Committee indicating concerns with the appointment/reappointment if the Service Chief is disinclined to make a favorable recommendation based on (a) a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or (b) perceived conduct or professional competence which affects or could adversely affect the health or welfare of a patient or patients.

After the Service Chiefs recommendation, the file is prepared for the monthly Credentials Committee and the applicant is added to the next monthly Credentials Committee Summary Report.

- B. Credentials Committee Evaluation Process:
The Credentials Committee reviews the Summary Report, discusses, and the Committee makes recommendations for appointment/reappointment. Committee meeting minutes document that this monthly process takes place. This report is then sent to the Medical

Executive Committee (MEC).

- C. Medical Executive Committee and Governing Body Evaluation Process:
The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

Actions on appointments/reappointments are updated in the Medical Staff Office database within 10 days of Governing Body approval. The Medical Staff Office updates the intranet database and privileging portal for all hospital staff to view. Notification of the Governing Body decision is forwarded to the applicant within 30 days.

D. Provider Enrollment:

Upon Governing Body approval, the Credentials Committee Summary Report is sent to the contracted Health Plan(s).

Temporary Privileges Process:

- A. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, temporary privileges may be granted on a case by case basis.
- B. The following information is required to begin the temporary privileges process:
- Completed Temporary Privileges Application
 - Curriculum Vitae/Resume including all professional work history
 - Faculty Appointment (if applicable)
 - Service Chief Recommendation
 - Requested Privileges
 - Requested Start Date
- C. Providers must complete the following items:
- Temporary Privileges Application including
Confidentiality Statement
Consent to Release Information and Privileges.
 - Review the Medical Staff Bylaws, Rules and Regulations
- D. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
- Copy of California License(s) (an on-line query is acceptable)
 - Copy of DEA Certificate and/or Furnishing certificate, as appropriate (a query is acceptable)
 - Evidence of Current Malpractice Coverage
 - Fluoroscopy Certificate, as appropriate
 - CPR, BLS, ACLS, if applicable
 - Current Curriculum Vitae (CV)
- E. The Medical Staff Office reviews the documents as follows:
1. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
 2. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
 3. Clinical urgency and venues are specified and appropriate.

4. Complete addresses, phone and fax numbers as listed for:
 - Hospitals and affiliations;
 - Peer references; and
 - Malpractice insurance company(ies)
 5. Privileging forms are completed, as appropriate.
 6. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.
- F. Verification of information begins as soon as the application appears complete, and is conducted as specified in **Appendix B - Verification Methods**. Verification for some items must be obtained from primary sources online, in writing, or oral verification. Online and written verifications require the date a document was queried and the name of the person performing the verification. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date, and time of verification.
- G. The Chief of Staff and the Executive Administrator (or authorized designee) may grant temporary privileges for a specified period of time after the above information has been evaluated by the applicable service chief and they have made an affirmative recommendation.

Expirables/Ongoing Monitoring:

Sanctions and expirables are monitored on a monthly basis as indicated in **Appendix B - Verification Methods**.

APPENDIX A- CREDENTIALING FILES**A. CREDENTIALS** (*available for provider review*)

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Delineation of privileges, recommended by the Service Chief in the service for which privileges are being requested.
3. Current unrestricted California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Current X-ray Supervisor and Operator Certificate, as applicable
6. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
7. Verification of previous affiliations prior to LHH Medical Staff appointment
8. Curriculum Vitae that includes a comprehensive work history
9. Evidence of current, adequate malpractice insurance
10. Professional liability claims history
11. Verification of Board Status Certification or Candidacy, as applicable
12. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
13. California Medical Board Status check for validation of license and sanction activity
14. Continuing Medical Education Compliance
15. Consent to release relevant information
16. Copies of the Governing Body Approval letters confirming Medical Staff appointment and/or approved privileges
17. For Active & As-Needed Staff only: CPR (BLS/ACLS) certification

B. QUALITY (*not available for provider review*)

The quality files contain the following historical and current documents (as applicable):

1. Any action taken as a result of a malpractice claim within the previous three (3) years.
2. Reports of disciplinary actions and the outcome of those actions.
3. Results of internal and health plan quality management review such as Peer Review, clinical activity reports, and other quality indicators.
4. State Medical Board reports on any state sanction activity (e.g. 805 reports).
5. Any supplemental information or documentation regarding quality of care including, but not limited to, letters of reference or service.
6. Letters of Reference that attests to clinical competence and ethical character of the applicant.

