Minimum Data Set (MDS) 3.0
Instructor Guide

Section K
Swallowing/ Nutritional Status

Objectives

- State the intent of Section K Swallowing and Nutritional Status.
- Describe how to conduct an assessment of a resident's nutritional status.
- Calculate resident weight change (gain or loss) accurately.
- Code Section K correctly and accurately.

Methodology

This lesson uses lecture, scenario-based examples, and scenario-based practice problems.

Training Resources

- Instructor Guide
- Slides 1 to 61

Instructor Preparation

- Review the Instructor Guide.
- Review learning objectives for the lesson.
- Rehearse with slide presentation.

SLIDES	INSTRUCTIONAL GUIDANCE

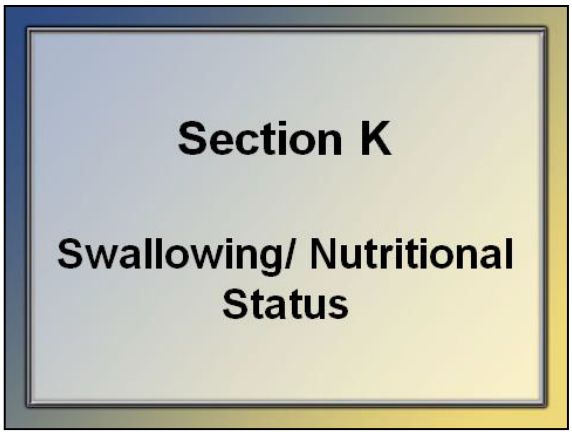
Instructor Notes

Notes

Direct participants to turn to Section K in the MDS 3.0 instrument.

Notes

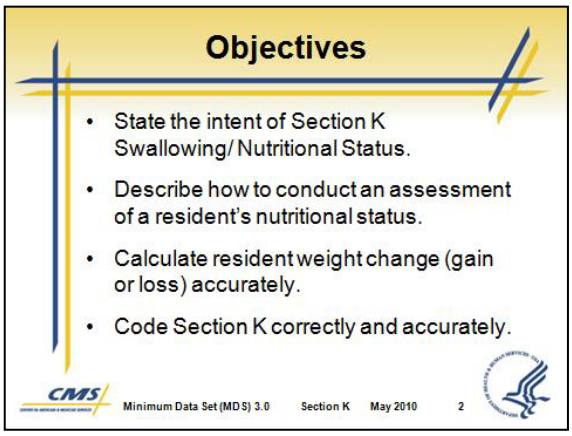
Instructor Notes



Slide 1

I. Introduction/ Objectives

A. This lesson covers the assessment of a resident's ability to swallow and other factors reflecting a resident's nutritional status.

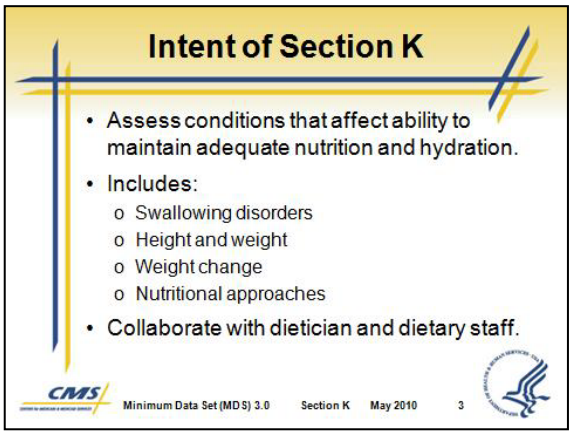


Slide 2

B. Objectives

- State the intent of Section K Swallowing and Nutritional Status.
- Describe how to conduct an assessment of a resident's nutritional status.
- Calculate resident weight change (gain or loss) accurately.
- Code Section K correctly and accurately.

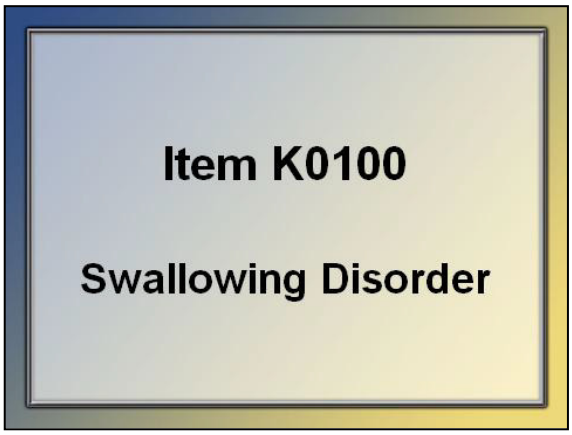
SLIDES	INSTRUCTIONAL GUIDANCE



Slide 3

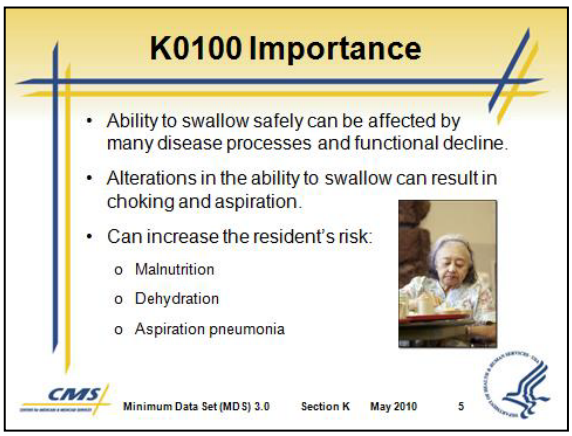
C. Intent of Section K

1. Section K is intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
2. This section covers
   - Swallowing disorders
   - Height and weight
   - Weight change
   - Nutritional approaches
3. Nurse assessors should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.



Slide 4

II. Item K0100 Swallowing Disorder

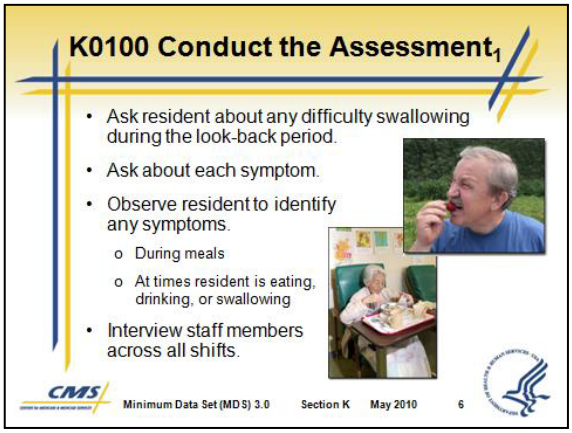


Slide 5

A. K0100 Importance

1. Ability to swallow safely can be affected by many disease processes and functional decline.
2. Alterations in the ability to swallow can result in choking and aspiration.
3. Can increase the resident's risk for:

SLIDES	INSTRUCTIONAL GUIDANCE



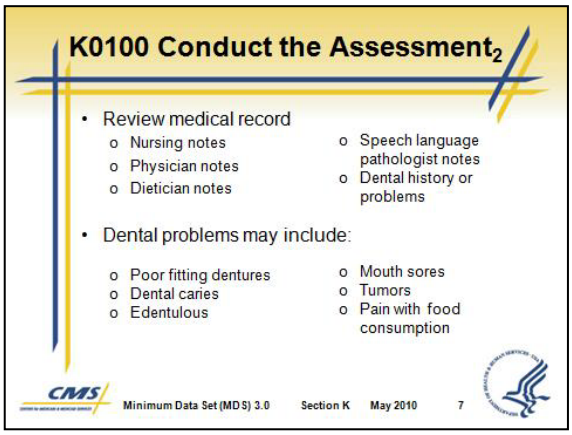
Slide 6

- Malnutrition
- Dehydration
- Aspiration pneumonia

B. K0100 Conduct the Assessment

1. Ask the resident if he or she has had any difficulty swallowing during the look-back period.
2. Ask about each of the symptoms in K0100A through K0100D.
   a. K0100A Loss of liquids/ solids from mouth when eating or drinking
   b. K0100B Holding food in mouth/ cheeks or residual food in mouth after meals
   c. K0100C Coughing or choking during meals or when swallowing medications
   d. K0100D Complaints of difficulty or pain with swallowing
3. Observe the resident during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.
4. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the look-back period.

