

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0100: Swallowing Disorder

K0100. Swallowing Disorder	
Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
<input type="checkbox"/>	A. Loss of liquids/solids from mouth when eating or drinking
<input type="checkbox"/>	B. Holding food in mouth/cheeks or residual food in mouth after meals
<input type="checkbox"/>	C. Coughing or choking during meals or when swallowing medications
<input type="checkbox"/>	D. Complaints of difficulty or pain with swallowing
<input type="checkbox"/>	Z. None of the above

Item Rationale

Health-related Quality of Life

- The ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration, which can increase the resident's risk for malnutrition, dehydration, and aspiration pneumonia.

Planning for Care

- Care planning should include provisions for monitoring the resident during mealtimes and during functions/activities that include the consumption of food and liquids.
- When necessary, the resident should be evaluated by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.
- Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the resident.
- Care plan should be developed to assist resident to maintain safe and effective swallow using compensatory techniques, alteration in diet consistency, and positioning during and following meals.

Steps for Assessment

1. Ask the resident if he or she has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D.
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.
2. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period.

K0100: Swallowing/Nutritional Status (cont.)

3. Review the medical record, including nursing, physician, dietician, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.

Coding Instructions


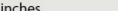
Check all that apply.

- K0100A, 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.
- K0100B, 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.
- K0100C, 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.”
- K0100D, complaints of difficulty or pain with swallowing. Resident may refuse food because it is painful or difficult to swallow.
- K0100Z, none of the above: if none of the K0100A through K0100D signs or symptoms were present during the look-back.

Coding Tips

- Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- Code even if the symptom occurred only once in the 7-day look-back period.

K0200: Height and Weight

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up	
 inches	A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry
 pounds	B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0200: Height and Weight (cont.)

Item Rationale

Health-related Quality of Life

- Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life.

Planning for Care

- 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. The measurement of weight is one guide for determining nutritional status.

Steps for Assessment for K0200A, Height

1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches.
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. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again.

Coding Instructions for K0200A, Height

- Record height to the nearest whole inch.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches.

Steps for Assessment for K0200B, Weight

1. Base weight on the most recent measure in the last 30 days.
2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment.
4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again.
5. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding Instructions for K0200B, Weight

- Use mathematical rounding (i.e., If weight is X.5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs, round down to the nearest whole pound). For example, a weight of 152.5 lbs would be rounded to 153 lbs and a weight of 152.4 lbs would be rounded to 152 lbs.

K0200: Height and Weight (cont.)

- 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.

K0300: Weight Loss

K0300. Weight Loss	
Enter Code <input type="checkbox"/>	Loss of 5% or more in the last month or loss of 10% or more in last 6 months 0. No or unknown 1. Yes, on physician-prescribed weight-loss regimen 2. Yes, not on physician-prescribed weight-loss regimen

Item Rationale

Health-related Quality of Life

- Weight loss can result in debility and adversely affect health, safety, and quality of life.
- For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
- For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.

Planning for Care

- Weight loss may be an important indicator of a change in the resident's health status or environment.
- If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.
- Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

DEFINITIONS

5% WEIGHT LOSS IN 30 DAYS

Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.

10% WEIGHT LOSS IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.

K0300: Weight Loss (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is less than the previous weight, calculate the percentage of weight loss.
4. Complete the same process to determine and calculate weight loss comparing the admission weight to the weight 30 and 180 days ago.

For 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.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- 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. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as **1**.

DEFINITIONS

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.

BODY MASS INDEX (BMI)

Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit

http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html.

K0300: Weight Loss (cont.)

- 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.

Coding Tips

- A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.
- If the resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0300 as **1, yes**, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.
- On occasion, a resident with normal BMI or even low BMI is placed on a diabetic or otherwise calorie-restricted diet. In this instance, the intent of the diet is not to induce weight loss, and it would not be considered a physician-ordered weight-loss regimen.