APPENDIX B - VERIFICATION METHOD

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	TEMPORARY PRIVILEGES
1	License to Practice in California Includes information related to licensure sanctions monitored monthly	Website as available for the type of provider. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
2	DEA Registration Provider attests if DEA is not applicable to scope of practice.	Obtain online verification. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
3	Fluoroscopy Certificate Provider attests if certificate is not applicable to scope of practice.	Obtain on line verification. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
4	Medical School (Domestic Graduates) Or Other Professional Schools (non-physician applicant)	May be obtained (in writing or by phone) from the institution(s) where medical school/other professional school completed or the AMA or AOA profile service, as applicable.	X				
5	ECFMG (Foreign Graduates) For physicians who enter USA-based internship/ residency programs.	www.ecfm.org or in writing from ECFMG	X				
6	Internship Or Other Professional Training	May be obtained (in writing or by phone) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X				

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	TEMPORARY PRIVILEGES
7	Residency Other Professional Training	May be obtained (in writing or by phone) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X		X If any new training during the previous appointment period		
8	Fellowship Other Professional Training	May be obtained (in writing or by phone) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X		X If any new training during the previous appointment period		
9	Board Certification Or other professional certification or registration	CertiFACTS, ABMS compendium, query of the ABMS database, AMA or AOA profile or confirmation (verbally or in writing) directly from the certifying organization.	X	X	X	X	X
10	Healthcare Organization Affiliations	Confirm in writing or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after two requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	X Verify all affiliation within the last five years after Medical/ Professional School	X Verify as necessary to obtain information related to competency	X Verify current affiliation		X Verify current affiliation
11	Work History	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 month gaps in work history. Gaps will be documented in the file.	X Verify all affiliation within the last five years after Medical/ Professional School		X Verify current affiliation		X Temps - the last five years, Visiting - current affiliation
12	Professional Liability Insurance	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: \$2 million per claim and \$6 million annual aggregate coverage.	X		X		X

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	TEMPORARY PRIVILEGES
13	Professional Liability Claims History	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	X	X	X		X
14	Continuing Medical Education	License attestation	X		X		
15	National Practitioner Data Bank (NPDB)	Continuous Query Ongoing Monitoring	X	X	X	Monthly	X
16	Medicare Sanctions	OIG Sanction Report	X	X	X	Monthly	X
17	Peer/ Professional References/ Recommendations Peer means an individual in the same professional discipline (same type of license) or MD for Affiliated Staff as appropriate.	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested and references from supervising Attending physicians, rather than co-residents, must be obtained.	X Obtain 3 Peer References, with at least one from the last two years	X As necessary to obtain confirmation of clinical competency	X Obtain 2 Peer References		X Obtain 1 Peer Reference
18	SAM (GSA/EPLS)	System for Award Management	X		X	Monthly	X
19	CA DHCS (S & I)	California Department of HealthCare Services; Sanctions and Ineligible List	X		X	Monthly	X

APPENDIX C - FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
GREEN	<p>No issues have been identified with the provider's application, and the file meets the following criteria:</p> <ul style="list-style-type: none"> • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified 	<p>No issues have been identified with the provider's reappointment, and the file meets the following criteria:</p> <ul style="list-style-type: none"> • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified • Applicant is not requesting new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified
YELLOW	<p>The provider's file may include sensitive information, such as:</p> <ul style="list-style-type: none"> • Peer references and prior affiliations indicate potential problems. • Malpractice claims • Criteria for Privileges requested is not met. 	<p>The provider's file may include sensitive information, such as:</p> <ul style="list-style-type: none"> • Peer references and prior affiliations indicate potential problems. • Malpractice claims in past 3 years • Health problem identified which will likely have impact on exercise of clinical privileges or standardized procedures. • Lack of clinical activity or difficulty in obtaining monitoring reports