SLIDES	INSTRUCTIONAL GUIDANCE

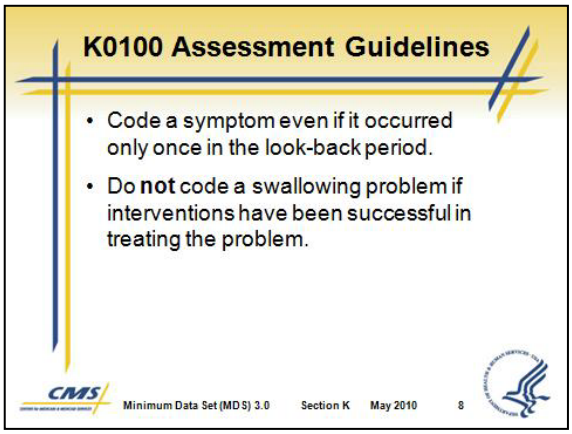


Slide 7

5. Review the medical record.
   a. Nursing notes
   b. Physician notes
   c. Dietician notes
   d. Speech language pathologist notes
   e. Any available information on dental history or problems
6. Dental problems may include:
   a. Poor fitting dentures
   b. Dental caries
   c. Edentulous
   d. Mouth sores
   e. Tumors

   and/ or

   f. Pain with food consumption

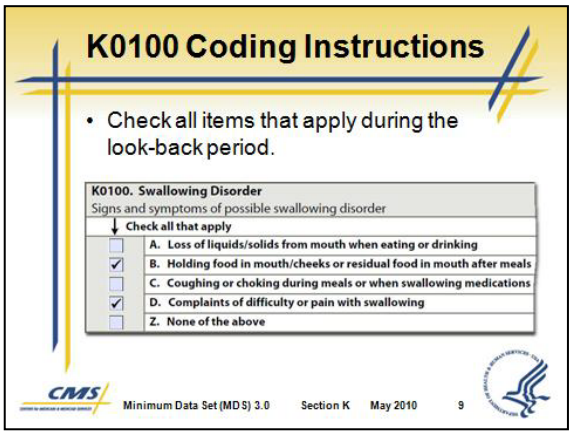


Slide 8

C. K0100 Assessment Guidelines

1. Code even if the symptom occurred only once in the look-back period.
2. **Do not** code a swallowing problem when interventions have been successful in treating the problem.

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 9

D. K0100 Coding Instructions

1. Check all items that apply during the look-back period.

Instructor Notes

Notes

Detailed Coding Instructions for Item K0100

A. Loss of liquids/solids from mouth when eating or drinking

When the resident has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.

A. **Holding food in mouth/cheeks or residual food in mouth after meals**

Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because resident failed to empty mouth completely.

B. **Coughing or choking during meals or when swallowing medications**

The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way."

C. **Complaints of difficulty or pain when swallowing**

Resident may refuse food because it is painful or difficult to swallow.

D. **None of the above**

If none of the K0100A through K0100D signs or symptoms were present during the look-back.

Notes

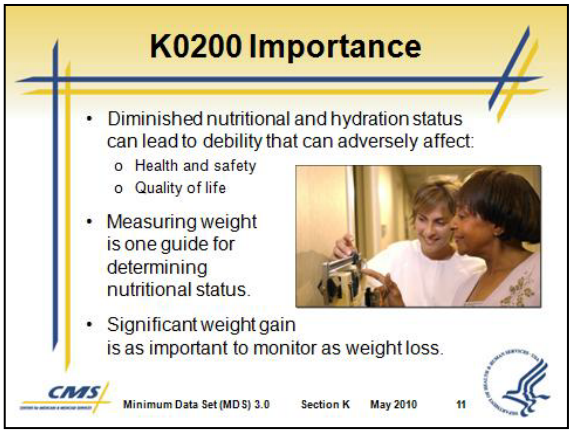
Instructor Notes

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 10

III. Item K0200 Height and Weight

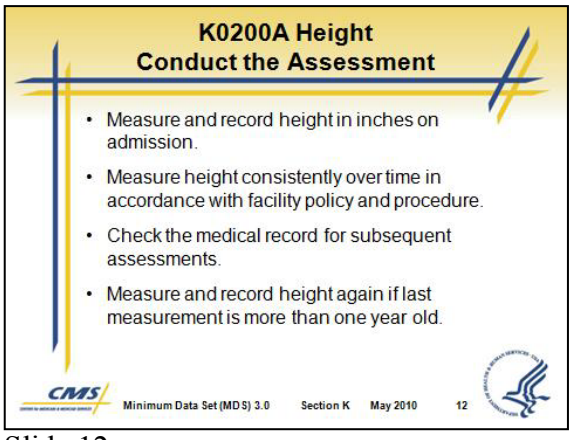
A. Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time.



Slide 11

B. K0200 Importance

1. Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life.
2. The measurement of weight is one guide for determining nutritional status.
3. Significant weight gain is as important to monitor as weight loss.

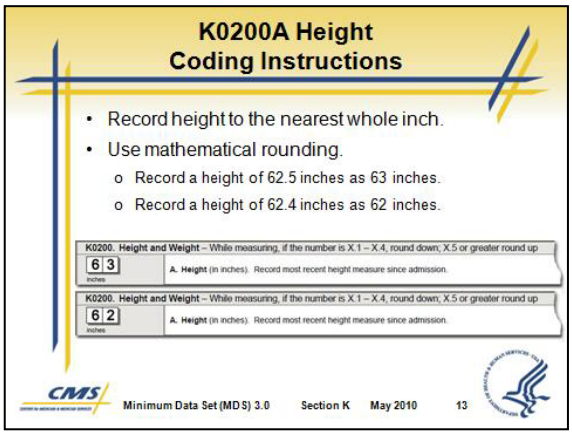


Slide 12

C. K0200A Height Conduct the Assessment

1. Measure and record height in inches on admission.
2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. Check the medical record for subsequent assessments.
4. If the last height recorded was more than one year ago, measure and record the resident's height again.

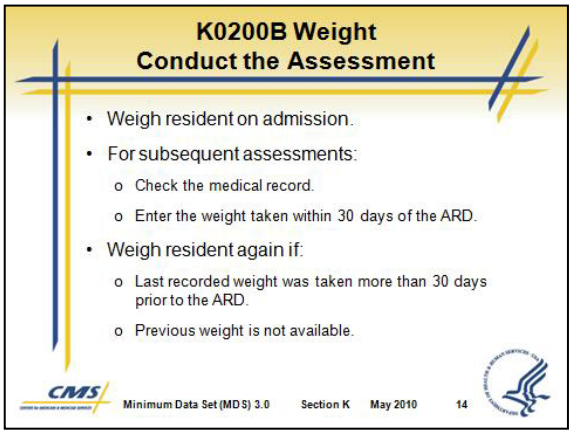
SLIDES	INSTRUCTIONAL GUIDANCE



Slide 13

D. K0200A Height Coding Instructions

1. Record height to the nearest whole inch.
2. Use mathematical rounding.
3. If height measurement is X.5 inches or greater, round height upward to the nearest whole inch.
4. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch.
5. For example:
   a. A height of 62.5 inches would be rounded to 63 inches.
   b. A height of 62.4 inches would be rounded to 62 inches.

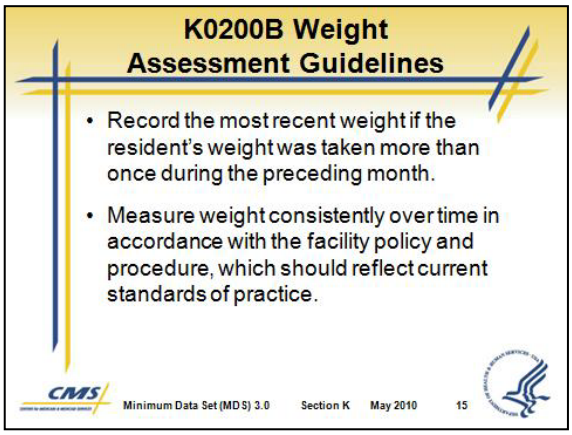


Slide 14

E. K0200B Weight Conduct the Assessment

1. Weigh the resident and record results on admission.
2. For subsequent assessments:
   a. Check the medical record.
   b. Enter the weight taken within 30 days of the ARD of this assessment.
3. Weigh the resident again if:
   a. The last recorded weight was taken more than 30 days prior to the ARD of this assessment.
   b. Previous weight is not available

