

NUTRITION FOCUSED PHYSICAL EXAM PREP - PRACTICE EXAM 5 (250 QUESTIONS)

This 250-question practice exam assesses NFPE observation, interpretation, documentation, and patient-centered technique. Select the single best answer for each question. Use it as a learning assessment; local policies and interdisciplinary procedures may vary.

1. During an inpatient NFPE, the dietitian observes temporal muscle wasting. Which documentation best reflects this observation?

- A. fluid accumulation around the orbit within this nutrition assessment context
- B. loss of muscle mass in the temporal region within this nutrition assessment context
- C. normal age-related facial rounding within this nutrition assessment context
- D. subcutaneous fat gain at the temple within this nutrition assessment context

2. During an inpatient NFPE, the dietitian observes orbital fat-pad loss. Which documentation best reflects this observation?

- A. periorbital swelling from fluid excess within this nutrition assessment context
- B. a typical facial expression at rest within this nutrition assessment context
- C. hollowing beneath the eyes from subcutaneous fat loss within this nutrition assessment context
- D. dark circles caused by sleep loss alone within this nutrition assessment context

3. During an inpatient NFPE, the dietitian observes buccal fat loss. Which documentation best reflects this observation?

- A. enlargement of the parotid gland within this nutrition assessment context
- B. a temporary cheek flush within this nutrition assessment context
- C. normal fullness of the lower face within this nutrition assessment context

D. reduced subcutaneous fat in the cheeks within this nutrition assessment context

4. During an inpatient NFPE, the dietitian observes clavicular prominence. Which documentation best reflects this observation?

A. reduced muscle or fat stores over the upper chest within this nutrition assessment context

B. acute shoulder dislocation within this nutrition assessment context

C. normal posture with retracted shoulders within this nutrition assessment context

D. isolated swelling of the sternum within this nutrition assessment context

5. During an inpatient NFPE, the dietitian observes acromion prominence. Which documentation best reflects this observation?

A. a new fracture without trauma history within this nutrition assessment context

B. visible bony shoulder contours from tissue loss within this nutrition assessment context

C. routine deltoid hypertrophy within this nutrition assessment context

D. generalized upper-body edema within this nutrition assessment context

6. During an inpatient NFPE, the dietitian observes interosseous hand wasting. Which documentation best reflects this observation?

A. a short-term increase in hand fluid within this nutrition assessment context

B. normal tendon visibility during grip within this nutrition assessment context

C. loss of muscle between the metacarpals within this nutrition assessment context

D. a callus from repetitive work within this nutrition assessment context

7. During an inpatient NFPE, the dietitian observes thenar muscle wasting. Which documentation best reflects this observation?

A. a localized thumb joint effusion within this nutrition assessment context

B. loss of muscle at the base of the thumb within this nutrition assessment context

- C. expected prominence after exercise within this nutrition assessment context
- D. a superficial skin abrasion within this nutrition assessment context

8. During an inpatient NFPE, the dietitian observes scapular prominence. Which documentation best reflects this observation?

- A. a harmless difference in shoulder height within this nutrition assessment context
- B. thoracic fluid retention alone within this nutrition assessment context
- C. normal rounding of the upper back within this nutrition assessment context
- D. reduced posterior shoulder muscle or fat stores within this nutrition assessment context

9. During an inpatient NFPE, the dietitian observes quadriceps wasting. Which documentation best reflects this observation?

- A. loss of muscle bulk in the anterior thigh within this nutrition assessment context
- B. acute knee swelling as the primary finding within this nutrition assessment context
- C. normal muscle definition after walking within this nutrition assessment context
- D. isolated calf fat gain within this nutrition assessment context

10. During an inpatient NFPE, the dietitian observes gastrocnemius wasting. Which documentation best reflects this observation?

- A. a normal ankle contour within this nutrition assessment context
- B. acute lower-leg fluid overload within this nutrition assessment context
- C. loss of calf muscle mass within this nutrition assessment context
- D. a superficial bruise without tissue loss within this nutrition assessment context

11. During an inpatient NFPE, the dietitian observes triceps skinfold depletion. Which documentation best reflects this observation?

- A. reduced posterior upper-arm subcutaneous fat within this nutrition assessment context

- B. localized arm inflammation within this nutrition assessment context
- C. normal muscle hypertrophy within this nutrition assessment context
- D. a measurement of bone density within this nutrition assessment context

12. During an inpatient NFPE, the dietitian observes rib visibility. Which documentation best reflects this observation?

- A. a definitive diagnosis from one observation within this nutrition assessment context
- B. evidence of pulmonary edema within this nutrition assessment context
- C. possible depletion of fat and muscle stores over the thorax within this nutrition assessment context
- D. a sign of excess visceral fat within this nutrition assessment context

13. During an inpatient NFPE, the dietitian observes dry scaling skin. Which documentation best reflects this observation?

- A. a diagnosis of one nutrient deficiency by itself within this nutrition assessment context
- B. a skin integrity finding requiring nutrition and hydration context within this nutrition assessment context
- C. proof of a food allergy within this nutrition assessment context
- D. a reliable marker of calorie excess within this nutrition assessment context

14. During an inpatient NFPE, the dietitian observes poor skin turgor. Which documentation best reflects this observation?

- A. a diagnostic test for protein status within this nutrition assessment context
- B. proof of chronic fat loss within this nutrition assessment context
- C. a normal response in every older adult within this nutrition assessment context
- D. a finding that may support concern for dehydration within this nutrition assessment context

15. During an inpatient NFPE, the dietitian observes brittle hair. Which documentation best reflects this observation?

- A. a definitive marker of zinc deficiency within this nutrition assessment context
- B. a nonspecific finding interpreted with the full assessment within this nutrition assessment context
- C. proof of acute infection within this nutrition assessment context
- D. a direct measure of lean body mass within this nutrition assessment context

16. During an inpatient NFPE, the dietitian observes pale conjunctiva. Which documentation best reflects this observation?

- A. a diagnosis of iron deficiency without testing within this nutrition assessment context
- B. evidence of fluid overload only within this nutrition assessment context
- C. a cue to consider anemia and correlate with laboratory data within this nutrition assessment context
- D. a measure of subcutaneous fat loss within this nutrition assessment context

17. During an inpatient NFPE, the dietitian observes glossitis. Which documentation best reflects this observation?

- A. an oral finding that warrants diet and clinical correlation within this nutrition assessment context
- B. a specific diagnosis from appearance alone within this nutrition assessment context
- C. a measure of muscle wasting within this nutrition assessment context
- D. evidence that intake is adequate within this nutrition assessment context

18. During an inpatient NFPE, the dietitian observes angular cheilosis. Which documentation best reflects this observation?

- A. a conclusive diagnosis of one vitamin deficit within this nutrition assessment context
- B. a sign of increased fat stores within this nutrition assessment context
- C. a muscle-strength measurement within this nutrition assessment context
- D. a lip finding that may prompt review of nutrient intake and absorption within this nutrition assessment context

19. During an inpatient NFPE, the dietitian observes taste alteration. Which documentation best reflects this observation?

- A. proof that a patient is well nourished within this nutrition assessment context
- B. a precise estimate of protein stores within this nutrition assessment context
- C. a symptom that can reduce intake and should be assessed further within this nutrition assessment context
- D. a substitute for diet history within this nutrition assessment context

20. During an inpatient NFPE, the dietitian observes dysphagia report. Which documentation best reflects this observation?

- A. a swallowing concern requiring prompt interdisciplinary follow-up within this nutrition assessment context
- B. a reason to ignore oral intake records within this nutrition assessment context
- C. a direct diagnosis of malnutrition within this nutrition assessment context
- D. a routine finding that needs no action within this nutrition assessment context

21. During an inpatient NFPE, the dietitian observes nausea with meals. Which documentation best reflects this observation?

- A. a measure of body fat stores within this nutrition assessment context
- B. proof of food intolerance without history within this nutrition assessment context
- C. a finding unrelated to nutrition care within this nutrition assessment context
- D. a barrier to intake that should be characterized and addressed within this nutrition assessment context

22. During an inpatient NFPE, the dietitian observes early satiety. Which documentation best reflects this observation?

- A. evidence of increased appetite within this nutrition assessment context
- B. a symptom that may limit meal volume and total intake within this nutrition assessment context
- C. proof of normal gastric function within this nutrition assessment context
- D. a finding that replaces calorie assessment within this nutrition assessment context

23. During an inpatient NFPE, the dietitian observes diarrhea. Which documentation best reflects this observation?

- A. a symptom that can affect hydration, absorption, and nutrient losses within this nutrition assessment context
- B. proof of a specific food trigger within this nutrition assessment context
- C. evidence of healthy bowel function within this nutrition assessment context
- D. a direct measure of muscle mass within this nutrition assessment context

24. During an inpatient NFPE, the dietitian observes constipation. Which documentation best reflects this observation?

- A. proof that protein intake is adequate within this nutrition assessment context
- B. a symptom to assess with fluid, fiber, mobility, and medication context within this nutrition assessment context
- C. a sign of acute fat depletion within this nutrition assessment context
- D. a laboratory result within this nutrition assessment context

25. During an inpatient NFPE, the dietitian observes bilateral ankle edema. Which documentation best reflects this observation?

- A. a reliable indicator of improved muscle stores within this nutrition assessment context
- B. proof of adequate protein intake within this nutrition assessment context
- C. a fluid-related finding that can mask weight loss within this nutrition assessment context
- D. a finding that rules out malnutrition within this nutrition assessment context

26. During an inpatient NFPE, the dietitian observes sacral edema. Which documentation best reflects this observation?

- A. a marker of increased subcutaneous fat within this nutrition assessment context
- B. proof of normal hydration within this nutrition assessment context
- C. a finding that always reflects infection within this nutrition assessment context

D. a dependent fluid finding requiring position-aware inspection within this nutrition assessment context

27. During an inpatient NFPE, the dietitian observes ascites. Which documentation best reflects this observation?

A. an accurate estimate of visceral fat within this nutrition assessment context

B. abdominal fluid accumulation that can obscure body-weight trends within this nutrition assessment context

C. proof of improved oral intake within this nutrition assessment context

D. a replacement for physical examination within this nutrition assessment context

28. During an inpatient NFPE, the dietitian observes handgrip weakness. Which documentation best reflects this observation?