RED	<p>The provider's file shows potentially adverse information, including:</p> <ul style="list-style-type: none"> • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • Any existing information shows a quality of care or competency issue 	<p>The provider's file shows potentially adverse information, including:</p> <ul style="list-style-type: none"> • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions) • Clinical privileges revoked, diminished or altered by another Healthcare organization • New privileges requested outside of normal scope of specialty • Any existing information shows a quality of care or competency issue
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APPENDIX D- SOURCES OF PERFORMANCE IMPROVEMENT DATA

When available, information from these sources is integrated into the credentialing process:

1. **Patient Complaints and Grievances:** Significant issues are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.
2. **Clinical Activity Reports:** For monthly reappointment cycles, physician volume statistics and comparative data are gathered by the Medical Staff Office. Providers with no clinical activity may provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges.
3. **Peer Review:** Individualized profiling information is assessed by the Service Chief during initial appointment and reappointment.
4. **Medical Record Delinquencies:** The Service Chief reviews and notates as appropriate.
5. **Risk Management/Malpractice Claims:** Risk Management entities report UC Regents and San Francisco City and County claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Service/Division Chief. Claims histories also are requested from external professional liability insurance companies, as applicable. Providers with one or more claims are flagged for review by the Service Chief and the Credentials Committee.
6. **Suspensions/Sanctions:** Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff Bylaws, and for infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff Bylaws for further information). These suspensions are monitored by the Medical Staff Office and identified for Service Chief and Credentials Committee review.
7. **Reporting of Adverse Action to Authorities and Contracted Health Plans:** Adverse action that has been taken against a practitioner which falls under the reporting guidelines for state and federal agencies will be reported as appropriate to the National Practitioner Data Bank, the California Medical or Nursing Board, and to contracted Health Plans. (refer to the LHH Medical Staff Bylaws for activities or professional conduct that constitutes a request for investigation).
8. **Provider Directories:** All information required to be published in the practitioner directories of managed healthcare plans per the contractual agreement will be consistent with the information required for the credentialing process

APPENDIXE – SYSTEM CONTROL POLICY

Part A – System Controls	
<p>1. How primary source verification information is received, dated and stored.</p>	<p>Credentialing applications are received via MD-Staff credentialing database. Supporting documentation such as primary source verifications (PSVs) are either uploaded into the MD-Staff credentialing database or queried directly through the database. All primary source verifications (PSVs) collected as part of the LHH credentialing process for initial and reappointment applications are reviewed by the LHH credentialing team.</p> <p>Primary source verifications (PSVs) include but are not limited to the following; State licensure, DEA, OIG, SAM/GSA, NPDB, AMA, NPI, Certifacts. PSVs are received or obtained by primary source websites, email, or verbally (over the phone):</p> <ol style="list-style-type: none"> a. Primary Source Websites – Verifications from primary source websites will show the name of the source, the provider(s) being verified, the type of verification (license, certificate, etc.), and expiration date if applicable. b. Email – Verifications received by email will be from an approved source and verify a provider’s name, type of information being verified, and relevant start/end/expiration dates if applicable. Verbal – Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training, educations, etc.) <p>PSVs are dated automatically via the MD-Staff credentialing database and the dates cannot be changed/modified.</p> <p>PSVs are stored in the MD-Staff Credentialing database hosted by the vendor.</p>