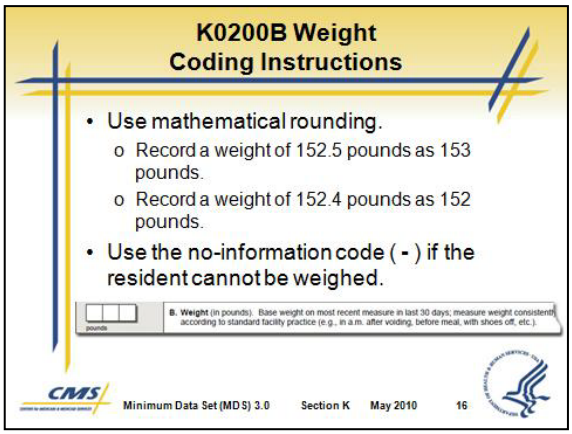
SLIDES	INSTRUCTIONAL GUIDANCE



Slide 15

F. K0200B Weight Assessment Guidelines

1. Record the most recent weight if the resident's weight was taken more than once during the preceding month.
2. Measure weight consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice.
    - After voiding
    - Before meal



Slide 16

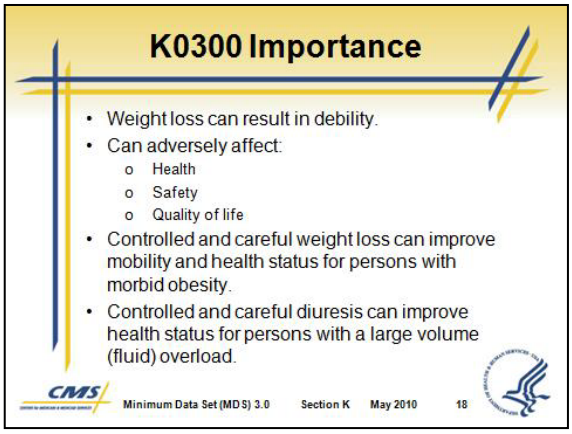
G. K0200B Weight Coding Instructions

1. Use mathematical rounding.
2. If weight is X.5 pounds or more, round weight upward to the nearest whole pound.
3. If weight is X.1 to X.4 pounds, round down to the nearest whole pound.
4. For example:
    a. A weight of 152.5 pounds would be rounded to 153 pounds and
    b. A weight of 152.4 pounds would be rounded to 152 pounds.
5. If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 17

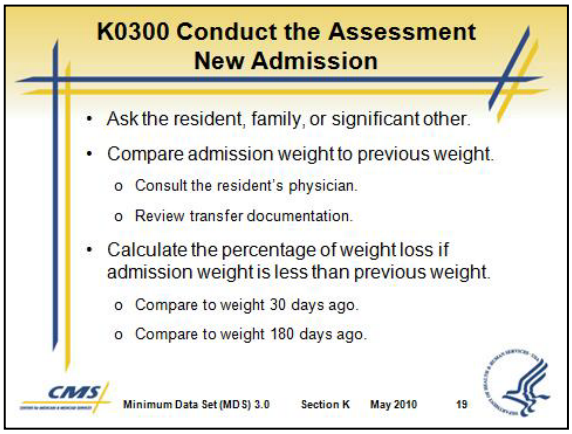
IV. Item K0300 Weight Loss



Slide 18

A. K0300 Importance

1. Weight loss can result in debility.
2. Can adversely affect:
   - Health
   - Safety
   - Quality of life
3. For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
4. For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.



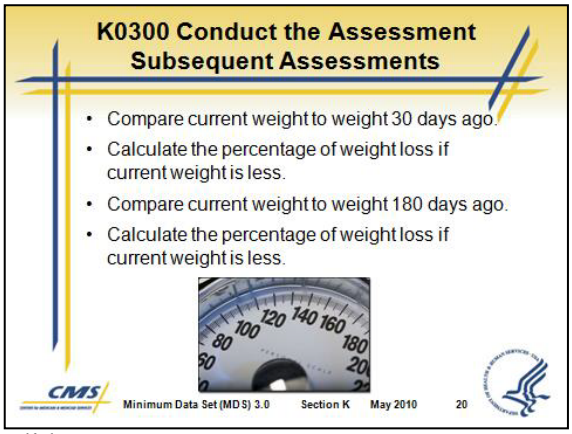
Slide 19

B. K0300 Conduct the Assessment: New Admission

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.
2. Compare admission weight to previous weights recorded for the resident.
   a. Consult the resident's physician.
   b. Review transfer documentation.

SLIDES	INSTRUCTIONAL GUIDANCE

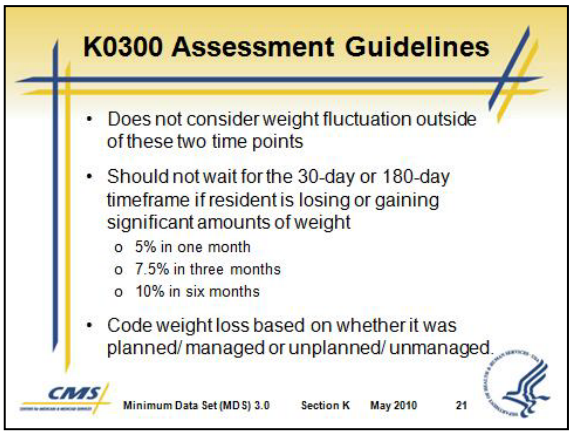
3. Calculate the percentage of weight loss if the admission weight is less than the previous weight.
   a. Complete this process to determine and calculate weight loss comparing the admission weight to the weight 30 and 180 days ago.



Slide 20

C. K0300 Conduct the Assessment: Subsequent Assessments

1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago.
2. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss.
3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago.
4. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss.



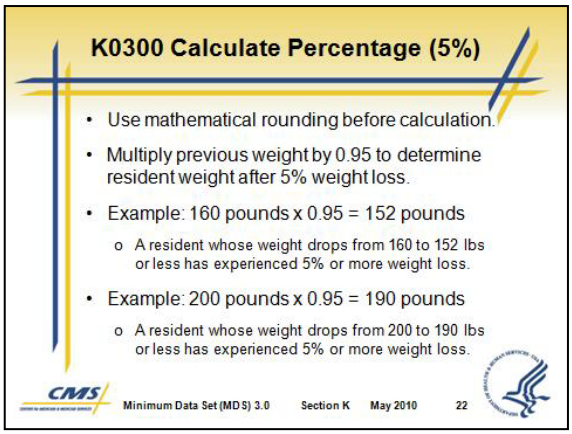
Slide 21

D. K0300 Assessment Guidelines

1. This item does not consider weight fluctuations outside of these time points.
2. A facility should not wait for the 30-day or 180-day timeframe if a resident is losing or gaining significant amounts of weight.
   - 5% in one month
   - 7.5% in three months
   - 10% in six months

SLIDES	INSTRUCTIONAL GUIDANCE

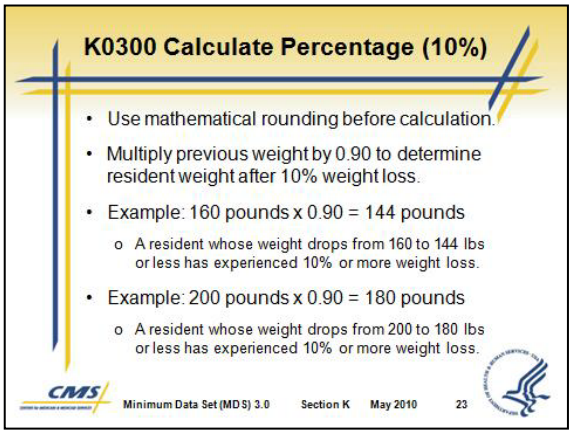
3. Code weight loss based on whether it was planned and managed or unplanned and unmanaged.



Slide 22

E. K0300 Calculate Percentage (5%)

1. If necessary, use mathematical rounding before starting any weight loss calculations.
   a. For example, round 160.2 pounds to 160 pounds.
2. Multiply the previous weight by 0.95 to determine what a resident's weight would be after experiencing a 5% weight loss.
3. Examples:
   a. A resident whose weight drops from 160 to 152 pounds or less has experienced at least 5% weight loss.
   b. A resident whose weight drops from 200 to 190 pounds or less has experienced at least 5% weight loss.



