

## Section

## K

## Swallowing/Nutritional Status

## K1. Swallowing Disorder

Signs and symptoms of possible swallowing disorder. Check all that applied in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Loss of liquids/solids from mouth when eating or drinking	48/
	<input type="checkbox"/>	b. Holding food in mouth/cheeks or residual food in mouth after meals	49/
	<input type="checkbox"/>	c. Coughing or choking during meals or when swallowing medications	50/
	<input type="checkbox"/>	d. Complaints of difficulty or pain with swallowing	51/
	<input type="checkbox"/>	e. None of the above	52/

## K2. Height and Weight

<input type="text"/> <input type="text"/>	a. Height (in inches) most recent height measure since admission. (If height includes a fraction, round up to nearest inch.)	53-54/
inches		
<input type="text"/> <input type="text"/> <input type="text"/>	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). (If weight includes a fraction, round up to nearest pound.)	55-57/
pounds		

## K3. Weight Loss

Enter <input type="text"/> Code	Loss of 5% or more in last 30 days (or since last assessment if sooner) or loss of 10% or more in last 180 days. 0. No or unknown 1. Yes, planned loss 2. Yes, unplanned loss	58/
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## K4. Nutritional Approaches

Check all that applied in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Parenteral/IV feeding	59/
	<input type="checkbox"/>	b. Feeding-tube—nasogastric or abdominal (PEG)	60/
	<input type="checkbox"/>	c. Mechanically altered diet—require change in texture of food or liquids (e.g., pureed food, thickened liquids)	61/
	<input type="checkbox"/>	d. Therapeutic diet (low salt, diabetic, low cholesterol)	62/
	<input type="checkbox"/>	e. None of the above	63/

## K5. Percent Intake by Artificial Route → Skip to Section L, Oral/Dental Status, if neither K4a or K4b is checked

Enter <input type="text"/> Code	a. Proportion of total calories the resident received through parenteral or tube feedings in the last 5 days. 1. 25% or less 2. 26–50% 3. 51% or more	64/
Enter <input type="text"/> Code	b. Average fluid intake per day by IV or tube in last 5 days. 1. 500 cc/day or less 2. 501 cc/day or more	65/

## Section

## L

## Oral/Dental Status

## L1. Dental

Check all that applied in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. <b>Broken or loosely fitting denture or partial</b> (chipped, cracked, uncleanable, or loose)	66/
	<input type="checkbox"/>	b. <b>No natural teeth or tooth fragment(s)</b> (edentulous)	67/
	<input type="checkbox"/>	c. <b>Abnormal mouth tissue</b> (ulcers, masses, oral lesions, including under denture or partial if one is worn)	68/
	<input type="checkbox"/>	d. <b>Obvious cavity or broken natural teeth</b>	69/
	<input type="checkbox"/>	e. <b>Inflamed or bleeding gums or loose natural teeth</b>	70/
	<input type="checkbox"/>	f. <b>Mouth or facial pain</b> , discomfort or difficulty with chewing	71/
	<input type="checkbox"/>	g. <b>None of the above</b> were present	72/
	<input type="checkbox"/>	h. <b>Unable to examine</b>	73/