MDS 3.0

Acronyms

- MDS
- RAI
- OMRA (SOT)
- OBRA
- RUG
- CMS
- COT OMRA
- ARD
- CAA
- CAT
- ADL
- BMI
- BIMS
- PT/OT/ST
- QI
- QM

Terminology & Definitions

- Active Disease Diagnosis
- Acute Change in Mental Status
- Assessment Period
- Assessment Reference Date
- Assessment Window
- Broken Tooth
- Comprehensive Assessment
- Constipation
- Continence
- Delusion
- Dose
- Entry Date
Terminology & Definitions

- Feeding Tube
- Hallucinations
- HIPPA
- Hospice Services
- Level of Consciousness
- Look Back Period
- Mechanically Altered
- Medication Interaction
- Monitoring
- Nutritional/Hydration Intervention to manage skin problems
- Oral Lesions
- Physician Prescribed weight loss program

Terminology & Definitions

- Re-entry
- Respite
- Therapeutic Diet
- Tooth Fragment
- Vomiting
- Worsening in Pressure Ulcer Status

Types of MDS Assessments

- OBRA
- OMRA
- Medicare PPS – Part A
  - 5 - day
  - 14 - day
  - 30 - day
  - 60 - day
  - 90 - day
- Annual
- Significant Change
OBRA

• OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but not completion of the CAA process and care planning. The OBRA non-comprehensive assessments include:
  – Quarterly Assessment – complete every 92 days
  – Significant Correction to Prior Quarterly Assessment
  – Discharge Assessment – Return not Anticipated
  – Discharge Assessment – Return Anticipated

The Quarterly and Significant Correction to Prior Quarterly assessments are not required for Swing Bed residents. However, Swing Bed providers are required to complete the OBRA Discharge assessments.

Section K

**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.

Section K-100 Swallowing

**Section K-100 Swallowing Disorder**

**Signs and symptoms of possible swallow disorder**

- A. Loss of liquids/solids from mouth when eating or drinking
- B. Holding food in mouth/cheeks or residual food in mouth after meals
- C. Coughing or choking during meals or when swallowing medications
- D. Complaints of difficulty or pain with swallowing
- Z. None of the above
K100 - Coding Instructions

• 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.

K100 - Coding Instructions

• 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 period.

K100 - 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.
K100 - Care Planning

- 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.

K100 - Care Planning

- 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.

K200: Height & Weight

- While measuring, the number is X.1-X.4 round down; X.5 or greater round up

<table>
<thead>
<tr>
<th>A. Height (in inches)</th>
<th>Record most recent height measure since the most recent admission/entry or reentry</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Weight (in pounds)</td>
<td>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.)</td>
</tr>
</tbody>
</table>

Video on obtaining heights and weights
K300 – Weight Loss

<table>
<thead>
<tr>
<th>K300. Weight Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of 5% or more in the last month or loss of 10% or more in the last 6 months.</td>
</tr>
<tr>
<td>0. No or unknown</td>
</tr>
<tr>
<td>1. Yes, on physician-prescribed weight-loss regimen</td>
</tr>
<tr>
<td>2. Yes, not on physician-prescribed weight-loss regimen</td>
</tr>
</tbody>
</table>

K300 – 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.

K300 - 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.
K300 - Coding Instructions

- 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.

K310 - Weight Gain

K310. Weight Gain

<table>
<thead>
<tr>
<th>Gain of 5% or more in the last month or gain of 10% or more in the last 6 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No or unknown</td>
</tr>
<tr>
<td>1. Yes, on physician-prescribed weight-gain regimen</td>
</tr>
<tr>
<td>2. Yes, not on physician-prescribed weight-gain regimen</td>
</tr>
</tbody>
</table>

K310 - 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.
K510 – Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days.

<table>
<thead>
<tr>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform while NOT a resident of this facility and within the last 7 days.</td>
<td>Check all that apply</td>
</tr>
</tbody>
</table>

- Parenteral/IV Feeding
- Feeding tube – NG or PEG
- Mechanically Altered Diet
- Therapeutic Diet (e.g., low salt, diabetic, etc.)
- None of the above

K510 - 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.

- **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.

- **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).
• 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 inpatient, provided they were administered for nutrition or hydration.

• Parenteral/IV feeding—The following fluids may be included:
  – 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
  – IV fluids 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 Mechanically Altered
  – 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 diabetes.
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 K510D, 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.

Refer to handout of Section K
This section will only be filled out upon Admit, readmission, and significant change
If a resident has received parenteral or enteral nutrition through the 7 day look back period it should be calculated by the RDN or RN.
CAA

- The RAI process, which includes the MDS, is the basis for an accurate assessment of nursing home residents.
- The MDS information and the CAA provide the foundation for the care plan.
- 20 problem-oriented CAAs, each includes MDS-based "trigger" conditions, require additional assessment & review of the triggered care area.