A. a diagnosis of malnutrition by itself within this nutrition assessment context

B. a substitute for a complete NFPE within this nutrition assessment context

C. a functional finding that should be measured consistently when used within this nutrition assessment context

D. proof of normal muscle reserves within this nutrition assessment context

29. During an inpatient NFPE, the dietitian observes reduced sit-to-stand performance. Which documentation best reflects this observation?

A. a direct measure of serum protein within this nutrition assessment context

B. proof of a vitamin deficiency within this nutrition assessment context

C. a finding unrelated to nutrition status within this nutrition assessment context

D. a functional cue that can support concern about strength and mobility within this nutrition assessment context

30. During an inpatient NFPE, the dietitian observes fatigue during meals. Which documentation best reflects this observation?

- A. a functional barrier that may reduce ability to meet needs within this nutrition assessment context
- B. proof that calorie needs are low within this nutrition assessment context
- C. a direct measure of edema within this nutrition assessment context
- D. a reason to omit meal observation within this nutrition assessment context

31. During an inpatient NFPE, the dietitian observes dentures that do not fit. Which documentation best reflects this observation?

- A. a direct diagnosis of nutrient deficiency within this nutrition assessment context
- B. proof that appetite is normal within this nutrition assessment context
- C. a sign of adequate chewing ability within this nutrition assessment context
- D. an oral-mechanical barrier that may limit food texture choices within this nutrition assessment context

32. During an inpatient NFPE, the dietitian observes missing teeth. Which documentation best reflects this observation?

- A. a factor that may affect chewing and food selection within this nutrition assessment context
- B. proof of inadequate protein stores within this nutrition assessment context
- C. a direct diagnosis of dysphagia within this nutrition assessment context
- D. a finding unrelated to intake within this nutrition assessment context

33. During an inpatient NFPE, the dietitian observes mouth pain. Which documentation best reflects this observation?

- A. evidence of normal food tolerance within this nutrition assessment context
- B. a direct measure of fat mass within this nutrition assessment context
- C. a symptom that can limit oral intake and needs cause assessment within this nutrition assessment context
- D. a sign that supplements are unnecessary within this nutrition assessment context

34. During an inpatient NFPE, the dietitian observes visible edema with weight gain. Which documentation best reflects this observation?

- A. proof of successful nutrition repletion within this nutrition assessment context
- B. a situation in which scale weight may not reflect improved tissue stores within this nutrition assessment context
- C. evidence that muscle mass increased within this nutrition assessment context
- D. a reason to stop assessing intake within this nutrition assessment context

35. During an inpatient NFPE, the dietitian observes unintentional weight loss history. Which documentation best reflects this observation?

- A. a finding to dismiss if BMI is high within this nutrition assessment context
- B. proof of one specific deficiency within this nutrition assessment context
- C. a high-priority trend to quantify by time frame and usual weight within this nutrition assessment context
- D. a reason to avoid physical assessment within this nutrition assessment context

36. During an inpatient NFPE, the dietitian observes reduced intake for several days. Which documentation best reflects this observation?

- A. proof that malnutrition is present without assessment within this nutrition assessment context
- B. a history that should be integrated with symptoms and physical findings within this nutrition assessment context
- C. a normal pattern that needs no follow-up within this nutrition assessment context
- D. a direct measure of body composition within this nutrition assessment context

37. During an inpatient NFPE, the dietitian observes severe fat loss at multiple sites. Which documentation best reflects this observation?

- A. a diagnosis based only on a single site within this nutrition assessment context
- B. evidence of fluid overload within this nutrition assessment context

- C. proof of normal nutrition status within this nutrition assessment context
- D. a pattern that supports concern when combined with the clinical history within this nutrition assessment context

38. During an inpatient NFPE, the dietitian observes severe muscle loss at multiple sites. Which documentation best reflects this observation?

- A. a pattern requiring documentation by site and severity within this nutrition assessment context
- B. a single numeric laboratory value within this nutrition assessment context
- C. a normal consequence of one missed meal within this nutrition assessment context
- D. evidence that edema is absent within this nutrition assessment context

39. During an inpatient NFPE, the dietitian observes unilateral limb size difference. Which documentation best reflects this observation?

- A. definite generalized muscle wasting within this nutrition assessment context
- B. proof of symmetric fat loss within this nutrition assessment context
- C. a finding that requires comparison and clinical context before interpretation within this nutrition assessment context
- D. a conclusion that needs no further assessment within this nutrition assessment context

40. During an inpatient NFPE, the dietitian observes contractures. Which documentation best reflects this observation?

- A. proof of inadequate dietary protein within this nutrition assessment context
- B. a factor that may complicate positioning and visual comparison within this nutrition assessment context
- C. a direct marker of edema severity within this nutrition assessment context
- D. a finding that makes NFPE impossible within this nutrition assessment context

41. During an inpatient NFPE, the dietitian observes darkly pigmented skin. Which documentation best reflects this observation?

- A. a characteristic that can affect visual assessment and requires careful technique within this nutrition assessment context
- B. a reason to omit skin assessment within this nutrition assessment context
- C. proof of dehydration within this nutrition assessment context
- D. a direct estimate of fat stores within this nutrition assessment context

42. During an inpatient NFPE, the dietitian observes patient discomfort during palpation. Which documentation best reflects this observation?

- A. a reason to continue without consent within this nutrition assessment context
- B. proof that tissue loss is severe within this nutrition assessment context
- C. a requirement to abandon all assessment within this nutrition assessment context
- D. a signal to pause, explain, and use a respectful modified approach within this nutrition assessment context

43. During an inpatient NFPE, the dietitian observes limited ability to reposition. Which documentation best reflects this observation?

- A. a practical constraint requiring adaptation of the examination sequence within this nutrition assessment context
- B. evidence that nutrition assessment is unnecessary within this nutrition assessment context
- C. proof of fluid overload within this nutrition assessment context
- D. a direct diagnosis of sarcopenia within this nutrition assessment context

44. During an inpatient NFPE, the dietitian observes medical tubing near an assessment site. Which documentation best reflects this observation?

- A. a reason to remove the tubing within this nutrition assessment context
- B. proof that the site is normal within this nutrition assessment context
- C. a sign that edema cannot be assessed within this nutrition assessment context

D. a cue to protect equipment and select another safe observation approach within this nutrition assessment context

45. During an inpatient NFPE, the dietitian observes recent surgery. Which documentation best reflects this observation?

A. proof of nutrient deficiency within this nutrition assessment context

B. a context that may alter appearance, tolerance, and interpretation of findings within this nutrition assessment context

C. a reason to use no clinical judgment within this nutrition assessment context

D. evidence that intake history is irrelevant within this nutrition assessment context

46. During an inpatient NFPE, the dietitian observes pressure injury. Which documentation best reflects this observation?

A. proof that the patient is overfed within this nutrition assessment context

B. a direct measurement of muscle mass within this nutrition assessment context

C. a skin finding that should be described and coordinated with the care team within this nutrition assessment context

D. a reason to avoid nutrition screening within this nutrition assessment context

47. During an inpatient NFPE, the dietitian observes frail older adult appearance. Which documentation best reflects this observation?

A. proof that muscle loss is always normal aging within this nutrition assessment context

B. a cue to assess trends and function without assuming cause from age alone within this nutrition assessment context

C. a reason to skip an NFPE within this nutrition assessment context

D. a definitive diagnosis of malnutrition within this nutrition assessment context

48. During an inpatient NFPE, the dietitian observes obesity with poor intake. Which documentation best reflects this observation?

- A. proof that fat stores ensure adequate nutrition within this nutrition assessment context
- B. a reason to ignore weight change within this nutrition assessment context
- C. evidence that an NFPE has no value within this nutrition assessment context
- D. a situation where body size does not exclude malnutrition risk within this nutrition assessment context

49. During an inpatient NFPE, the dietitian observes facial asymmetry. Which documentation best reflects this observation?

- A. proof of bilateral temporal wasting within this nutrition assessment context
- B. a direct measure of edema within this nutrition assessment context
- C. a reason to compare sides and avoid overcalling generalized loss within this nutrition assessment context
- D. evidence of adequate fat stores within this nutrition assessment context

50. During an inpatient NFPE, the dietitian observes visible wound drainage. Which documentation best reflects this observation?

- A. a clinical concern to report and integrate with nutrition support planning within this nutrition assessment context
- B. proof of a specific vitamin deficiency within this nutrition assessment context
- C. a direct measure of food intake within this nutrition assessment context
- D. a finding unrelated to healing needs within this nutrition assessment context

51. While assessing a patient with reduced intake, the clinician notes temporal muscle wasting. What is the most appropriate interpretation?

- A. loss of muscle mass in the temporal region within this nutrition assessment context
- B. fluid accumulation around the orbit within this nutrition assessment context
- C. normal age-related facial rounding within this nutrition assessment context
- D. subcutaneous fat gain at the temple within this nutrition assessment context

52. While assessing a patient with reduced intake, the clinician notes orbital fat-pad loss. What is the most appropriate interpretation?

- A. periorbital swelling from fluid excess within this nutrition assessment context
- B. a typical facial expression at rest within this nutrition assessment context
- C. dark circles caused by sleep loss alone within this nutrition assessment context
- D. hollowing beneath the eyes from subcutaneous fat loss within this nutrition assessment context

53. While assessing a patient with reduced intake, the clinician notes buccal fat loss. What is the most appropriate interpretation?

- A. enlargement of the parotid gland within this nutrition assessment context
- B. reduced subcutaneous fat in the cheeks within this nutrition assessment context
- C. a temporary cheek flush within this nutrition assessment context
- D. normal fullness of the lower face within this nutrition assessment context

54. While assessing a patient with reduced intake, the clinician notes clavicular prominence. What is the most appropriate interpretation?

- A. acute shoulder dislocation within this nutrition assessment context
- B. normal posture with retracted shoulders within this nutrition assessment context
- C. reduced muscle or fat stores over the upper chest within this nutrition assessment context
- D. isolated swelling of the sternum within this nutrition assessment context

55. While assessing a patient with reduced intake, the clinician notes acromion prominence. What is the most appropriate interpretation?