Examples

1. Mrs. J has been on a physician ordered calorie-restricted diet for the past year. She and her physician agreed to a plan of weight reduction. Her current weight is 169 lbs. Her weight 30 days ago was 172 lbs. Her weight 180 days ago was 192 lbs.

Coding: K0300 would be coded 1, yes, on physician-prescribed weight-loss regimen.

Rationale:

- 30-day calculation: $172 \times 0.95 = 163.4$. Since the resident's current weight of 169 lbs is more than 163.4 lbs, which is the 5% point, she **has not** lost 5% body weight in the last 30 days.
- 180-day calculation: $192 \times .90 = 172.8$. Since the resident's current weight of 169 lbs **is** less than 172.8 lbs, which is the 10% point, she **has** lost 10% or more of body weight in the last 180 days.

K0300: Weight Loss (cont.)

2. Mr. S has had increasing need for assistance with eating over the past 6 months. His current weight is 195 lbs. His weight 30 days ago was 197 lbs. His weight 180 days ago was 185 lbs.

Coding: K0300 would be coded 0, No.

Rationale:

- 30-day calculation: $197 \times 0.95 = 187.15$. Because the resident's current weight of 195 lbs is more than 187.15 lbs, which is the 5% point, he **has not** lost 5% body weight in the last 30 days.
- 180-day calculation: Mr. S's current weight of 195 lbs is greater than his weight 180 days ago, so there is no need to calculate his weight loss. He has gained weight over this time period.

3. Ms. K underwent a BKA (below the knee amputation). Her preoperative weight 30 days ago was 130 lbs. Her most recent postoperative weight is 102 lbs. The amputated leg weighed 8 lbs. Her weight 180 days ago was 125 lbs.

Was the change in weight significant? Calculation of change in weight must take into account the weight of the amputated limb (which in this case is 6% of 130 lbs = 7.8 lbs).

- 30-day calculation:
Step 1: Add the weight of the amputated limb to the current weight to obtain the weight if no amputation occurred:
 $102 \text{ lbs (current weight)} + 8 \text{ lbs (weight of leg)} = 110 \text{ lbs (current body weight taking the amputated leg into account)}$
Step 2: Calculate the difference between the most recent weight (including weight of the limb) and the previous weight (at 30 days)
 $130 \text{ lbs (preoperative weight)} - 110 \text{ lbs (present weight if had two legs)} = 20 \text{ lbs (weight lost)}$
Step 3: Calculate the percent weight change relative to the initial weight:
 $20 \text{ lbs (weight change)} / 130 \text{ lbs (preoperative weight)} = 15\% \text{ weight loss}$
Step 4: The percent weight change is significant if >5% at 30 days
Therefore, the most recent postoperative weight of 102 lbs (110 lbs, taking the amputated limb into account) is >5% weight loss (significant at 30 days).
- 180-day calculation:
Step 1: Add the weight of the amputated limb to the current weight to obtain the weight if no amputation occurred:
 $102 \text{ lbs (current weight)} + 8 \text{ lbs (weight of leg)} = 110 \text{ lbs (current body weight taking the amputated leg into account)}$
Step 2: Calculate the difference between the most recent weight (including weight of the limb) and the previous weight (at 180 days):
 $125 \text{ lbs (preoperative weight 180 days ago)} - 110 \text{ lbs (present weight if had two legs)} = 15 \text{ lbs (weight lost)}$
Step 3: Calculate the percent weight change relative to the initial weight:
 $15 \text{ lbs (weight change)} / 130 \text{ lbs (preoperative weight)} = 12\% \text{ weight loss}$
Step 4: The percent weight change is significant if >10% at 180 days

K0300: Weight Loss (cont.)

The most recent postoperative weight of 110 lbs (110 lbs, taking the amputated limb into account) is >10% weight loss (significant at 180 days).

Present weight of 110 lbs >10% weight loss (significant at 180 days).