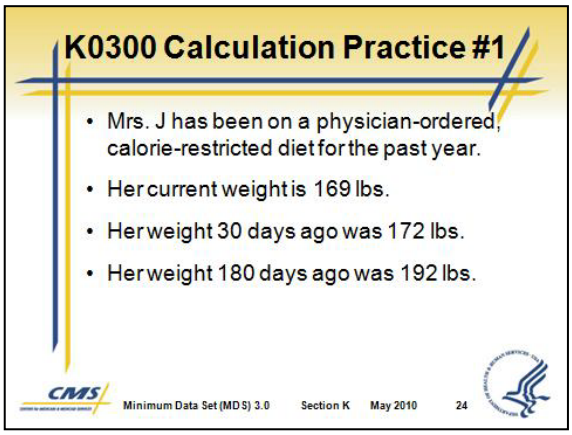
Slide 23

F. K0300 Calculate Percentage (10%)

1. If necessary, use mathematical rounding before starting any weight loss calculations.
2. Multiply the previous weight by 0.90 to determine what a resident's weight would be after experiencing a 10% weight loss.
3. Examples:
   a. A resident whose weight drops from 160 to 144 pounds or less has experienced at least 10% weight loss.

SLIDES	INSTRUCTIONAL GUIDANCE

b. A resident whose weight drops from 200 to 180 pounds or less has experienced at least 10% weight loss.

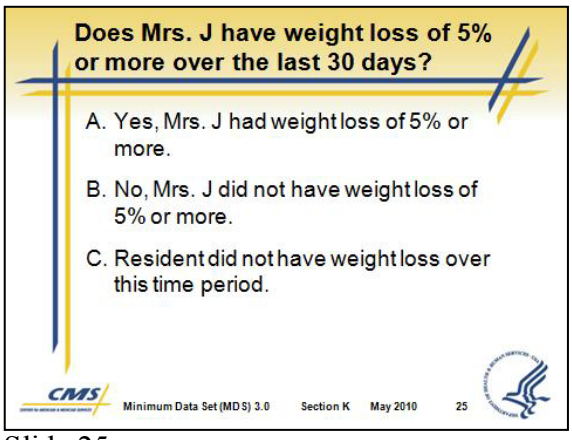


Slide 24

G. K0300 Calculation Practice #1

1. Mrs. J has been on a physician-ordered calorie-restricted diet for the past year.
   a. Her current weight is 169 lbs.
   b. Her weight 30 days ago was 172 lbs.
   c. Her weight 180 days ago was 192 lbs.

Go to next slide for question and choice of answers for this scenario.



Slide 25

2. Does Mrs. J have weight loss of 5% or more over the past 30 days?

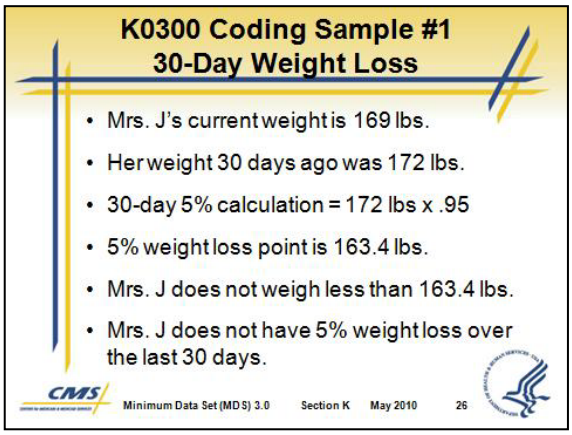
Give participants time to do the calculation.

Have participants use clickers to select an answer.

   a. Correct answer is B.
   b. No, Mrs. J did not have weight loss of 5% or more.

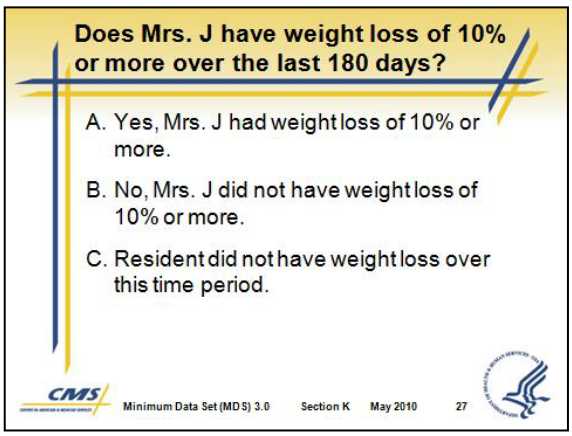
See next slide for calculation of whether resident had 5% weight loss over the previous 30 days.

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 26

3. 30-day calculation for Mrs. J
    a. Mrs. J's current weight is 169 lbs.
    b. Mrs. J's weight 30 days ago was 172 lbs.
    c. 30-day 5% weight loss calculation = 172 x .95.
    d. 5% weight loss point is 163.4 lbs.
    e. Mrs. J does not weigh 163.4 pounds or less.
    f. Mrs. J does not have 5% weight loss over the last 30 days.



Slide 27

4. Does Mrs. J have weight loss of 10% or move over the past 180 days?

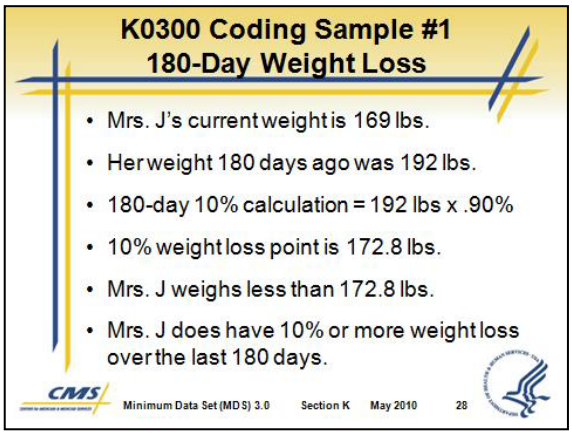
Give participants time to do the calculation.

Have participants use clickers to select an answer.

    a. Correct answer is A.
    b. Yes, Mrs. J had weight loss of 10% or more in the past 180 days.

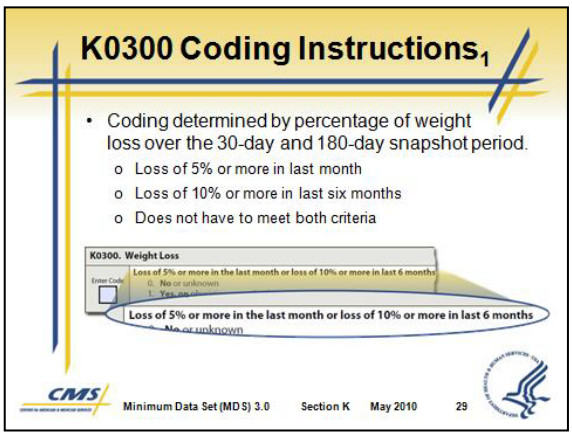
See next slide for calculation of whether resident had 10% weight loss over the previous 180 days.

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 28

5. 180-day calculation for Mrs. J
   a. Mrs. J's current weight is 169 lbs.
   b. Mrs. J's weight 180 days ago was 192 lbs.
   c. 180-day 10% weight loss calculation = 192 x .90.
   d. 10% weight loss point is 172.8 lbs.
   e. Mrs. J does weigh less than 172.8 lbs.
   f. Mrs. J does have 10% or more weight loss over the last 180 days.

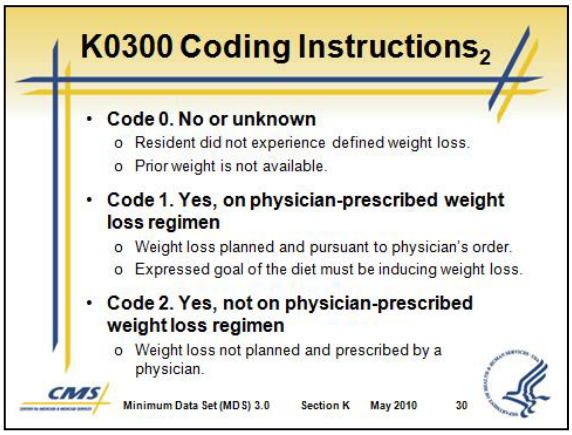


Slide 29

H. K0300 Coding Instructions

1. Coding for K0300 is determined by the percentage of weight loss over the 30-day and 180-day snapshot period.
2. If the resident has experienced weight loss, determine the extent of the weight loss.
   a. 5% or more in the last month
   b. 10% or more in the last six months
3. The resident's weight loss does not have to meet both criteria.

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 30

- **Code 0. No or unknown**

  If the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.

- **Code 1. Yes, on physician-prescribed weight loss regimen**

  If the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order.

- The expressed goal of the diet must be inducing weight loss to use this code.

- **Code 2. Yes, not on physician-prescribed weight loss regimen**

  If the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.