- A. visible bony shoulder contours from tissue loss within this nutrition assessment context
- B. a new fracture without trauma history within this nutrition assessment context
- C. routine deltoid hypertrophy within this nutrition assessment context

D. generalized upper-body edema within this nutrition assessment context

56. While assessing a patient with reduced intake, the clinician notes interosseous hand wasting. What is the most appropriate interpretation?

- A. a short-term increase in hand fluid within this nutrition assessment context
- B. normal tendon visibility during grip within this nutrition assessment context
- C. a callus from repetitive work within this nutrition assessment context
- D. loss of muscle between the metacarpals within this nutrition assessment context

57. While assessing a patient with reduced intake, the clinician notes thenar muscle wasting. What is the most appropriate interpretation?

- A. a localized thumb joint effusion within this nutrition assessment context
- B. loss of muscle at the base of the thumb within this nutrition assessment context
- C. expected prominence after exercise within this nutrition assessment context
- D. a superficial skin abrasion within this nutrition assessment context

58. While assessing a patient with reduced intake, the clinician notes scapular prominence. What is the most appropriate interpretation?

- A. a harmless difference in shoulder height within this nutrition assessment context
- B. thoracic fluid retention alone within this nutrition assessment context
- C. normal rounding of the upper back within this nutrition assessment context
- D. reduced posterior shoulder muscle or fat stores within this nutrition assessment context

59. While assessing a patient with reduced intake, the clinician notes quadriceps wasting. What is the most appropriate interpretation?

- A. acute knee swelling as the primary finding within this nutrition assessment context
- B. normal muscle definition after walking within this nutrition assessment context

- C. loss of muscle bulk in the anterior thigh within this nutrition assessment context
- D. isolated calf fat gain within this nutrition assessment context

60. While assessing a patient with reduced intake, the clinician notes gastrocnemius wasting. What is the most appropriate interpretation?

- A. a normal ankle contour within this nutrition assessment context
- B. loss of calf muscle mass within this nutrition assessment context
- C. acute lower-leg fluid overload within this nutrition assessment context
- D. a superficial bruise without tissue loss within this nutrition assessment context

61. While assessing a patient with reduced intake, the clinician notes triceps skinfold depletion. What is the most appropriate interpretation?

- A. localized arm inflammation within this nutrition assessment context
- B. normal muscle hypertrophy within this nutrition assessment context
- C. reduced posterior upper-arm subcutaneous fat within this nutrition assessment context
- D. a measurement of bone density within this nutrition assessment context

62. While assessing a patient with reduced intake, the clinician notes rib visibility. What is the most appropriate interpretation?

- A. possible depletion of fat and muscle stores over the thorax within this nutrition assessment context
- B. a definitive diagnosis from one observation within this nutrition assessment context
- C. evidence of pulmonary edema within this nutrition assessment context
- D. a sign of excess visceral fat within this nutrition assessment context

63. While assessing a patient with reduced intake, the clinician notes dry scaling skin. What is the most appropriate interpretation?

- A. a skin integrity finding requiring nutrition and hydration context within this nutrition assessment context
- B. a diagnosis of one nutrient deficiency by itself within this nutrition assessment context
- C. proof of a food allergy within this nutrition assessment context
- D. a reliable marker of calorie excess within this nutrition assessment context

64. While assessing a patient with reduced intake, the clinician notes poor skin turgor. What is the most appropriate interpretation?

- A. a diagnostic test for protein status within this nutrition assessment context
- B. proof of chronic fat loss within this nutrition assessment context
- C. a finding that may support concern for dehydration within this nutrition assessment context
- D. a normal response in every older adult within this nutrition assessment context

65. While assessing a patient with reduced intake, the clinician notes brittle hair. What is the most appropriate interpretation?

- A. a definitive marker of zinc deficiency within this nutrition assessment context
- B. a nonspecific finding interpreted with the full assessment within this nutrition assessment context
- C. proof of acute infection within this nutrition assessment context
- D. a direct measure of lean body mass within this nutrition assessment context

66. While assessing a patient with reduced intake, the clinician notes pale conjunctiva. What is the most appropriate interpretation?

- A. a diagnosis of iron deficiency without testing within this nutrition assessment context
- B. evidence of fluid overload only within this nutrition assessment context
- C. a measure of subcutaneous fat loss within this nutrition assessment context
- D. a cue to consider anemia and correlate with laboratory data within this nutrition assessment context

67. While assessing a patient with reduced intake, the clinician notes glossitis. What is the most appropriate interpretation?

- A. a specific diagnosis from appearance alone within this nutrition assessment context
- B. a measure of muscle wasting within this nutrition assessment context
- C. evidence that intake is adequate within this nutrition assessment context
- D. an oral finding that warrants diet and clinical correlation within this nutrition assessment context

68. While assessing a patient with reduced intake, the clinician notes angular cheilosis. What is the most appropriate interpretation?

- A. a conclusive diagnosis of one vitamin deficit within this nutrition assessment context
- B. a lip finding that may prompt review of nutrient intake and absorption within this nutrition assessment context
- C. a sign of increased fat stores within this nutrition assessment context
- D. a muscle-strength measurement within this nutrition assessment context

69. While assessing a patient with reduced intake, the clinician notes taste alteration. What is the most appropriate interpretation?

- A. proof that a patient is well nourished within this nutrition assessment context
- B. a precise estimate of protein stores within this nutrition assessment context
- C. a symptom that can reduce intake and should be assessed further within this nutrition assessment context
- D. a substitute for diet history within this nutrition assessment context

70. While assessing a patient with reduced intake, the clinician notes dysphagia report. What is the most appropriate interpretation?

- A. a swallowing concern requiring prompt interdisciplinary follow-up within this nutrition assessment context
- B. a reason to ignore oral intake records within this nutrition assessment context
- C. a direct diagnosis of malnutrition within this nutrition assessment context
- D. a routine finding that needs no action within this nutrition assessment context

71. While assessing a patient with reduced intake, the clinician notes nausea with meals. What is the most appropriate interpretation?

- A. a barrier to intake that should be characterized and addressed within this nutrition assessment context
- B. a measure of body fat stores within this nutrition assessment context
- C. proof of food intolerance without history within this nutrition assessment context
- D. a finding unrelated to nutrition care within this nutrition assessment context

72. While assessing a patient with reduced intake, the clinician notes early satiety. What is the most appropriate interpretation?

- A. evidence of increased appetite within this nutrition assessment context
- B. proof of normal gastric function within this nutrition assessment context
- C. a finding that replaces calorie assessment within this nutrition assessment context
- D. a symptom that may limit meal volume and total intake within this nutrition assessment context

73. While assessing a patient with reduced intake, the clinician notes diarrhea. What is the most appropriate interpretation?

- A. proof of a specific food trigger within this nutrition assessment context
- B. evidence of healthy bowel function within this nutrition assessment context
- C. a symptom that can affect hydration, absorption, and nutrient losses within this nutrition assessment context
- D. a direct measure of muscle mass within this nutrition assessment context

74. While assessing a patient with reduced intake, the clinician notes constipation. What is the most appropriate interpretation?

- A. proof that protein intake is adequate within this nutrition assessment context

- B. a symptom to assess with fluid, fiber, mobility, and medication context within this nutrition assessment context
- C. a sign of acute fat depletion within this nutrition assessment context
- D. a laboratory result within this nutrition assessment context

75. While assessing a patient with reduced intake, the clinician notes bilateral ankle edema. What is the most appropriate interpretation?

- A. a fluid-related finding that can mask weight loss within this nutrition assessment context
- B. a reliable indicator of improved muscle stores within this nutrition assessment context
- C. proof of adequate protein intake within this nutrition assessment context
- D. a finding that rules out malnutrition within this nutrition assessment context

76. While assessing a patient with reduced intake, the clinician notes sacral edema. What is the most appropriate interpretation?

- A. a marker of increased subcutaneous fat within this nutrition assessment context
- B. proof of normal hydration within this nutrition assessment context
- C. a finding that always reflects infection within this nutrition assessment context
- D. a dependent fluid finding requiring position-aware inspection within this nutrition assessment context

77. While assessing a patient with reduced intake, the clinician notes ascites. What is the most appropriate interpretation?

- A. an accurate estimate of visceral fat within this nutrition assessment context
- B. proof of improved oral intake within this nutrition assessment context
- C. abdominal fluid accumulation that can obscure body-weight trends within this nutrition assessment context
- D. a replacement for physical examination within this nutrition assessment context

78. While assessing a patient with reduced intake, the clinician notes handgrip weakness. What is the most appropriate interpretation?

- A. a diagnosis of malnutrition by itself within this nutrition assessment context
- B. a substitute for a complete NFPE within this nutrition assessment context
- C. a functional finding that should be measured consistently when used within this nutrition assessment context
- D. proof of normal muscle reserves within this nutrition assessment context

79. While assessing a patient with reduced intake, the clinician notes reduced sit-to-stand performance. What is the most appropriate interpretation?

- A. a direct measure of serum protein within this nutrition assessment context
- B. a functional cue that can support concern about strength and mobility within this nutrition assessment context
- C. proof of a vitamin deficiency within this nutrition assessment context
- D. a finding unrelated to nutrition status within this nutrition assessment context

80. While assessing a patient with reduced intake, the clinician notes fatigue during meals. What is the most appropriate interpretation?

- A. proof that calorie needs are low within this nutrition assessment context
- B. a direct measure of edema within this nutrition assessment context
- C. a reason to omit meal observation within this nutrition assessment context
- D. a functional barrier that may reduce ability to meet needs within this nutrition assessment context

81. While assessing a patient with reduced intake, the clinician notes dentures that do not fit. What is the most appropriate interpretation?

- A. a direct diagnosis of nutrient deficiency within this nutrition assessment context
- B. an oral-mechanical barrier that may limit food texture choices within this nutrition assessment context
- C. proof that appetite is normal within this nutrition assessment context
- D. a sign of adequate chewing ability within this nutrition assessment context

82. While assessing a patient with reduced intake, the clinician notes missing teeth. What is the most appropriate interpretation?

- A. a factor that may affect chewing and food selection within this nutrition assessment context
- B. proof of inadequate protein stores within this nutrition assessment context
- C. a direct diagnosis of dysphagia within this nutrition assessment context
- D. a finding unrelated to intake within this nutrition assessment context

83. While assessing a patient with reduced intake, the clinician notes mouth pain. What is the most appropriate interpretation?

