## Policy

Documentation of Medical Nutrition Therapy (MNT) for each resident is the responsibility of the RD/RDN with assistance as assigned to the DTR as appropriate within each professional’s scope of practice and function under the direction of a RD/RDN within their competency level. All Medical Nutrition Therapy documentation will be in accordance of state and federal regulations and will use The Academy of Nutrition and Dietetics Nutrition Care Process of Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation.

## Purpose

# To conduct and assist in the completion of Medical Nutrition Therapy under the direction of a RD/RDN and in accordance with the federal and state requirements.

# **Procedure**

Information for the MNT will be gathered through interview with individuals, family and staff, observations, and review of the medical record and other tools and assessments.

The RD/RDN and/or DTR under the direction of the RD/RDN will complete the following:

1. For each Comprehensive Admission OBRA Minimum Data Set (MDS): a Comprehensive Nutrition Assessment with Progress Note, Completion of Section K of MDS, Care Area Triggers (CAT) , Comprehensive Assessment (CAA) for Nutritional Status and Dehydration/Fluid Maintenance (if triggered), and Mini Nutritional Assessment for Malnutrition will be completed in the ARD (Mini nutritional assessment to be completed for admissions and readmissions only) window and Care Plans will be completed according to Resident Assessment Instrument (RAI) Manual.
2. The Comprehensive Nutrition Assessment, progress note, MDS, CAT’s, CAA’s and Care Plans will be completed by day 14 of admission
3. Note that the Comprehensive Nutrition Assessment may represent the CAA however RD/RDN and/or DTR must address the CAA’s by stating why the resident is at nutrition risk and if the care plan will or will not be developed on the CAA as well as signing the CAA.
4. For each Comprehensive Annual and Significant Change OBRA MDS Assessment will complete: A Comprehensive Nutrition Assessment with Progress Note, Completion of Section K of MDS, Care Area Triggers (CAT), Comprehensive Assessment (CAA) for Nutritional Status and Dehydration/Fluid Maintenance (if triggered), and Care Plans will be completed according to RAI Manual.
5. Detailed progress note titled “ANNUAL NUTRITION ASSESSMENT” or “SIGNIFICANT CHANGE NUTRITION ASSESSMENT” may be used for an Annual or Significant Change Assessments unless a full nutrition assessment is warranted which is to be decided by the RD/RDN or DTR
6. Care plan review with MNT reassessment and update care plan as needed. If goals are not met for the problems on the care plan, the approach or goal should be changed. If not changed then the reasons for little or no progress should be documented.
7. Note that the Comprehensive Nutrition Assessment may represent the CAA however RD/RDN and/or DTR must address the CAA’s by stating why the resident is at nutrition risk and if the care plan will or will not be developed on the CAA as well as signing the CAA.
8. Quarterly Assessments will be completed at least quarterly according to RAI manual.
9. Complete section K on MDS along with detailed progress note titled “QUARTELRY NUTRITION ASSESSMENT” may be used for a Quarterly Assessment unless a full nutrition assessment is warranted which is to be decided by the RD/RDN or DTR. Care plan review with MNT reassessment and update care plan as needed. If goals are not met for the problems on the care plan, the approach or goal should be changed. If not changed then the reasons for little or no progress should be documented.
10. MNT reassessments and/or progress note are to be completed with each Medicare assessment (i.e. 30, 60, 90 days). For non-Medicare individuals, reassessments or progress notes are completed a minimum of every quarter or more often as needed.
11. Progress notes will be made on an as needed basis or when significant changes occur (changes in condition, diet order, food intake and weight, and skin alterations etc.) and may include, but not limited to, information from mealtime visitation, discussion with the individual and with care givers, review of the medical record, evaluation of the care plan and goals, weight status, food intake, physician order or condition changes, lab values, medication.