Instructor Notes

Notes

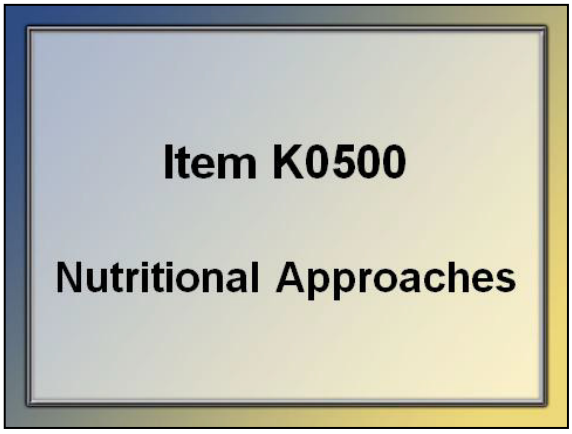
Physician-Prescribed Weight-Loss Regimen

A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.

Notes

Instructor Notes

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 31

V. Item K0500 Nutritional Approaches

A. Nutritional approaches that vary from the normal or that rely on alternative methods such as:

- Mechanically altered food
- Parenteral/ IV or feeding tubes

B. Can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.

Instructor Notes

Notes

Parenteral/ IV Feeding

Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).

Notes

Instructor Notes

Instructor Notes

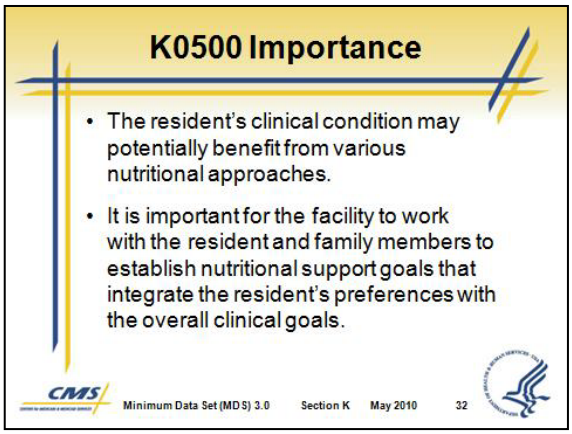
Notes

Feeding Tube

Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include but are not limited to nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.

Notes

Instructor Notes

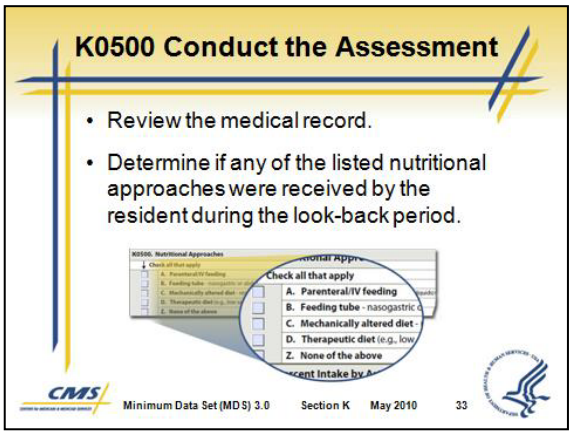


Slide 32

C. K0500 Importance

1. The resident's clinical condition may potentially benefit from various nutritional approaches.
2. It is important for the facility to work with the resident and family members to establish nutritional support goals that integrate the resident's preferences with the overall clinical goals.

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 33

D. K0500 Conduct the Assessment

1. Review the medical record.
2. Determine if any of the listed nutritional approaches were received by the resident during the look-back period.

Briefly review approaches listed in the graphic.

Instructor Notes

Notes

Mechanically Altered Diet

A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

Notes

Instructor Notes

Instructor Notes

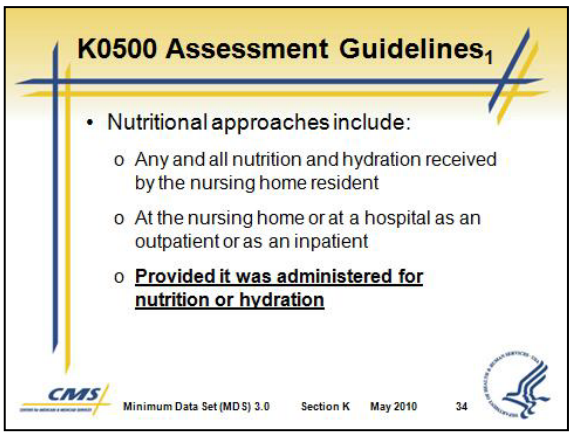
Notes

Therapeutic Diet

A diet ordered to manage problematic health conditions. Therapeutic refers to the nutritional content of the food. Examples include calorie-specific, low-salt, low-fat, lactose-free, no added sugar, and supplements during meals.

Notes

Instructor Notes

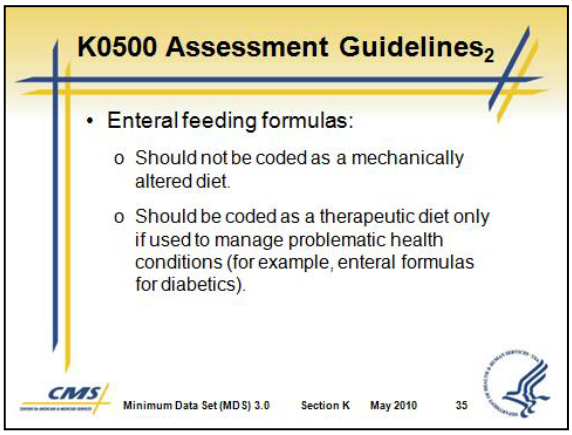


Slide 34

E. K0500 Assessment Guidelines

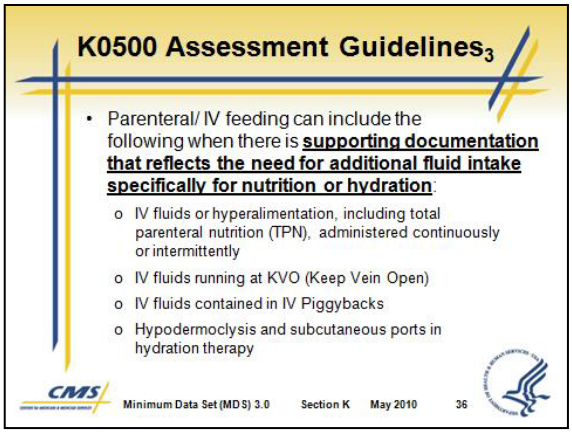
1. Nutritional approaches include:
   a. Any and all nutrition and hydration received by the nursing home resident
   b. At the nursing home or at a hospital as an outpatient or as an inpatient
   c. Provided it was administered for nutrition or hydration

SLIDES	INSTRUCTIONAL GUIDANCE



Slide 35

2. Enteral feeding formulas:
   a. Should not be coded as a mechanically altered diet.
   b. Should be coded as a therapeutic diet only if used to manage a problematic health condition such as diabetes.



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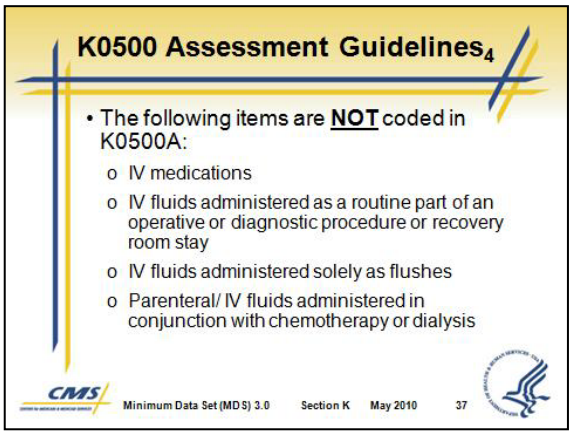
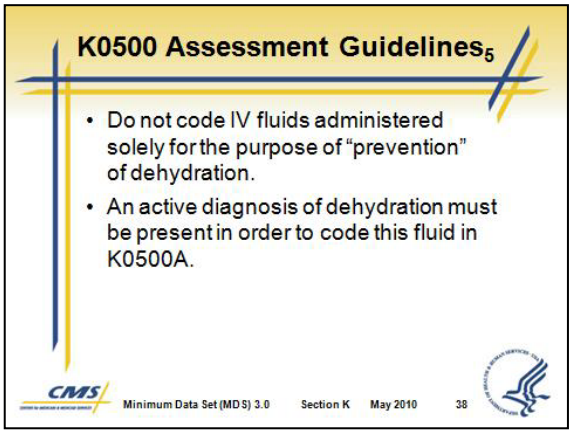
3. Parenteral/ IV feeding can include the following **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need:**
   a. IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
   b. IV fluids running at KVO (Keep Vein Open)
   c. IV fluids contained in IV Piggybacks
   d. Hypodermoclysis and subcutaneous ports in hydration therapy
4. This supporting documentation should be noted in the resident's medical record according to State and/ or internal facility policy.