- A. evidence of normal food tolerance within this nutrition assessment context
- B. a symptom that can limit oral intake and needs cause assessment within this nutrition assessment context
- C. a direct measure of fat mass within this nutrition assessment context
- D. a sign that supplements are unnecessary within this nutrition assessment context

84. While assessing a patient with reduced intake, the clinician notes visible edema with weight gain. What is the most appropriate interpretation?

- A. proof of successful nutrition repletion within this nutrition assessment context
- B. evidence that muscle mass increased within this nutrition assessment context
- C. a situation in which scale weight may not reflect improved tissue stores within this nutrition assessment context
- D. a reason to stop assessing intake within this nutrition assessment context

85. While assessing a patient with reduced intake, the clinician notes unintentional weight loss history. What is the most appropriate interpretation?

- A. a high-priority trend to quantify by time frame and usual weight within this nutrition assessment context
- B. a finding to dismiss if BMI is high within this nutrition assessment context
- C. proof of one specific deficiency within this nutrition assessment context
- D. a reason to avoid physical assessment within this nutrition assessment context

86. While assessing a patient with reduced intake, the clinician notes reduced intake for several days. What is the most appropriate interpretation?

- A. proof that malnutrition is present without assessment within this nutrition assessment context
- B. a normal pattern that needs no follow-up within this nutrition assessment context
- C. a direct measure of body composition within this nutrition assessment context
- D. a history that should be integrated with symptoms and physical findings within this nutrition assessment context

87. While assessing a patient with reduced intake, the clinician notes severe fat loss at multiple sites. What is the most appropriate interpretation?

- A. a diagnosis based only on a single site within this nutrition assessment context
- B. a pattern that supports concern when combined with the clinical history within this nutrition assessment context
- C. evidence of fluid overload within this nutrition assessment context
- D. proof of normal nutrition status within this nutrition assessment context

88. While assessing a patient with reduced intake, the clinician notes severe muscle loss at multiple sites. What is the most appropriate interpretation?

- A. a pattern requiring documentation by site and severity within this nutrition assessment context
- B. a single numeric laboratory value within this nutrition assessment context
- C. a normal consequence of one missed meal within this nutrition assessment context
- D. evidence that edema is absent within this nutrition assessment context

89. While assessing a patient with reduced intake, the clinician notes unilateral limb size difference. What is the most appropriate interpretation?

- A. definite generalized muscle wasting within this nutrition assessment context
- B. proof of symmetric fat loss within this nutrition assessment context
- C. a finding that requires comparison and clinical context before interpretation within this nutrition assessment context
- D. a conclusion that needs no further assessment within this nutrition assessment context

90. While assessing a patient with reduced intake, the clinician notes contractures. What is the most appropriate interpretation?

- A. proof of inadequate dietary protein within this nutrition assessment context
- B. a direct marker of edema severity within this nutrition assessment context
- C. a finding that makes NFPE impossible within this nutrition assessment context
- D. a factor that may complicate positioning and visual comparison within this nutrition assessment context

91. While assessing a patient with reduced intake, the clinician notes darkly pigmented skin. What is the most appropriate interpretation?

- A. a reason to omit skin assessment within this nutrition assessment context
- B. proof of dehydration within this nutrition assessment context
- C. a characteristic that can affect visual assessment and requires careful technique within this nutrition assessment context
- D. a direct estimate of fat stores within this nutrition assessment context

92. While assessing a patient with reduced intake, the clinician notes patient discomfort during palpation. What is the most appropriate interpretation?

- A. a reason to continue without consent within this nutrition assessment context
- B. proof that tissue loss is severe within this nutrition assessment context

- C. a requirement to abandon all assessment within this nutrition assessment context
- D. a signal to pause, explain, and use a respectful modified approach within this nutrition assessment context

93. While assessing a patient with reduced intake, the clinician notes limited ability to reposition. What is the most appropriate interpretation?

- A. a practical constraint requiring adaptation of the examination sequence within this nutrition assessment context
- B. evidence that nutrition assessment is unnecessary within this nutrition assessment context
- C. proof of fluid overload within this nutrition assessment context
- D. a direct diagnosis of sarcopenia within this nutrition assessment context

94. While assessing a patient with reduced intake, the clinician notes medical tubing near an assessment site. What is the most appropriate interpretation?

- A. a reason to remove the tubing within this nutrition assessment context
- B. a cue to protect equipment and select another safe observation approach within this nutrition assessment context
- C. proof that the site is normal within this nutrition assessment context
- D. a sign that edema cannot be assessed within this nutrition assessment context

95. While assessing a patient with reduced intake, the clinician notes recent surgery. What is the most appropriate interpretation?

- A. proof of nutrient deficiency within this nutrition assessment context
- B. a context that may alter appearance, tolerance, and interpretation of findings within this nutrition assessment context
- C. a reason to use no clinical judgment within this nutrition assessment context
- D. evidence that intake history is irrelevant within this nutrition assessment context

96. While assessing a patient with reduced intake, the clinician notes pressure injury. What is the most appropriate interpretation?

- A. a skin finding that should be described and coordinated with the care team within this nutrition assessment context
- B. proof that the patient is overfed within this nutrition assessment context
- C. a direct measurement of muscle mass within this nutrition assessment context
- D. a reason to avoid nutrition screening within this nutrition assessment context

97. While assessing a patient with reduced intake, the clinician notes frail older adult appearance. What is the most appropriate interpretation?

- A. proof that muscle loss is always normal aging within this nutrition assessment context
- B. a reason to skip an NFPE within this nutrition assessment context
- C. a cue to assess trends and function without assuming cause from age alone within this nutrition assessment context
- D. a definitive diagnosis of malnutrition within this nutrition assessment context

98. While assessing a patient with reduced intake, the clinician notes obesity with poor intake. What is the most appropriate interpretation?

- A. proof that fat stores ensure adequate nutrition within this nutrition assessment context
- B. a reason to ignore weight change within this nutrition assessment context
- C. evidence that an NFPE has no value within this nutrition assessment context
- D. a situation where body size does not exclude malnutrition risk within this nutrition assessment context

99. While assessing a patient with reduced intake, the clinician notes facial asymmetry. What is the most appropriate interpretation?

- A. proof of bilateral temporal wasting within this nutrition assessment context
- B. a direct measure of edema within this nutrition assessment context

- C. evidence of adequate fat stores within this nutrition assessment context
- D. a reason to compare sides and avoid overcalling generalized loss within this nutrition assessment context

100. While assessing a patient with reduced intake, the clinician notes visible wound drainage. What is the most appropriate interpretation?

- A. proof of a specific vitamin deficiency within this nutrition assessment context
- B. a clinical concern to report and integrate with nutrition support planning within this nutrition assessment context
- C. a direct measure of food intake within this nutrition assessment context
- D. a finding unrelated to healing needs within this nutrition assessment context

101. In a focused nutrition assessment, temporal muscle wasting is identified. Which response is most accurate?

- A. fluid accumulation around the orbit within this nutrition assessment context
- B. normal age-related facial rounding within this nutrition assessment context
- C. loss of muscle mass in the temporal region within this nutrition assessment context
- D. subcutaneous fat gain at the temple within this nutrition assessment context

102. In a focused nutrition assessment, orbital fat-pad loss is identified. Which response is most accurate?

- A. hollowing beneath the eyes from subcutaneous fat loss within this nutrition assessment context
- B. periorbital swelling from fluid excess within this nutrition assessment context
- C. a typical facial expression at rest within this nutrition assessment context
- D. dark circles caused by sleep loss alone within this nutrition assessment context

103. In a focused nutrition assessment, buccal fat loss is identified. Which response is most accurate?

- A. enlargement of the parotid gland within this nutrition assessment context
- B. a temporary cheek flush within this nutrition assessment context
- C. reduced subcutaneous fat in the cheeks within this nutrition assessment context
- D. normal fullness of the lower face within this nutrition assessment context

104. In a focused nutrition assessment, clavicular prominence is identified. Which response is most accurate?

- A. reduced muscle or fat stores over the upper chest within this nutrition assessment context
- B. acute shoulder dislocation within this nutrition assessment context
- C. normal posture with retracted shoulders within this nutrition assessment context
- D. isolated swelling of the sternum within this nutrition assessment context

105. In a focused nutrition assessment, acromion prominence is identified. Which response is most accurate?

- A. a new fracture without trauma history within this nutrition assessment context
- B. routine deltoid hypertrophy within this nutrition assessment context
- C. generalized upper-body edema within this nutrition assessment context
- D. visible bony shoulder contours from tissue loss within this nutrition assessment context

106. In a focused nutrition assessment, interosseous hand wasting is identified. Which response is most accurate?

- A. a short-term increase in hand fluid within this nutrition assessment context
- B. loss of muscle between the metacarpals within this nutrition assessment context
- C. normal tendon visibility during grip within this nutrition assessment context
- D. a callus from repetitive work within this nutrition assessment context

107. In a focused nutrition assessment, thenar muscle wasting is identified. Which response is most accurate?

- A. a localized thumb joint effusion within this nutrition assessment context
- B. loss of muscle at the base of the thumb within this nutrition assessment context
- C. expected prominence after exercise within this nutrition assessment context
- D. a superficial skin abrasion within this nutrition assessment context

108. In a focused nutrition assessment, scapular prominence is identified. Which response is most accurate?

- A. reduced posterior shoulder muscle or fat stores within this nutrition assessment context
- B. a harmless difference in shoulder height within this nutrition assessment context
- C. thoracic fluid retention alone within this nutrition assessment context
- D. normal rounding of the upper back within this nutrition assessment context

109. In a focused nutrition assessment, quadriceps wasting is identified. Which response is most accurate?

- A. acute knee swelling as the primary finding within this nutrition assessment context
- B. normal muscle definition after walking within this nutrition assessment context
- C. isolated calf fat gain within this nutrition assessment context
- D. loss of muscle bulk in the anterior thigh within this nutrition assessment context

110. In a focused nutrition assessment, gastrocnemius wasting is identified. Which response is most accurate?

- A. a normal ankle contour within this nutrition assessment context
- B. acute lower-leg fluid overload within this nutrition assessment context
- C. loss of calf muscle mass within this nutrition assessment context
- D. a superficial bruise without tissue loss within this nutrition assessment context