Coding: K0300 would be coded 2, yes, weight change is significant; not on physician-prescribed weight-loss regimen.

Rationale: The resident had a significant weight loss of >5% in 30 days and did have a weight loss of >10% in 180 days, the item would be coded as 2, yes weight change is significant; not on physician-prescribed weight-loss regime, with one of the items being triggered. This item is coded for either a 5% 30-day weight loss or a 10% 180-day weight loss. In this example both items, the criteria are met but the coding does not change as long as one of them are met.

K0310: Weight Gain

K0310. Weight Gain	
Enter Code <input type="checkbox"/>	Gain of 5% or more in the last month or gain of 10% or more in last 6 months 0. No or unknown 1. Yes, on physician-prescribed weight-gain regimen 2. Yes, not on physician-prescribed weight-gain regimen

Item Rationale

Health-related Quality of Life

- Weight gain can result in debility and adversely affect health, safety, and quality of life.

Planning for Care

- Weight gain may be an important indicator of a change in the resident's health status or environment.
- If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., steroids), or changed fluid volume status.
- Weight gain should be monitored on a continuing basis; weight gain should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS

Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight.

10% WEIGHT GAIN IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

K0310: Weight Gain (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight gain assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is more than the previous weight, calculate the percentage of weight gain.
4. Complete the same process to determine and calculate weight gain comparing the admission weight to the weight 30 and 180 days ago.

For 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 more than the weight in the observation period 30 days ago, calculate the percentage of weight gain.
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 more than the weight in the observation period 180 days ago, calculate the percentage of weight gain.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- Code 0, no or unknown: if the resident has not experienced weight gain 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-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as **1**.
- Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips

- A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.

K0310: Weight Gain (cont.)

- If the resident is gaining a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0310 as **1, yes**, the expressed goal of the weight gain diet must be documented.

K0510: Nutritional Approaches

K0510. Nutritional Approaches		
Check all of the following nutritional approaches that were performed during the last 7 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the last 7 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed <i>while a resident</i> of this facility and within the last 7 days	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

DEFINITIONS

PARENTERAL/IV FEEDING

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

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, percutaneous endoscopic gastrostomy (PEG) tubes.

K0510: Nutritional Approaches (cont.)

Steps for Assessment

- Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.

Coding Instructions for Column 1

Check all nutritional approaches performed **prior** to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.

Coding Instructions for Column 2

Check all nutritional approaches performed **after** admission/entry or reentry to the facility and within the 7-day look-back period.

Check all that apply. If none apply, check K0510Z, None of the above

- K0510A, parenteral/IV feeding
- K0510B, feeding tube – nasogastric or abdominal (PEG)
- K0510C, mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- K0510D, therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- K0510Z, none of the above

Coding Tips for K0510A

K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.

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

DEFINITIONS

MECHANICALLY ALTERED DIET

A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake.

Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

THERAPEUTIC DIET

A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011).

K0510: Nutritional Approaches (cont.)

- IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.
- **The following items are NOT to be coded in K0510A:**
 - IV Medications—**Code these when appropriate in O0100H, IV Medications.**
 - IV fluids used to reconstitute and/or dilute medications for IV administration.
 - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
 - IV fluids administered solely as flushes.
 - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
- Enteral feeding formulas:
 - Should not be coded as a mechanically altered diet.
 - Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

Coding Tips for K0510D

- Therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).
- Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.

K0510: Nutritional Approaches (cont.)

Examples

1. Mrs. H is receiving an antibiotic in 100 cc of normal saline via IV. She has a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. She is placed on the nursing home's hydration plan to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

Coding: K0510A would be checked. The IV medication would be coded at **IV Medications** item (O0100H).

Rationale: The resident received 100 cc of IV fluid **and** there is supporting documentation that reflected an identified need for additional fluid intake for hydration.