SLIDES	INSTRUCTIONAL GUIDANCE



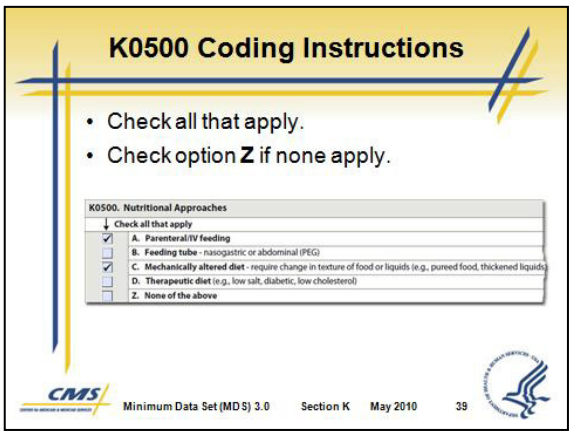
Slide 37

5. The following items are **NOT** to be coded in K0500A:
   a. IV medications (code when appropriate in O0100H IV Medications)
   b. IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
   c. IV fluids administered solely as flushes
   d. Parenteral/ IV fluids administered in conjunction with chemotherapy or dialysis



Slide 38

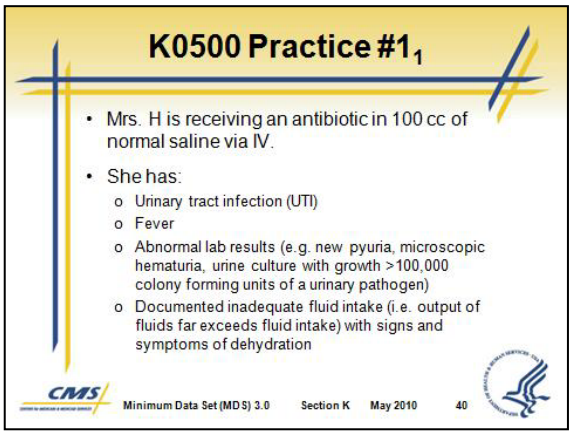
6. Do not code IV fluids administered solely for the purpose of "prevention" of dehydration.
7. An active diagnosis of dehydration must be present in order to code this fluid in K0500A.



Slide 39

F. K0500 Coding Instructions
   1. Check all that apply.
   2. Check option **Z** if none apply.

SLIDES	INSTRUCTIONAL GUIDANCE



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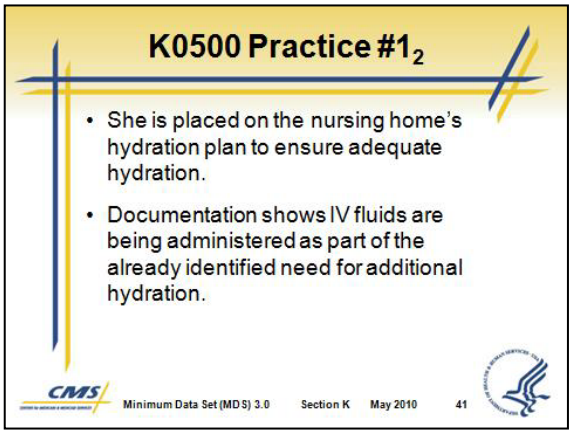
G. K0500 Practice #1

1. Mrs. H. is receiving an antibiotic in 100 cc of normal saline via IV.
2. She has:
   a. Urinary tract infection (UTI)
   b. Fever
   c. Abnormal lab results (e.g. new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen)
   d. Documented inadequate fluid intake (i.e. output of fluids far exceeds fluid intake) with signs and symptoms of dehydration



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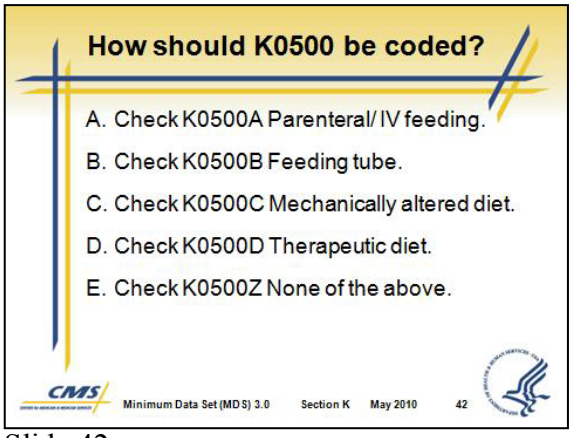
3. She is placed on the nursing home's hydration plan to ensure adequate hydration.
4. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.



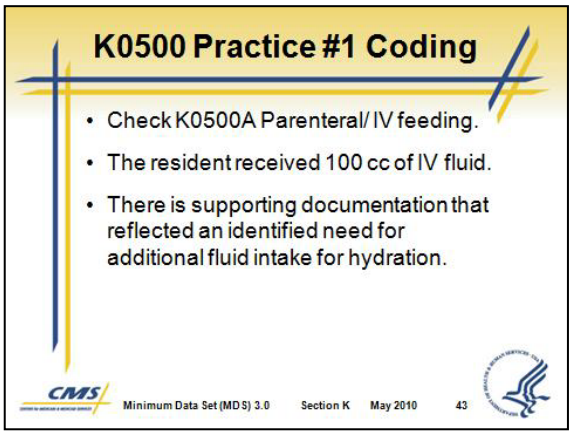
Slide 42

5. How should K0500 be coded?

   Give participants time to answer the question.

   a. Correct answer is A. Check K0500A Parenteral/ IV feeding.

SLIDES	INSTRUCTIONAL GUIDANCE



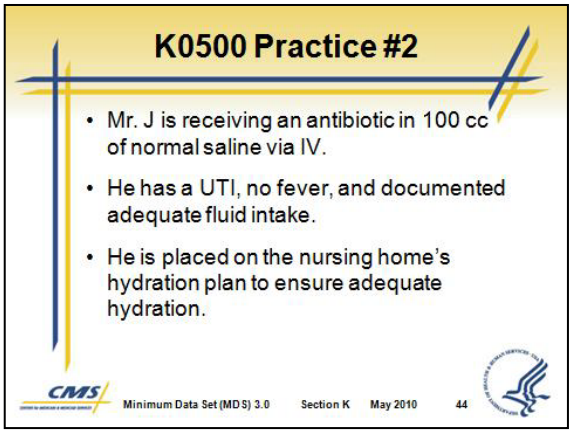
Slide 43

6. K0500 Practice #1 Coding

   b. Check K0500A Parenteral/ IV feeding.

   c. The resident received 100 cc of IV fluid.

   d. There is supporting documentation that reflected an identified need for additional fluid intake for hydration.



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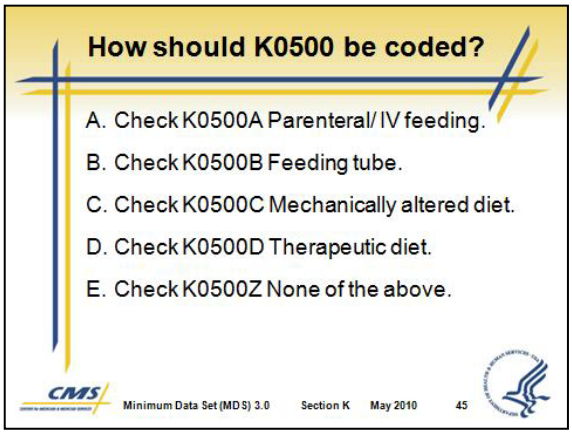
H. K0500 Practice #2

1. Mr. J is receiving an antibiotic in 100 cc of normal saline via IV.
2. He has a UTI, no fever, and documented adequate fluid intake.
3. He is placed on the nursing home's hydration plan to ensure adequate hydration.