111. In a focused nutrition assessment, triceps skinfold depletion is identified. Which response is most accurate?

- A. reduced posterior upper-arm subcutaneous fat within this nutrition assessment context
- B. localized arm inflammation within this nutrition assessment context
- C. normal muscle hypertrophy within this nutrition assessment context
- D. a measurement of bone density within this nutrition assessment context

112. In a focused nutrition assessment, rib visibility is identified. Which response is most accurate?

- A. a definitive diagnosis from one observation within this nutrition assessment context
- B. evidence of pulmonary edema within this nutrition assessment context
- C. a sign of excess visceral fat within this nutrition assessment context
- D. possible depletion of fat and muscle stores over the thorax within this nutrition assessment context

113. In a focused nutrition assessment, dry scaling skin is identified. Which response is most accurate?

- A. a diagnosis of one nutrient deficiency by itself within this nutrition assessment context
- B. proof of a food allergy within this nutrition assessment context
- C. a skin integrity finding requiring nutrition and hydration context within this nutrition assessment context
- D. a reliable marker of calorie excess within this nutrition assessment context

114. In a focused nutrition assessment, poor skin turgor is identified. Which response is most accurate?

- A. a diagnostic test for protein status within this nutrition assessment context
- B. a finding that may support concern for dehydration within this nutrition assessment context
- C. proof of chronic fat loss within this nutrition assessment context
- D. a normal response in every older adult within this nutrition assessment context

115. In a focused nutrition assessment, brittle hair is identified. Which response is most accurate?

- A. a nonspecific finding interpreted with the full assessment within this nutrition assessment context
- B. a definitive marker of zinc deficiency within this nutrition assessment context

- C. proof of acute infection within this nutrition assessment context
- D. a direct measure of lean body mass within this nutrition assessment context

116. In a focused nutrition assessment, pale conjunctiva is identified. Which response is most accurate?

- A. a diagnosis of iron deficiency without testing within this nutrition assessment context
- B. evidence of fluid overload only within this nutrition assessment context
- C. a measure of subcutaneous fat loss within this nutrition assessment context
- D. a cue to consider anemia and correlate with laboratory data within this nutrition assessment context

117. In a focused nutrition assessment, glossitis is identified. Which response is most accurate?

- A. a specific diagnosis from appearance alone within this nutrition assessment context
- B. an oral finding that warrants diet and clinical correlation within this nutrition assessment context
- C. a measure of muscle wasting within this nutrition assessment context
- D. evidence that intake is adequate within this nutrition assessment context

118. In a focused nutrition assessment, angular cheilosis is identified. Which response is most accurate?

- A. a conclusive diagnosis of one vitamin deficit within this nutrition assessment context
- B. a sign of increased fat stores within this nutrition assessment context
- C. a lip finding that may prompt review of nutrient intake and absorption within this nutrition assessment context
- D. a muscle-strength measurement within this nutrition assessment context

119. In a focused nutrition assessment, taste alteration is identified. Which response is most accurate?

- A. a symptom that can reduce intake and should be assessed further within this nutrition assessment context
- B. proof that a patient is well nourished within this nutrition assessment context
- C. a precise estimate of protein stores within this nutrition assessment context

D. a substitute for diet history within this nutrition assessment context

120. In a focused nutrition assessment, dysphagia report is identified. Which response is most accurate?

- A. a reason to ignore oral intake records within this nutrition assessment context
- B. a swallowing concern requiring prompt interdisciplinary follow-up within this nutrition assessment context
- C. a direct diagnosis of malnutrition within this nutrition assessment context
- D. a routine finding that needs no action within this nutrition assessment context

121. In a focused nutrition assessment, nausea with meals is identified. Which response is most accurate?

- A. a measure of body fat stores within this nutrition assessment context
- B. proof of food intolerance without history within this nutrition assessment context
- C. a barrier to intake that should be characterized and addressed within this nutrition assessment context
- D. a finding unrelated to nutrition care within this nutrition assessment context

122. In a focused nutrition assessment, early satiety is identified. Which response is most accurate?

- A. evidence of increased appetite within this nutrition assessment context
- B. proof of normal gastric function within this nutrition assessment context
- C. a finding that replaces calorie assessment within this nutrition assessment context
- D. a symptom that may limit meal volume and total intake within this nutrition assessment context

123. In a focused nutrition assessment, diarrhea is identified. Which response is most accurate?

- A. proof of a specific food trigger within this nutrition assessment context
- B. evidence of healthy bowel function within this nutrition assessment context
- C. a symptom that can affect hydration, absorption, and nutrient losses within this nutrition assessment context

D. a direct measure of muscle mass within this nutrition assessment context

124. In a focused nutrition assessment, constipation is identified. Which response is most accurate?

- A. proof that protein intake is adequate within this nutrition assessment context
- B. a sign of acute fat depletion within this nutrition assessment context
- C. a laboratory result within this nutrition assessment context
- D. a symptom to assess with fluid, fiber, mobility, and medication context within this nutrition assessment context

125. In a focused nutrition assessment, bilateral ankle edema is identified. Which response is most accurate?

- A. a reliable indicator of improved muscle stores within this nutrition assessment context
- B. a fluid-related finding that can mask weight loss within this nutrition assessment context
- C. proof of adequate protein intake within this nutrition assessment context
- D. a finding that rules out malnutrition within this nutrition assessment context

126. In a focused nutrition assessment, sacral edema is identified. Which response is most accurate?

- A. a dependent fluid finding requiring position-aware inspection within this nutrition assessment context
- B. a marker of increased subcutaneous fat within this nutrition assessment context
- C. proof of normal hydration within this nutrition assessment context
- D. a finding that always reflects infection within this nutrition assessment context

127. In a focused nutrition assessment, ascites is identified. Which response is most accurate?

- A. an accurate estimate of visceral fat within this nutrition assessment context
- B. proof of improved oral intake within this nutrition assessment context
- C. abdominal fluid accumulation that can obscure body-weight trends within this nutrition assessment context

D. a replacement for physical examination within this nutrition assessment context

128. In a focused nutrition assessment, handgrip weakness is identified. Which response is most accurate?

- A. a diagnosis of malnutrition by itself within this nutrition assessment context
- B. a functional finding that should be measured consistently when used within this nutrition assessment context
- C. a substitute for a complete NFPE within this nutrition assessment context
- D. proof of normal muscle reserves within this nutrition assessment context

129. In a focused nutrition assessment, reduced sit-to-stand performance is identified. Which response is most accurate?

- A. a functional cue that can support concern about strength and mobility within this nutrition assessment context
- B. a direct measure of serum protein within this nutrition assessment context
- C. proof of a vitamin deficiency within this nutrition assessment context
- D. a finding unrelated to nutrition status within this nutrition assessment context

130. In a focused nutrition assessment, fatigue during meals is identified. Which response is most accurate?

- A. proof that calorie needs are low within this nutrition assessment context
- B. a direct measure of edema within this nutrition assessment context
- C. a reason to omit meal observation within this nutrition assessment context
- D. a functional barrier that may reduce ability to meet needs within this nutrition assessment context

131. In a focused nutrition assessment, dentures that do not fit is identified. Which response is most accurate?

- A. a direct diagnosis of nutrient deficiency within this nutrition assessment context
- B. proof that appetite is normal within this nutrition assessment context
- C. an oral-mechanical barrier that may limit food texture choices within this nutrition assessment context
- D. a sign of adequate chewing ability within this nutrition assessment context

132. In a focused nutrition assessment, missing teeth is identified. Which response is most accurate?

- A. proof of inadequate protein stores within this nutrition assessment context
- B. a factor that may affect chewing and food selection within this nutrition assessment context
- C. a direct diagnosis of dysphagia within this nutrition assessment context
- D. a finding unrelated to intake within this nutrition assessment context

133. In a focused nutrition assessment, mouth pain is identified. Which response is most accurate?

- A. evidence of normal food tolerance within this nutrition assessment context
- B. a direct measure of fat mass within this nutrition assessment context
- C. a sign that supplements are unnecessary within this nutrition assessment context
- D. a symptom that can limit oral intake and needs cause assessment within this nutrition assessment context

134. In a focused nutrition assessment, visible edema with weight gain is identified. Which response is most accurate?

- A. a situation in which scale weight may not reflect improved tissue stores within this nutrition assessment context
- B. proof of successful nutrition repletion within this nutrition assessment context
- C. evidence that muscle mass increased within this nutrition assessment context
- D. a reason to stop assessing intake within this nutrition assessment context

135. In a focused nutrition assessment, unintentional weight loss history is identified. Which response is most accurate?

- A. a finding to dismiss if BMI is high within this nutrition assessment context
- B. proof of one specific deficiency within this nutrition assessment context
- C. a high-priority trend to quantify by time frame and usual weight within this nutrition assessment context
- D. a reason to avoid physical assessment within this nutrition assessment context

136. In a focused nutrition assessment, reduced intake for several days is identified. Which response is most accurate?

- A. a history that should be integrated with symptoms and physical findings within this nutrition assessment context
- B. proof that malnutrition is present without assessment within this nutrition assessment context
- C. a normal pattern that needs no follow-up within this nutrition assessment context
- D. a direct measure of body composition within this nutrition assessment context

137. In a focused nutrition assessment, severe fat loss at multiple sites is identified. Which response is most accurate?

- A. a diagnosis based only on a single site within this nutrition assessment context
- B. evidence of fluid overload within this nutrition assessment context
- C. proof of normal nutrition status within this nutrition assessment context
- D. a pattern that supports concern when combined with the clinical history within this nutrition assessment context

138. In a focused nutrition assessment, severe muscle loss at multiple sites is identified. Which response is most accurate?