<p>2. How modified information is tracked and dated from its initial verification.</p>	<p>PSVs uploaded into the MD-Staff Credentialing database cannot be modified. The LHH credentialing team is oriented not to attempt to modify any type of PSV prior to upload within MD-Staff Credentialing database.</p> <p>If a verification contains discrepant information that requires additional clarification, the credentialing team may include additional information to supplement the original PSV. Supplemental information should include the credentialing team member's name and date additional information was obtained.</p> <p>For verbal verifications, a memo to the file (or email from the credentialing team member) is included in the credentialing database as PDF supplemental documentation to the original information verified. Uploaded supplemental documentation from the credentialing staff should indicate the reason that the team member is requiring additional clarification.</p>												
<p>3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.</p>	<p>All users are authorized to review information. No users have ability to modify PSVs uploaded into MD-Staff. Authorized users are instructed to use good judgement and even consult a team member whenever a question arises regarding a need to remove/delete information in MD-Staff.</p> <p>Access to MD-Staff is role-based and granted based on job function within the Medical Staff Services department or ZSFG facility. Access is reviewed quarterly and adjusted as needed.</p> <table border="1" data-bbox="527 1176 1409 1927"> <thead> <tr> <th>Role</th> <th>Access Level</th> <th>Permissions</th> <th>Staff Positions</th> </tr> </thead> <tbody> <tr> <td>Administrator (all facilities)</td> <td>Full System Access</td> <td>View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit logs.</td> <td>SFHN Director; ZSFG Manager</td> </tr> <tr> <td>Administrator (respective facility)</td> <td>Full Access</td> <td>View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit</td> <td>SFHN Director; ZSFG Manager; ZSFG Medical Staff Analysts; HR Managers/ Senior Analysts</td> </tr> </tbody> </table>	Role	Access Level	Permissions	Staff Positions	Administrator (all facilities)	Full System Access	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit logs.	SFHN Director; ZSFG Manager	Administrator (respective facility)	Full Access	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit	SFHN Director; ZSFG Manager; ZSFG Medical Staff Analysts; HR Managers/ Senior Analysts
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		logs.	
General Users (respective facility)	General Access	View and modify provider information; document credentialing activities; upload documents; no deletion rights.	ZSFG/LHH/BHS Medical Staff Specialists; HR Analysts/Clerks
Read-Only User	View Only	View provider profiles and non-sensitive documents; no rights to modify or delete.	DPH Information Technology; DPH Patient Financial Services; DPH Provider Enrollment; ZSFG OPPE Coordinator

Data Deletion Protocols

Authorized users are encouraged to check with their direct manager when a need to delete information presents itself. This includes instances when a PSV may need to be re-run for a provider’s profile.

Examples of appropriate modifications to credentialing information include but are not limited to:

- **Erroneous Data Entry:** Updates to expired licensure or other documents (updating the database data fields to reflect current/accurate information)
- Changes/updates to education, training, or privileges when supporting PSVs are obtained
- Correcting/rectifying any data entry errors
- Addressing/identifying duplicative provider profiles
- **Misfiled Documents:** Documents uploaded incorrectly (e.g. wrong provider profile)
- **Duplicate Provider Records:** When duplicate profiles are identified, data is consolidated into the correct profile.

Examples of inappropriate modifications to credentialing information include but are not limited to:

- Altering credentialing approval dates unsanctioned by the Joint Conference Committee (JCC) or prior to temporarily approval by the LHH clinical leadership while awaiting JCC final approval
- Altering dates on verifications cannot be performed

	<ul style="list-style-type: none"> • Whited out of dates or signatures on hard copy documents • Unauthorized/inappropriate deletion of provider files or supporting documentation.
<p>4. The security controls in place to protect the information from unauthorized modification.</p>	<p>An excerpt from the City of San Francisco Employee Handbook is detailed below (pg. 54) of the New Employee Handbook.</p> <p><u>Work Site Security</u> To prevent and discourage unauthorized access to your work site, do not leave your office area unattended. Do not prop open doors or windows that are normally kept locked. Lock all office doors after business hours or when you leave. Prevent and discourage theft by securing your valuables.</p> <p>Work-site keys and passes may not be shared, may not be duplicated without permission and must be returned upon separation.</p> <p>Access to credentialing information is limited to authorized users only. Only authorized users are granted access to the MD-Staff credentialing database based on business need.</p> <p>Authorized users are required to complete Annual Compliance and Privacy Training (DPH) along with Cybersecurity Training to ensure safeguard of credentialing database information.</p> <p>Authorized users should:</p> <ul style="list-style-type: none"> • Use strong passphrases containing unique combinations of uppercase letters, lowercase letters, numerals and symbols • Refrain from writing down passwords • Only use a unique password for any of their accounts, and not use a password more than once • Update/change their passwords periodically, including when appropriate such as when passwords may be compromised <p>Authorized user’s accounts are inactivated upon separation from the organization, and every 30 days from their last login. The MD-Staff credentialing database is only accessible via hospital intranet or VPN access. When the organization inactivates the user’s active directory account, the user will no longer have a mechanism/pathway to log-in to MD-Staff for access to credentialing information.</p>