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

Coding: K0510A would NOT be checked. The IV medication would be coded at **IV Medications** item (O0100H).

Rationale: Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

K0710: Percent Intake by Artificial Route

Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B.

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B			
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>			
3. During Entire 7 Days Performed during the entire <i>last 7 days</i>			
	↓	Enter Codes	↓
A. Proportion of total calories the resident received through parenteral or tube feeding			
1. 25% or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 26-50%			
3. 51% or more			
B. Average fluid intake per day by IV or tube feeding			
1. 500 cc/day or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 501 cc/day or more			

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal, such as parenteral/IV or feeding tubes, can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.

K0710: Percent Intake by Artificial Route (cont.)

Planning for Care

- The proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration.
- Periodic reassessment is necessary to facilitate transition to increased oral intake as indicated by the resident's condition.

K0710A, Proportion of Total Calories the Resident Received through Parental or Tube Feeding

Steps for Assessment

1. Review intake records to determine actual intake through parenteral or tube feeding routes.
2. Calculate proportion of total calories received through these routes.
 - If the resident took no food or fluids by mouth or took just sips of fluid, stop here and **code 3, 51% or more.**
 - If the resident had more substantial oral intake than this, consult with the dietician.

Coding Instructions

- Select the best response:
 1. 25% or less
 2. 26% to 50%
 3. 51% or more

Example

1. Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery two weeks ago. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past 7 days, he has been receiving tube feedings for nutritional supplementation. The dietitian has totaled his calories per day as follows:

Oral and Tube Feeding Intake		
	Oral	Tube
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	350	2,000
Total	2,450	15,000

K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710A columns 2 and 3 would be coded **3, 51% or more**.

Rationale: Total Oral intake is 2,450 calories

Total Tube intake is 15,000 calories

Total calories is $2,450 + 15,000 = 17,450$

Calculation of the percentage of total calories by tube feeding:

$15,000/17,450 = .859 \times 100 = 85.9\%$

Mr. H received 85.9% of his calories by tube feeding, therefore K0710A **code 3, 51% or more** is correct.

K0710B, Average Fluid Intake per Day by IV or Tube Feeding

Steps for 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.

Coding Instructions

Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.

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

Examples

1. Calculation for Average Daily Fluid Intake

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

IV Fluid Intake	
Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	500 cc
Sat.	450 cc
Total	6,300 cc

K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710B columns 2 and 3 would be coded **2, 501cc/day or more**.

Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc
 6,300 cc divided by 7 days = 900 cc/day
 900 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more** is correct.

2. Calculation for Average Daily Fluid Intake

Mrs. G. received 1 liter of IV fluids in the hospital on the Tuesday prior to her admission to the nursing home on Saturday afternoon. She received no other intake via IV or tube feeding during the last 7 days.

IV Fluid Intake	
Sun.	0 cc
Mon.	0 cc
Tues.	1,000 cc
Wed.	0 cc
Thurs.	0 cc
Fri.	0 cc
Sat.	0 cc
Total	1,000 cc

Coding: K0710B column 1 would be coded **1, 500 cc/day or less**.

Rationale: The total fluid intake by supplemental tube feedings = 1000 cc
 1000 cc divided by 7 days = 142.9 cc/day
 142.9 cc is less than 500 cc, therefore **code 1, 500 cc/day or less** is correct.

3. Mr. K. has been able to take some fluids orally; however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

While in the Hospital		While in the Nursing Home	
Mon.	400 cc	Fri.	510 cc
Tues.	520 cc	Sat.	520 cc
Wed.	500 cc	Sun.	490 cc
Thurs.	480 cc		
Total	1,900 cc	Total	1,520 cc

K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710B1 would be coded 1, 500 cc/day or less. K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.

Rationale: The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc = 1,900 cc). Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days). 475 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B1, While NOT a Resident.**

The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more is correct for K0710B2, While a Resident.**

The total fluid intake during the entire 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days.**