- A. a single numeric laboratory value within this nutrition assessment context
- B. a pattern requiring documentation by site and severity within this nutrition assessment context
- C. a normal consequence of one missed meal within this nutrition assessment context
- D. evidence that edema is absent within this nutrition assessment context

139. In a focused nutrition assessment, unilateral limb size difference is identified. Which response is most accurate?

- A. definite generalized muscle wasting within this nutrition assessment context
- B. a finding that requires comparison and clinical context before interpretation within this nutrition assessment context
- C. proof of symmetric fat loss within this nutrition assessment context
- D. a conclusion that needs no further assessment within this nutrition assessment context

140. In a focused nutrition assessment, contractures is identified. Which response is most accurate?

- A. proof of inadequate dietary protein within this nutrition assessment context
- B. a direct marker of edema severity within this nutrition assessment context
- C. a finding that makes NFPE impossible within this nutrition assessment context
- D. a factor that may complicate positioning and visual comparison within this nutrition assessment context

141. In a focused nutrition assessment, darkly pigmented skin is identified. Which response is most accurate?

- A. a characteristic that can affect visual assessment and requires careful technique within this nutrition assessment context
- B. a reason to omit skin assessment within this nutrition assessment context
- C. proof of dehydration within this nutrition assessment context
- D. a direct estimate of fat stores within this nutrition assessment context

142. In a focused nutrition assessment, patient discomfort during palpation is identified. Which response is most accurate?

- A. a reason to continue without consent within this nutrition assessment context

- B. proof that tissue loss is severe within this nutrition assessment context
- C. a signal to pause, explain, and use a respectful modified approach within this nutrition assessment context
- D. a requirement to abandon all assessment within this nutrition assessment context

143. In a focused nutrition assessment, limited ability to reposition is identified. Which response is most accurate?

- A. evidence that nutrition assessment is unnecessary within this nutrition assessment context
- B. proof of fluid overload within this nutrition assessment context
- C. a practical constraint requiring adaptation of the examination sequence within this nutrition assessment context
- D. a direct diagnosis of sarcopenia within this nutrition assessment context

144. In a focused nutrition assessment, medical tubing near an assessment site is identified. Which response is most accurate?

- A. a cue to protect equipment and select another safe observation approach within this nutrition assessment context
- B. a reason to remove the tubing within this nutrition assessment context
- C. proof that the site is normal within this nutrition assessment context
- D. a sign that edema cannot be assessed within this nutrition assessment context

145. In a focused nutrition assessment, recent surgery is identified. Which response is most accurate?

- A. proof of nutrient deficiency within this nutrition assessment context
- B. a context that may alter appearance, tolerance, and interpretation of findings within this nutrition assessment context
- C. a reason to use no clinical judgment within this nutrition assessment context
- D. evidence that intake history is irrelevant within this nutrition assessment context

146. In a focused nutrition assessment, pressure injury is identified. Which response is most accurate?

- A. proof that the patient is overfed within this nutrition assessment context
- B. a direct measurement of muscle mass within this nutrition assessment context
- C. a reason to avoid nutrition screening within this nutrition assessment context
- D. a skin finding that should be described and coordinated with the care team within this nutrition assessment context

147. In a focused nutrition assessment, frail older adult appearance is identified. Which response is most accurate?

- A. a cue to assess trends and function without assuming cause from age alone within this nutrition assessment context
- B. proof that muscle loss is always normal aging within this nutrition assessment context
- C. a reason to skip an NFPE within this nutrition assessment context
- D. a definitive diagnosis of malnutrition within this nutrition assessment context

148. In a focused nutrition assessment, obesity with poor intake is identified. Which response is most accurate?

- A. proof that fat stores ensure adequate nutrition within this nutrition assessment context
- B. a situation where body size does not exclude malnutrition risk within this nutrition assessment context
- C. a reason to ignore weight change within this nutrition assessment context
- D. evidence that an NFPE has no value within this nutrition assessment context

149. In a focused nutrition assessment, facial asymmetry is identified. Which response is most accurate?

- A. proof of bilateral temporal wasting within this nutrition assessment context
- B. a direct measure of edema within this nutrition assessment context
- C. evidence of adequate fat stores within this nutrition assessment context
- D. a reason to compare sides and avoid overcalling generalized loss within this nutrition assessment context

150. In a focused nutrition assessment, visible wound drainage is identified. Which response is most accurate?

- A. proof of a specific vitamin deficiency within this nutrition assessment context
- B. a direct measure of food intake within this nutrition assessment context
- C. a clinical concern to report and integrate with nutrition support planning within this nutrition assessment context
- D. a finding unrelated to healing needs within this nutrition assessment context

151. A patient is being evaluated for nutrition risk and has temporal muscle wasting. Which conclusion should guide the next step?

- A. fluid accumulation around the orbit within this nutrition assessment context
- B. normal age-related facial rounding within this nutrition assessment context
- C. loss of muscle mass in the temporal region within this nutrition assessment context
- D. subcutaneous fat gain at the temple within this nutrition assessment context

152. A patient is being evaluated for nutrition risk and has orbital fat-pad loss. Which conclusion should guide the next step?

- A. hollowing beneath the eyes from subcutaneous fat loss within this nutrition assessment context
- B. periorbital swelling from fluid excess within this nutrition assessment context
- C. a typical facial expression at rest within this nutrition assessment context
- D. dark circles caused by sleep loss alone within this nutrition assessment context

153. A patient is being evaluated for nutrition risk and has buccal fat loss. Which conclusion should guide the next step?

- A. enlargement of the parotid gland within this nutrition assessment context
- B. a temporary cheek flush within this nutrition assessment context

- C. normal fullness of the lower face within this nutrition assessment context
- D. reduced subcutaneous fat in the cheeks within this nutrition assessment context

154. A patient is being evaluated for nutrition risk and has clavicular prominence. Which conclusion should guide the next step?

- A. acute shoulder dislocation within this nutrition assessment context
- B. reduced muscle or fat stores over the upper chest within this nutrition assessment context
- C. normal posture with retracted shoulders within this nutrition assessment context
- D. isolated swelling of the sternum within this nutrition assessment context

155. A patient is being evaluated for nutrition risk and has acromion prominence. Which conclusion should guide the next step?

- A. a new fracture without trauma history within this nutrition assessment context
- B. routine deltoid hypertrophy within this nutrition assessment context
- C. generalized upper-body edema within this nutrition assessment context
- D. visible bony shoulder contours from tissue loss within this nutrition assessment context

156. A patient is being evaluated for nutrition risk and has interosseous hand wasting. Which conclusion should guide the next step?

- A. loss of muscle between the metacarpals within this nutrition assessment context
- B. a short-term increase in hand fluid within this nutrition assessment context
- C. normal tendon visibility during grip within this nutrition assessment context
- D. a callus from repetitive work within this nutrition assessment context

157. A patient is being evaluated for nutrition risk and has thenar muscle wasting. Which conclusion should guide the next step?

- A. a localized thumb joint effusion within this nutrition assessment context

- B. expected prominence after exercise within this nutrition assessment context
- C. loss of muscle at the base of the thumb within this nutrition assessment context
- D. a superficial skin abrasion within this nutrition assessment context

158. A patient is being evaluated for nutrition risk and has scapular prominence. Which conclusion should guide the next step?

- A. a harmless difference in shoulder height within this nutrition assessment context
- B. reduced posterior shoulder muscle or fat stores within this nutrition assessment context
- C. thoracic fluid retention alone within this nutrition assessment context
- D. normal rounding of the upper back within this nutrition assessment context

159. A patient is being evaluated for nutrition risk and has quadriceps wasting. Which conclusion should guide the next step?

- A. acute knee swelling as the primary finding within this nutrition assessment context
- B. normal muscle definition after walking within this nutrition assessment context
- C. isolated calf fat gain within this nutrition assessment context
- D. loss of muscle bulk in the anterior thigh within this nutrition assessment context

160. A patient is being evaluated for nutrition risk and has gastrocnemius wasting. Which conclusion should guide the next step?

- A. loss of calf muscle mass within this nutrition assessment context
- B. a normal ankle contour within this nutrition assessment context
- C. acute lower-leg fluid overload within this nutrition assessment context
- D. a superficial bruise without tissue loss within this nutrition assessment context

161. A patient is being evaluated for nutrition risk and has triceps skinfold depletion. Which conclusion should guide the next step?

- A. localized arm inflammation within this nutrition assessment context
- B. reduced posterior upper-arm subcutaneous fat within this nutrition assessment context
- C. normal muscle hypertrophy within this nutrition assessment context
- D. a measurement of bone density within this nutrition assessment context

162. A patient is being evaluated for nutrition risk and has rib visibility. Which conclusion should guide the next step?

- A. a definitive diagnosis from one observation within this nutrition assessment context
- B. evidence of pulmonary edema within this nutrition assessment context
- C. possible depletion of fat and muscle stores over the thorax within this nutrition assessment context
- D. a sign of excess visceral fat within this nutrition assessment context

163. A patient is being evaluated for nutrition risk and has dry scaling skin. Which conclusion should guide the next step?

- A. a diagnosis of one nutrient deficiency by itself within this nutrition assessment context
- B. a skin integrity finding requiring nutrition and hydration context within this nutrition assessment context
- C. proof of a food allergy within this nutrition assessment context
- D. a reliable marker of calorie excess within this nutrition assessment context

164. A patient is being evaluated for nutrition risk and has poor skin turgor. Which conclusion should guide the next step?

- A. a diagnostic test for protein status within this nutrition assessment context
- B. proof of chronic fat loss within this nutrition assessment context
- C. a finding that may support concern for dehydration within this nutrition assessment context
- D. a normal response in every older adult within this nutrition assessment context

165. A patient is being evaluated for nutrition risk and has brittle hair. Which conclusion should guide the next step?

- A. a definitive marker of zinc deficiency within this nutrition assessment context
- B. proof of acute infection within this nutrition assessment context
- C. a direct measure of lean body mass within this nutrition assessment context
- D. a nonspecific finding interpreted with the full assessment within this nutrition assessment context

166. A patient is being evaluated for nutrition risk and has pale conjunctiva. Which conclusion should guide the next step?

- A. a cue to consider anemia and correlate with laboratory data within this nutrition assessment context
- B. a diagnosis of iron deficiency without testing within this nutrition assessment context
- C. evidence of fluid overload only within this nutrition assessment context
- D. a measure of subcutaneous fat loss within this nutrition assessment context

167. A patient is being evaluated for nutrition risk and has glossitis. Which conclusion should guide the next step?

- A. an oral finding that warrants diet and clinical correlation within this nutrition assessment context
- B. a specific diagnosis from appearance alone within this nutrition assessment context
- C. a measure of muscle wasting within this nutrition assessment context
- D. evidence that intake is adequate within this nutrition assessment context

168. A patient is being evaluated for nutrition risk and has angular cheilosis. Which conclusion should guide the next step?