Slide 45

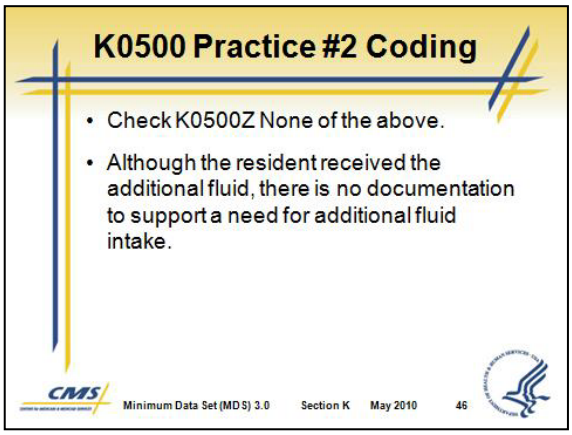
4. How should K0500 be coded?

   Give participants time to answer the question.

   Have participants use clickers to indicate an answer.

   a. Correct answer is E. Check K0500Z None of the above.

SLIDES	INSTRUCTIONAL GUIDANCE



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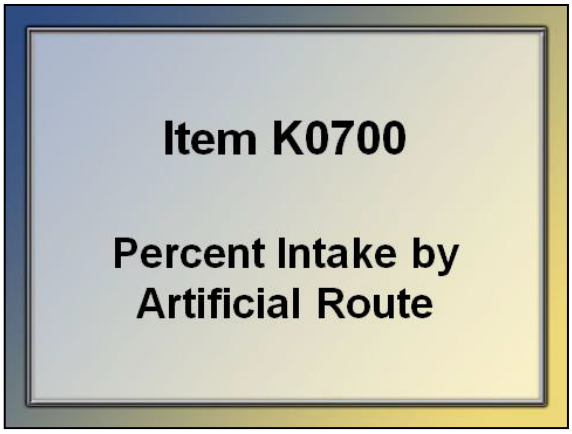
5. K0500 Practice #2 Coding
   b. Check K0500Z None of the above.
   c. Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.



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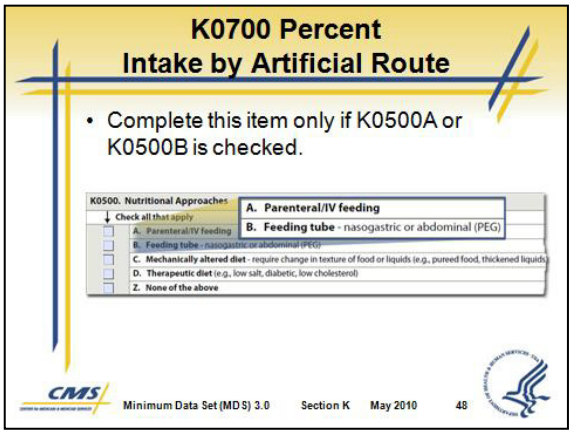
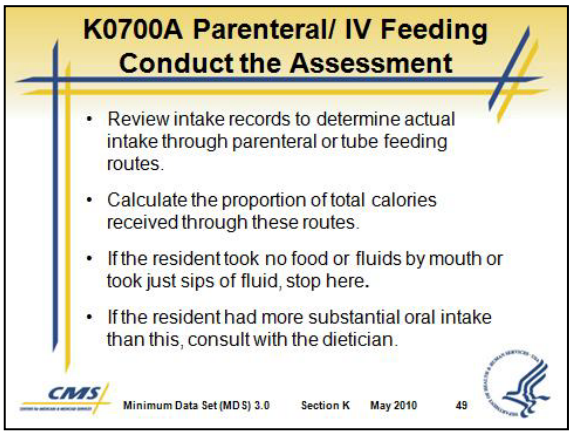
VI. Item K0700 Percent Intake by Artificial Route



Slide 48

A. K0700 Percent Intake by Artificial Route
   1. Complete this item only if K0500A or K0500B is checked.

SLIDES	INSTRUCTIONAL GUIDANCE



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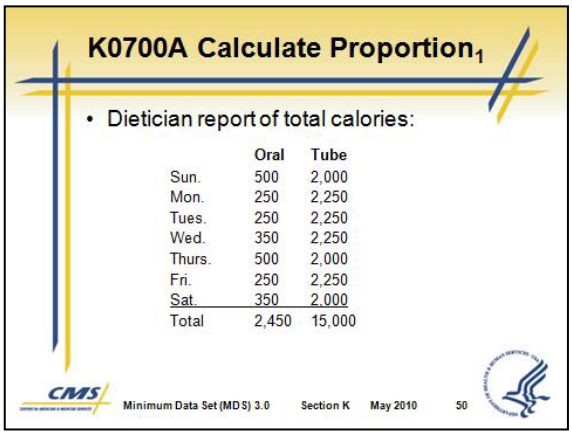
B. K0700A Parenteral/ IV Feeding: Conduct the Assessment

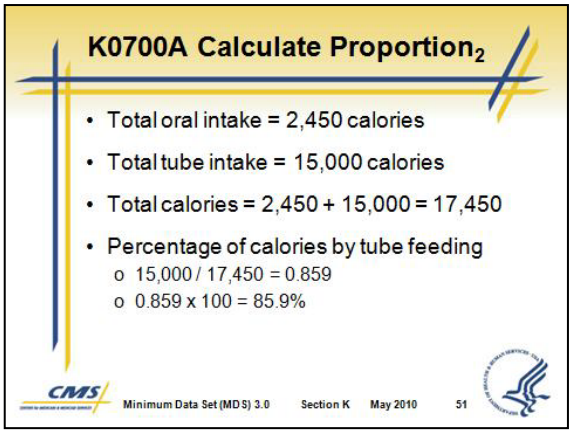
1. Review intake records to determine actual intake through parenteral or tube feeding routes.
2. Calculate the proportion of total calories received through these routes.
3. If the resident took no food or fluids by mouth or took just sips of fluid, stop here.
4. If the resident had more substantial oral intake than this, consult with the dietician.



Slide 50

C. K0700A Calculate Proportion

1. The dietician report indicates the total number of calories taken in by a resident over the week.
2. The total equals 2,450 calories orally and 15,000 calories by tube feeding.



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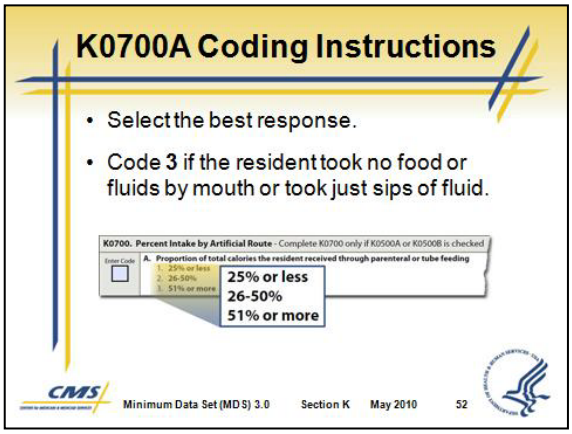
3. The dietician report indicates:
   a. Total of 2,450 calories taken orally
   b. Total of 15,000 calories taken by tube
   c. Total calories taken in equal 17,450
4. Calculate the percentage of calories taken in by tube feeding.
   a. Divide the number of calories taken by tube feeding by the total number of calories.

SLIDES	INSTRUCTIONAL GUIDANCE

b. Dividing 15,000 by 17,450 equals .859.

c. Multiply .859 by 100 to generate a percentage.



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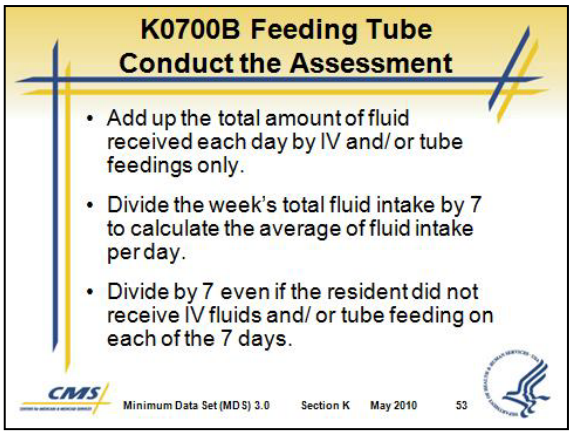
D. K0700A Coding Instructions

1. Select the best response.
2. The example we just worked would be coded option **3. 51% or more**.
3. Also code **3** if the resident took no food or fluids by mouth or took just sips of fluid.