Nutrition Triggers

- Dehydration
- BMI
- Weight Loss or gain
- Parenteral/IV feeding
- Mechanically Altered Diet
- Therapeutic diet
- Pressure ulcer – more than 1 Stage 2 or >
- Feeding Tubes
Sources


Nutrition Documentation & Care Planning

What grade would you receive?

Objectives

• Relate the information presented throughout the conference to incorporate documentation strategies.
• Define nutrition screen vs nutrition assessment.
• Identify key steps in the care planning process.
• Utilize critical thinking when selecting nutritional interventions.
• Understand the importance of monitoring and evaluation nutrition interventions.
Screen

• Screen – data collection such as observed food and fluid intake, calculation of nutrient intake, heights, weights, lab values, changes in diagnosis or health status, oral health, or other nutritional problems and nutritional status parameters for further assessment by the dietitian. 

DM’s Role

• Initial Interview
• Data collection on the Admission Assessment
• Communicate any high risk to RD prior to RD visit
• Monitoring Nutrition Interventions and working with RD to initiate appropriate changes

Assessment

• Assessment means the process of evaluating the nutritional status of patients. The assessment includes review and analysis of medical and diet histories, biochemical lab values, and anthropometric measurements to determine nutritional status and appropriate nutritional treatment.
RD's Role

- Complete assessment of Resident and evaluate need for nutrition intervention
- Diet Education with Resident and Staff
- Work with DM to individualize the interventions for the resident
- Communicate with IDT identified concerns and POC
- Assess effectiveness of interventions and change if needed

COMMUNICATION!

DOCUMENTATION: WHEN, WHY AND HOW
When & Why

- Initial/Admit
- Med A – 14, 30, 60, 90 day
- Quarterly, Annual, Significant Changes
- Residents at Risk – weekly or bi-monthly
- Monitoring of interventions
- Problem Identified

How

- See Handout on Charting Examples
- MDS, Progress Note, Care Plan

Types of Care Plans

- Medical Model
  - Third person
  - Identifies a diagnosis or problem, set a goal and list interventions.
- "I" Care Plans
  - Resident driven
  - Written in first person and in resident’s own words
  - Individualized
Building the Care Plan

Assessment
- Gather information
- Interview the resident
- RD completes assessment
- RD & DM work together to identify problems

Building The Care Plan

Problem
- Identify potential or actual problem
- May have more than one problem
- MDS - triggers

Building The Care Plan

Goals
- Measurable
- Resident driven
Building The Care Plan

• Resident driven
• Specific to problem
• Manageable by staff

Interventions need to be monitored for effectiveness.
Re-assessment need to take place.

Developing The Care Plan

• Gather information
• Interview the resident
• RD completes assessment
• RD & OM work together to identify problems
• MDS - triggers
• RD & DM work together to identify problem

Interventions need to be monitored for effectiveness.
Re-assessment need to take place.

• Resident driven
• Specific to problem
• Manageable by staff

• Measurable
• Resident driven
• Identify potential or actual problem
• May have more than one problem

Assessment

Monitor

Interventions

Goals

Problem

Assessment
Initial Problems

• Weight gain r/t increased fluid retention secondary to CHF AEB increased pitting 3+-4+ edema BLE, 40# weight gain x 3 years.
• Chewing problems r/t poor dentition AEB several missing teeth, res declines dentures, poor to fair PO intakes at meals and snacks.

New Problems

• Planned weight loss r/t initiation of diuretics per MD AEB 5% weight loss x 30d, decreased edema to BLE.
• Potential for suboptimal PO intakes and weight loss r/t chewing problems, patient declines mechanical altered diet and supplements.

Goals

• Weight stabilization 192# +/-5# through next review (90 days).
• PO intakes >50-75% of most meals.
• PO intakes >75% of supplements/snacks.
• Weight loss of 1-2# per week per MD initiation of diuretics. Goal weight 180# per MD.
Interventions

- Monitor weights daily as directed by MD. Notify MD of gain of 2# in 24 hr.
- Offer NAS diet.
- Offer mechanical soft texture d/t chewing difficulties.
- Offer fortified hot cereal with BRK daily.
- Offer House supplement 120cc BID b/t meals.

Interventions

- CDM and RD education regarding diet texture safety.
- RD education regarding benefits of supplements and risks of declining.
- RD education regarding appropriate weight loss (resident desires weight loss).
- Monitor food/fluid intakes at meals and snacks.
- Notify RD of supplement refusals.