<p>5. The policies and procedures describe the organization's audit process for identifying and assessing risks and ensuring that specified policies and procedures are followed. At a minimum, the description includes:</p> <ul style="list-style-type: none"> ○ the audit elements include: ○ methodology used; ○ including sampling; ○ individuals involved in the audit; and ○ audit frequency. <p>➤ Oversight of the department responsible for the audit.</p>	<p>Monitoring of our processes must occur at least annually. The audits of our process will be performed by a director in conjunction with selected members of the medical staff office team. The audits may include but are not limited to the following:</p> <ol style="list-style-type: none"> 1. A description of the system functionality that prevents or disallows modifications of credentialing information. 2. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly. 3. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags. <p>Primary source documentation uploaded into our MD Staff credentialing database cannot be modified. An annual review sampling 20 active records (10 initial & 10 recredential) from our provider roster will be reviewed at random and conducted by department management/senior staff to ensure that the MD Staff provider records are complete and possesses accurate information.</p> <p>When auditing is used as the method for monitoring, sampling using the "5% or 50 files" audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files.</p> <p>Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system's audit trail function reporting capability.</p> <p>Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours – i.e., in locked drawers/filing cabinets, not left on workstations, etc.</p> <p>Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder.</p> <p>Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.</p>
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Part B - Oversight	
<p>1. Identify all modifications to credentialing and recredentialing information that did not meet the organizations policies/procedures for modifications as described in CR 1, Element C, Credentialing System Controls.</p>	<p>At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies, procedures shall be reported to the LHH MSO and AH Credentials Committee and Medical Executive Committee. The report will need to include:</p> <ul style="list-style-type: none"> A. A review of all modifications that did not meet the policies and procedures <ul style="list-style-type: none"> i. Conduct a qualitative and quantitative analysis of all modifications that did not meet policies. ii. Actions taken to address any modifications that did not meet established policy. iii. Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review. B. The report shall include the person/role/title of the person performing the monitoring. C. The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.
<p>2. Document and analyze all modifications that did not meet standards by doing a qualitative and quantitative analysis of all modifications.</p>	<ul style="list-style-type: none"> i. Credentialing System Controls Oversight Report – this template will be included in the request for documents at the time of the annual oversight assessment. ii. Monitoring and Reporting of Inappropriate Modifications - This template will be included in the request for documents at the time of the annual oversight assessment. LHH MSO would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.
<p>3. Acting on all findings. (Not applicable if no findings above.)</p>	<p>Findings will be acted upon by the LHH MSO, if any are identified.</p>

APPROVED BY:

CREDENTIALS COMMITTEE	MEDICAL EXECUTIVE COMMITTEE	JOINT COMMISSION COMMITTEE
03/04/2025	04/03/2025	06/09/2025
10/01/2024	11/07/2024	
11/06/2020	11/05/2020	

Revised Nursing Policies and Procedures

Vital Signs

VITAL SIGNS

POLICY:

1. Any nursing staff member may perform vital signs (V/S) measurements.
2. Vital signs include blood pressure (BP), pulse rate (PR), respiratory rate (RR), temperature (T), and oxygen saturation (O2 sat).
3. Only oral temperature readings can be taken when using the Masimo Root automated vital signs machine. If unable to obtain temperature via oral route, staff may use facility approved tympanic temperature machine.
4. Staff who find a resident/patient, unresponsive, pulseless or apneic shall initiate a Code Blue per Code Blue Policy {Refer to Hospital-wide Policy & Procedure (HWPP) #24-16 Code Blue}.
 - a. For staff required to have Basic Life Support (BLS), staff shall assess for resident's/patient's responsiveness, breathing and pulse per BLS guidelines. Cardiopulmonary Resuscitation (CPR) shall be initiated immediately when needed.
5. Orthostatic V/S, are measured as per policies and procedures, as per physician's order, and whenever clinically indicated based on the assessment of the licensed nurse.
6. For residents/patients whose reimbursement for skilled nursing care is Medicare, V/S should be taken and recorded at least daily. In long-term care neighborhoods, V/S are checked ~~monthly~~ weekly with the weekly summary at a minimum, unless otherwise ordered.
7. Residents/patients receiving certain cardiovascular or antihypertensive medications are monitored as per Medication Administration procedure. (Refer to HWPP #25-15 Medication Administration)
8. Residents/patients in isolation rooms will have designated automated V/S machine and tympanic thermometer available. When available, individual BP cuffs are kept at the resident's/patient's bedside.
9. The use of individualized BP cuffs is encouraged. When an individualized BP cuff is not available, use the multi-use BP cuffs, and clean the cuff in between resident/patient use with facility approved disinfectant.

PURPOSE:

To outline frequency of vital sign measurement and nursing responsibilities.

PROCEDURES:

A. Frequency of Monitoring V/S

1. Admission for all SNF Neighborhoods: V/S are taken upon admission to any neighborhood in Laguna Honda Hospital (LHH) at a minimum of once per shift for the first three (3) days, unless otherwise ordered. Orthostatic BP/PR is done once as part of the admission nursing assessment to evaluate for hypotension and whenever clinically indicated.

Vital Signs

2. Acute Units:
 - Pavilion Mezzanine Acute (Medical): upon admission and every four (4) hours, or more frequently as clinically indicated.
 - Pavilion Mezzanine Acute (Rehab): upon admission and then daily or as clinically indicated.
3. Discharge: before discharge from Pavilion Mezzanine Acute or to outside acute facility or hospital.
4. Relocation from one neighborhood to another within LHH: every shift for the first 3 days of relocation or as clinically indicated.
5. Receiving course of antimicrobial: once per shift for the entire course of the antimicrobials
 - a. For antimicrobials prescribed for prophylaxis – refer to NPP C 3.0 Documentation of Resident Care by LN for frequency.
6. Unanticipated change in resident/patient condition or potential/actual decline: check V/S once per shift at a minimum for 3 days as often as clinically indicated depending on the nature of the change.
7. Fall incident (Refer to HWPP #24-13 Falls).
8. New wounds or worsening of skin ulcers/wounds - check V/S once per shift at a minimum for 3 days and as clinically indicated.

B. Reporting

1. CNA or PCA should report immediately to the licensed nurse in charge of the resident/patient if:
 - BP is less than 90/50 or greater than 160/90
 - PR less than 50 or greater than 100
 - RR less than 14 or greater than 25
 - T over 100 degrees F
 - O2 sat of less than 90
 - Orthostatic V/S changes
2. Licensed Nurse (LN) is to assess resident/patient immediately and notify physician as needed for further medical evaluation if vital signs are outside of normal parameters (FYI: Critical values identified for vital signs in EHR are for guideline purposes).

C. Documentation:

1. Record V/S (BP, PR, RR, T, & O2 sat) in the electronic health record (EHR).
2. A LN reviews the V/S. If further assessment is required, LN shall notify physician and will document notification in the EHR.

Vital Signs

REFERENCES:

- Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier
- Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadelphia, PA: Lippincott Williams & Wilkins
- Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospital-wide Policies & Procedures
24-16 Code Blue
25-06 Pain Assessment and Management
25-15 Medication Administration

Nursing Policies & Procedures
C 1.0 Resident Admission and Readmission for Skilled Nursing Facility
C 1.2 Relocation Between Laguna Honda SNF Neighborhoods
C 1.3 Discharge Procedure to Acute
C 3.0 Documentation of Resident Care by Licensed Nurse - SNF
C 3.2 Documentation of Resident Care by Nursing Assistant
G 2.0 Neurological Status Assessment

ATTACHMENTS:

None

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