- A. a conclusive diagnosis of one vitamin deficit within this nutrition assessment context
- B. a sign of increased fat stores within this nutrition assessment context
- C. a lip finding that may prompt review of nutrient intake and absorption within this nutrition assessment context
- D. a muscle-strength measurement within this nutrition assessment context

169. A patient is being evaluated for nutrition risk and has taste alteration. Which conclusion should guide the next step?

- A. proof that a patient is well nourished within this nutrition assessment context
- B. a symptom that can reduce intake and should be assessed further within this nutrition assessment context
- C. a precise estimate of protein stores within this nutrition assessment context
- D. a substitute for diet history within this nutrition assessment context

170. A patient is being evaluated for nutrition risk and has dysphagia report. Which conclusion should guide the next step?

- A. a reason to ignore oral intake records within this nutrition assessment context
- B. a direct diagnosis of malnutrition within this nutrition assessment context
- C. a routine finding that needs no action within this nutrition assessment context
- D. a swallowing concern requiring prompt interdisciplinary follow-up within this nutrition assessment context

171. A patient is being evaluated for nutrition risk and has nausea with meals. Which conclusion should guide the next step?

- A. a measure of body fat stores within this nutrition assessment context
- B. proof of food intolerance without history within this nutrition assessment context
- C. a barrier to intake that should be characterized and addressed within this nutrition assessment context
- D. a finding unrelated to nutrition care within this nutrition assessment context

172. A patient is being evaluated for nutrition risk and has early satiety. Which conclusion should guide the next step?

- A. a symptom that may limit meal volume and total intake within this nutrition assessment context
- B. evidence of increased appetite within this nutrition assessment context
- C. proof of normal gastric function within this nutrition assessment context

D. a finding that replaces calorie assessment within this nutrition assessment context

173. A patient is being evaluated for nutrition risk and has diarrhea. Which conclusion should guide the next step?

- A. proof of a specific food trigger within this nutrition assessment context
- B. a symptom that can affect hydration, absorption, and nutrient losses within this nutrition assessment context
- C. evidence of healthy bowel function within this nutrition assessment context
- D. a direct measure of muscle mass within this nutrition assessment context

174. A patient is being evaluated for nutrition risk and has constipation. Which conclusion should guide the next step?

- A. proof that protein intake is adequate within this nutrition assessment context
- B. a sign of acute fat depletion within this nutrition assessment context
- C. a laboratory result within this nutrition assessment context
- D. a symptom to assess with fluid, fiber, mobility, and medication context within this nutrition assessment context

175. A patient is being evaluated for nutrition risk and has bilateral ankle edema. Which conclusion should guide the next step?

- A. a reliable indicator of improved muscle stores within this nutrition assessment context
- B. a fluid-related finding that can mask weight loss within this nutrition assessment context
- C. proof of adequate protein intake within this nutrition assessment context
- D. a finding that rules out malnutrition within this nutrition assessment context

176. A patient is being evaluated for nutrition risk and has sacral edema. Which conclusion should guide the next step?

- A. a marker of increased subcutaneous fat within this nutrition assessment context
- B. proof of normal hydration within this nutrition assessment context
- C. a dependent fluid finding requiring position-aware inspection within this nutrition assessment context
- D. a finding that always reflects infection within this nutrition assessment context

177. A patient is being evaluated for nutrition risk and has ascites. Which conclusion should guide the next step?

- A. abdominal fluid accumulation that can obscure body-weight trends within this nutrition assessment context
- B. an accurate estimate of visceral fat within this nutrition assessment context
- C. proof of improved oral intake within this nutrition assessment context
- D. a replacement for physical examination within this nutrition assessment context

178. A patient is being evaluated for nutrition risk and has handgrip weakness. Which conclusion should guide the next step?

- A. a diagnosis of malnutrition by itself within this nutrition assessment context
- B. a substitute for a complete NFPE within this nutrition assessment context
- C. proof of normal muscle reserves within this nutrition assessment context
- D. a functional finding that should be measured consistently when used within this nutrition assessment context

179. A patient is being evaluated for nutrition risk and has reduced sit-to-stand performance. Which conclusion should guide the next step?

- A. a direct measure of serum protein within this nutrition assessment context
- B. proof of a vitamin deficiency within this nutrition assessment context
- C. a finding unrelated to nutrition status within this nutrition assessment context
- D. a functional cue that can support concern about strength and mobility within this nutrition assessment context

180. A patient is being evaluated for nutrition risk and has fatigue during meals. Which conclusion should guide the next step?

- A. proof that calorie needs are low within this nutrition assessment context
- B. a functional barrier that may reduce ability to meet needs within this nutrition assessment context
- C. a direct measure of edema within this nutrition assessment context
- D. a reason to omit meal observation within this nutrition assessment context

181. A patient is being evaluated for nutrition risk and has dentures that do not fit. Which conclusion should guide the next step?

- A. an oral-mechanical barrier that may limit food texture choices within this nutrition assessment context
- B. a direct diagnosis of nutrient deficiency within this nutrition assessment context
- C. proof that appetite is normal within this nutrition assessment context
- D. a sign of adequate chewing ability within this nutrition assessment context

182. A patient is being evaluated for nutrition risk and has missing teeth. Which conclusion should guide the next step?

- A. proof of inadequate protein stores within this nutrition assessment context
- B. a direct diagnosis of dysphagia within this nutrition assessment context
- C. a factor that may affect chewing and food selection within this nutrition assessment context
- D. a finding unrelated to intake within this nutrition assessment context

183. A patient is being evaluated for nutrition risk and has mouth pain. Which conclusion should guide the next step?

- A. evidence of normal food tolerance within this nutrition assessment context
- B. a symptom that can limit oral intake and needs cause assessment within this nutrition assessment context
- C. a direct measure of fat mass within this nutrition assessment context

D. a sign that supplements are unnecessary within this nutrition assessment context

184. A patient is being evaluated for nutrition risk and has visible edema with weight gain. Which conclusion should guide the next step?

- A. proof of successful nutrition repletion within this nutrition assessment context
- B. evidence that muscle mass increased within this nutrition assessment context
- C. a situation in which scale weight may not reflect improved tissue stores within this nutrition assessment context
- D. a reason to stop assessing intake within this nutrition assessment context

185. A patient is being evaluated for nutrition risk and has unintentional weight loss history. Which conclusion should guide the next step?

- A. a finding to dismiss if BMI is high within this nutrition assessment context
- B. proof of one specific deficiency within this nutrition assessment context
- C. a reason to avoid physical assessment within this nutrition assessment context
- D. a high-priority trend to quantify by time frame and usual weight within this nutrition assessment context

186. A patient is being evaluated for nutrition risk and has reduced intake for several days. Which conclusion should guide the next step?

- A. a history that should be integrated with symptoms and physical findings within this nutrition assessment context
- B. proof that malnutrition is present without assessment within this nutrition assessment context
- C. a normal pattern that needs no follow-up within this nutrition assessment context
- D. a direct measure of body composition within this nutrition assessment context

187. A patient is being evaluated for nutrition risk and has severe fat loss at multiple sites. Which conclusion should guide the next step?

- A. a diagnosis based only on a single site within this nutrition assessment context
- B. evidence of fluid overload within this nutrition assessment context
- C. a pattern that supports concern when combined with the clinical history within this nutrition assessment context
- D. proof of normal nutrition status within this nutrition assessment context

188. A patient is being evaluated for nutrition risk and has severe muscle loss at multiple sites. Which conclusion should guide the next step?

- A. a single numeric laboratory value within this nutrition assessment context
- B. a normal consequence of one missed meal within this nutrition assessment context
- C. evidence that edema is absent within this nutrition assessment context
- D. a pattern requiring documentation by site and severity within this nutrition assessment context

189. A patient is being evaluated for nutrition risk and has unilateral limb size difference. Which conclusion should guide the next step?

- A. definite generalized muscle wasting within this nutrition assessment context
- B. a finding that requires comparison and clinical context before interpretation within this nutrition assessment context
- C. proof of symmetric fat loss within this nutrition assessment context
- D. a conclusion that needs no further assessment within this nutrition assessment context

190. A patient is being evaluated for nutrition risk and has contractures. Which conclusion should guide the next step?

- A. a factor that may complicate positioning and visual comparison within this nutrition assessment context
- B. proof of inadequate dietary protein within this nutrition assessment context
- C. a direct marker of edema severity within this nutrition assessment context
- D. a finding that makes NFPE impossible within this nutrition assessment context

191. A patient is being evaluated for nutrition risk and has darkly pigmented skin. Which conclusion should guide the next step?

- A. a reason to omit skin assessment within this nutrition assessment context
- B. a characteristic that can affect visual assessment and requires careful technique within this nutrition assessment context
- C. proof of dehydration within this nutrition assessment context
- D. a direct estimate of fat stores within this nutrition assessment context

192. A patient is being evaluated for nutrition risk and has patient discomfort during palpation. Which conclusion should guide the next step?

- A. a signal to pause, explain, and use a respectful modified approach within this nutrition assessment context
- B. a reason to continue without consent within this nutrition assessment context
- C. proof that tissue loss is severe within this nutrition assessment context
- D. a requirement to abandon all assessment within this nutrition assessment context

193. A patient is being evaluated for nutrition risk and has limited ability to reposition. Which conclusion should guide the next step?

- A. evidence that nutrition assessment is unnecessary within this nutrition assessment context
- B. proof of fluid overload within this nutrition assessment context
- C. a direct diagnosis of sarcopenia within this nutrition assessment context
- D. a practical constraint requiring adaptation of the examination sequence within this nutrition assessment context

194. A patient is being evaluated for nutrition risk and has medical tubing near an assessment site. Which conclusion should guide the next step?

- A. a reason to remove the tubing within this nutrition assessment context
- B. proof that the site is normal within this nutrition assessment context

- C. a cue to protect equipment and select another safe observation approach within this nutrition assessment context
- D. a sign that edema cannot be assessed within this nutrition assessment context

195. A patient is being evaluated for nutrition risk and has recent surgery. Which conclusion should guide the next step?

- A. proof of nutrient deficiency within this nutrition assessment context
- B. a reason to use no clinical judgment within this nutrition assessment context
- C. a context that may alter appearance, tolerance, and interpretation of findings within this nutrition assessment context
- D. evidence that intake history is irrelevant within this nutrition assessment context

196. A patient is being evaluated for nutrition risk and has pressure injury. Which conclusion should guide the next step?