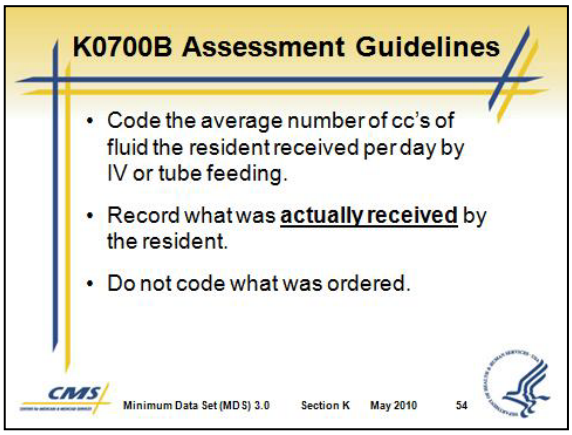


Slide 53

E. K0700B Feeding Tube: Conduct the Assessment

1. Review intake records from the last 7 days.
2. Add up the total amount of fluid received each day by IV and/or tube feedings only.
3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day.
4. Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days.

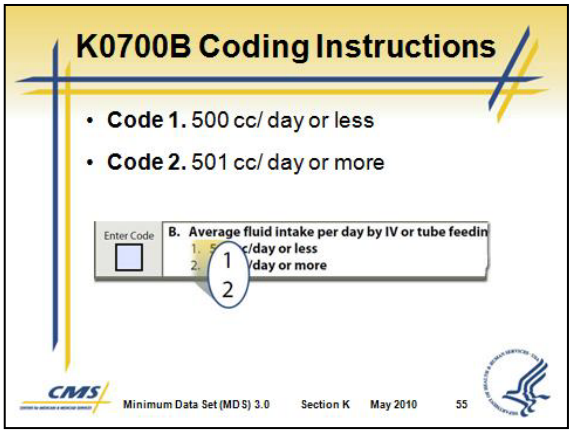
SLIDES	INSTRUCTIONAL GUIDANCE



Slide 54

F. K0700B Assessment Guidelines

1. Code the average number of cc's of fluid the resident received per day by IV or tube feeding.
2. Record what was **actually received** by the resident.
3. Do not code what was ordered.



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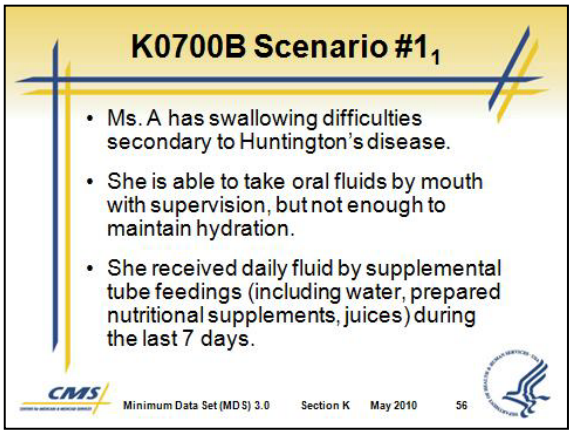
G. K0700B Coding Instructions

- **Code 1.** 500 cc/day or less
- **Code 2.** 501 cc/day or more



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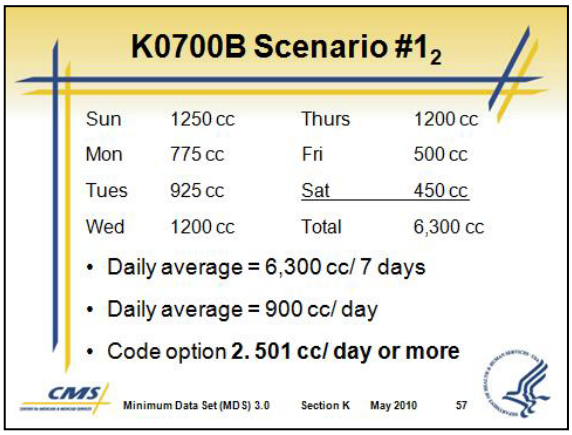
H. K0700B Coding Scenario #1

1. Ms. A has swallowing difficulties secondary to Huntington's disease.
2. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration.
3. She received daily fluid by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

SLIDES	INSTRUCTIONAL GUIDANCE



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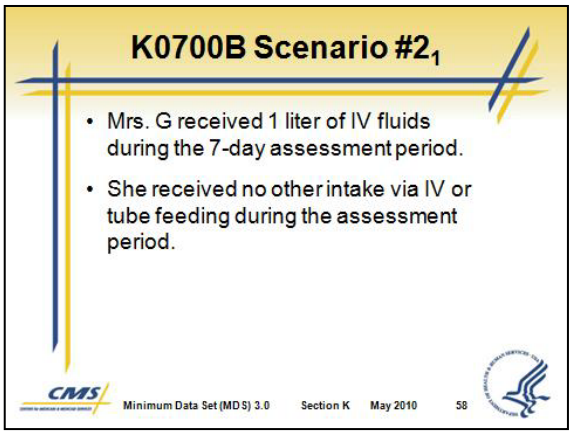
4. The total of Ms. A's fluid intake by tube feeding over the 7-day period is 6,300 cc.
5. Calculate the daily average of fluid intake by tube feeding.
   a. Divide 6,300 cc by 7 days.
   b. The daily average of fluid intake by tube feeding is 900 cc per day.
6. The correct code is option **2.** 501 cc/ day or more.



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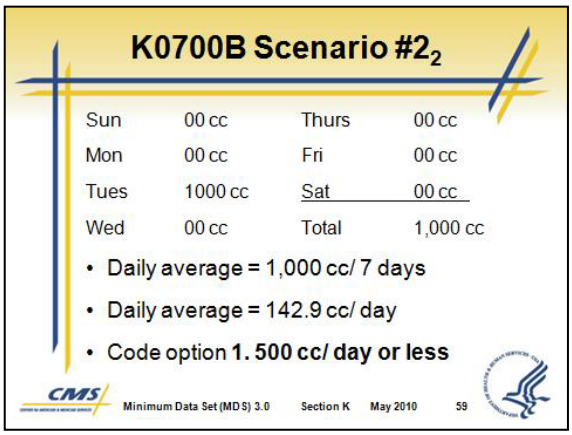
I. K0700B Scenario #2

1. Mrs. G. received 1 liter of IV fluids during the 7-day assessment period.
2. She received no other intake via IV or tube feeding during the assessment period.



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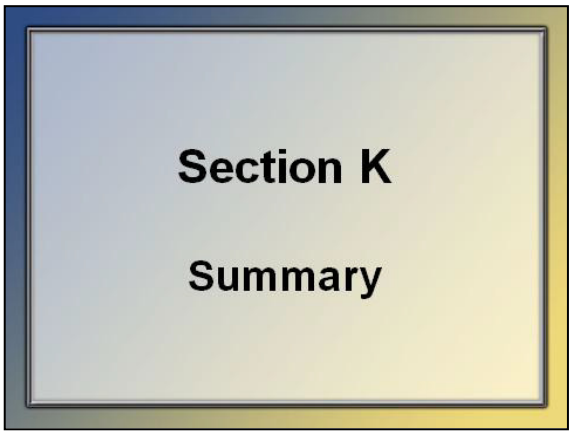
3. The total of Mrs. G's fluid intake by tube feeding over the 7-day period is 1000 cc.
4. Calculate the daily average of fluid intake by tube feeding.
   a. Divide 1,000 cc by 7 days.
   b. The daily average of fluid intake by tube feeding is 142.9 cc per day.
5. The correct code is **1.** 500 cc/ day or less.

SLIDES	INSTRUCTIONAL GUIDANCE



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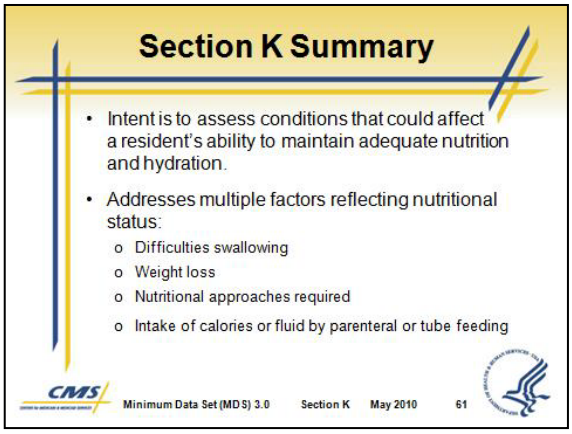
VII. Summary



Slide 61

A. Intent is to assess conditions that could affect a resident's ability to maintain adequate nutrition and hydration.

B. Addresses multiple factors reflecting nutritional status:

   1. Difficulties swallowing
   2. Weight loss
   3. Nutritional approaches required
   4. Intake of calories or fluid by parenteral or tube feeding