- A. proof that the patient is overfed within this nutrition assessment context
- B. a skin finding that should be described and coordinated with the care team within this nutrition assessment context
- C. a direct measurement of muscle mass within this nutrition assessment context
- D. a reason to avoid nutrition screening within this nutrition assessment context

197. A patient is being evaluated for nutrition risk and has frail older adult appearance. Which conclusion should guide the next step?

- A. a cue to assess trends and function without assuming cause from age alone within this nutrition assessment context
- B. proof that muscle loss is always normal aging within this nutrition assessment context
- C. a reason to skip an NFPE within this nutrition assessment context
- D. a definitive diagnosis of malnutrition within this nutrition assessment context

198. A patient is being evaluated for nutrition risk and has obesity with poor intake. Which conclusion should guide the next step?

- A. proof that fat stores ensure adequate nutrition within this nutrition assessment context
- B. a reason to ignore weight change within this nutrition assessment context
- C. evidence that an NFPE has no value within this nutrition assessment context
- D. a situation where body size does not exclude malnutrition risk within this nutrition assessment context

199. A patient is being evaluated for nutrition risk and has facial asymmetry. Which conclusion should guide the next step?

- A. a reason to compare sides and avoid overcalling generalized loss within this nutrition assessment context
- B. proof of bilateral temporal wasting within this nutrition assessment context
- C. a direct measure of edema within this nutrition assessment context
- D. evidence of adequate fat stores within this nutrition assessment context

200. A patient is being evaluated for nutrition risk and has visible wound drainage. Which conclusion should guide the next step?

- A. proof of a specific vitamin deficiency within this nutrition assessment context
- B. a direct measure of food intake within this nutrition assessment context
- C. a clinical concern to report and integrate with nutrition support planning within this nutrition assessment context
- D. a finding unrelated to healing needs within this nutrition assessment context

201. During a bedside examination, temporal muscle wasting is present. How should this finding be handled in the NFPE record?

- A. fluid accumulation around the orbit within this nutrition assessment context
- B. normal age-related facial rounding within this nutrition assessment context

- C. subcutaneous fat gain at the temple within this nutrition assessment context
- D. loss of muscle mass in the temporal region within this nutrition assessment context

202. During a bedside examination, orbital fat-pad loss is present. How should this finding be handled in the NFPE record?

- A. periorbital swelling from fluid excess within this nutrition assessment context
- B. hollowing beneath the eyes from subcutaneous fat loss within this nutrition assessment context
- C. a typical facial expression at rest within this nutrition assessment context
- D. dark circles caused by sleep loss alone within this nutrition assessment context

203. During a bedside examination, buccal fat loss is present. How should this finding be handled in the NFPE record?

- A. enlargement of the parotid gland within this nutrition assessment context
- B. a temporary cheek flush within this nutrition assessment context
- C. normal fullness of the lower face within this nutrition assessment context
- D. reduced subcutaneous fat in the cheeks within this nutrition assessment context

204. During a bedside examination, clavicular prominence is present. How should this finding be handled in the NFPE record?

- A. acute shoulder dislocation within this nutrition assessment context
- B. normal posture with retracted shoulders within this nutrition assessment context
- C. reduced muscle or fat stores over the upper chest within this nutrition assessment context
- D. isolated swelling of the sternum within this nutrition assessment context

205. During a bedside examination, acromion prominence is present. How should this finding be handled in the NFPE record?

- A. visible bony shoulder contours from tissue loss within this nutrition assessment context

- B. a new fracture without trauma history within this nutrition assessment context
- C. routine deltoid hypertrophy within this nutrition assessment context
- D. generalized upper-body edema within this nutrition assessment context

206. During a bedside examination, interosseous hand wasting is present. How should this finding be handled in the NFPE record?

- A. a short-term increase in hand fluid within this nutrition assessment context
- B. loss of muscle between the metacarpals within this nutrition assessment context
- C. normal tendon visibility during grip within this nutrition assessment context
- D. a callus from repetitive work within this nutrition assessment context

207. During a bedside examination, thenar muscle wasting is present. How should this finding be handled in the NFPE record?

- A. a localized thumb joint effusion within this nutrition assessment context
- B. expected prominence after exercise within this nutrition assessment context
- C. loss of muscle at the base of the thumb within this nutrition assessment context
- D. a superficial skin abrasion within this nutrition assessment context

208. During a bedside examination, scapular prominence is present. How should this finding be handled in the NFPE record?

- A. a harmless difference in shoulder height within this nutrition assessment context
- B. reduced posterior shoulder muscle or fat stores within this nutrition assessment context
- C. thoracic fluid retention alone within this nutrition assessment context
- D. normal rounding of the upper back within this nutrition assessment context

209. During a bedside examination, quadriceps wasting is present. How should this finding be handled in the NFPE record?

- A. loss of muscle bulk in the anterior thigh within this nutrition assessment context
- B. acute knee swelling as the primary finding within this nutrition assessment context
- C. normal muscle definition after walking within this nutrition assessment context
- D. isolated calf fat gain within this nutrition assessment context

210. During a bedside examination, gastrocnemius wasting is present. How should this finding be handled in the NFPE record?

- A. a normal ankle contour within this nutrition assessment context
- B. acute lower-leg fluid overload within this nutrition assessment context
- C. a superficial bruise without tissue loss within this nutrition assessment context
- D. loss of calf muscle mass within this nutrition assessment context

211. During a bedside examination, triceps skinfold depletion is present. How should this finding be handled in the NFPE record?

- A. localized arm inflammation within this nutrition assessment context
- B. normal muscle hypertrophy within this nutrition assessment context
- C. reduced posterior upper-arm subcutaneous fat within this nutrition assessment context
- D. a measurement of bone density within this nutrition assessment context

212. During a bedside examination, rib visibility is present. How should this finding be handled in the NFPE record?

- A. possible depletion of fat and muscle stores over the thorax within this nutrition assessment context
- B. a definitive diagnosis from one observation within this nutrition assessment context
- C. evidence of pulmonary edema within this nutrition assessment context
- D. a sign of excess visceral fat within this nutrition assessment context

213. During a bedside examination, dry scaling skin is present. How should this finding be handled in the NFPE record?

- A. a diagnosis of one nutrient deficiency by itself within this nutrition assessment context
- B. proof of a food allergy within this nutrition assessment context
- C. a reliable marker of calorie excess within this nutrition assessment context
- D. a skin integrity finding requiring nutrition and hydration context within this nutrition assessment context

214. During a bedside examination, poor skin turgor is present. How should this finding be handled in the NFPE record?

- A. a diagnostic test for protein status within this nutrition assessment context
- B. a finding that may support concern for dehydration within this nutrition assessment context
- C. proof of chronic fat loss within this nutrition assessment context
- D. a normal response in every older adult within this nutrition assessment context

215. During a bedside examination, brittle hair is present. How should this finding be handled in the NFPE record?

- A. a definitive marker of zinc deficiency within this nutrition assessment context
- B. proof of acute infection within this nutrition assessment context
- C. a direct measure of lean body mass within this nutrition assessment context
- D. a nonspecific finding interpreted with the full assessment within this nutrition assessment context

216. During a bedside examination, pale conjunctiva is present. How should this finding be handled in the NFPE record?

- A. a cue to consider anemia and correlate with laboratory data within this nutrition assessment context
- B. a diagnosis of iron deficiency without testing within this nutrition assessment context
- C. evidence of fluid overload only within this nutrition assessment context
- D. a measure of subcutaneous fat loss within this nutrition assessment context

217. During a bedside examination, glossitis is present. How should this finding be handled in the NFPE record?

- A. a specific diagnosis from appearance alone within this nutrition assessment context
- B. an oral finding that warrants diet and clinical correlation within this nutrition assessment context
- C. a measure of muscle wasting within this nutrition assessment context
- D. evidence that intake is adequate within this nutrition assessment context

218. During a bedside examination, angular cheilosis is present. How should this finding be handled in the NFPE record?

- A. a conclusive diagnosis of one vitamin deficit within this nutrition assessment context
- B. a sign of increased fat stores within this nutrition assessment context
- C. a lip finding that may prompt review of nutrient intake and absorption within this nutrition assessment context
- D. a muscle-strength measurement within this nutrition assessment context

219. During a bedside examination, taste alteration is present. How should this finding be handled in the NFPE record?

- A. proof that a patient is well nourished within this nutrition assessment context
- B. a symptom that can reduce intake and should be assessed further within this nutrition assessment context
- C. a precise estimate of protein stores within this nutrition assessment context
- D. a substitute for diet history within this nutrition assessment context

220. During a bedside examination, dysphagia report is present. How should this finding be handled in the NFPE record?

- A. a reason to ignore oral intake records within this nutrition assessment context
- B. a direct diagnosis of malnutrition within this nutrition assessment context
- C. a swallowing concern requiring prompt interdisciplinary follow-up within this nutrition assessment context
- D. a routine finding that needs no action within this nutrition assessment context

221. During a bedside examination, nausea with meals is present. How should this finding be handled in the NFPE record?

- A. a barrier to intake that should be characterized and addressed within this nutrition assessment context
- B. a measure of body fat stores within this nutrition assessment context
- C. proof of food intolerance without history within this nutrition assessment context
- D. a finding unrelated to nutrition care within this nutrition assessment context

222. During a bedside examination, early satiety is present. How should this finding be handled in the NFPE record?

- A. evidence of increased appetite within this nutrition assessment context
- B. proof of normal gastric function within this nutrition assessment context
- C. a finding that replaces calorie assessment within this nutrition assessment context
- D. a symptom that may limit meal volume and total intake within this nutrition assessment context

223. During a bedside examination, diarrhea is present. How should this finding be handled in the NFPE record?

- A. a symptom that can affect hydration, absorption, and nutrient losses within this nutrition assessment context
- B. proof of a specific food trigger within this nutrition assessment context
- C. evidence of healthy bowel function within this nutrition assessment context
- D. a direct measure of muscle mass within this nutrition assessment context

224. During a bedside examination, constipation is present. How should this finding be handled in the NFPE record?

- A. proof that protein intake is adequate within this nutrition assessment context

- B. a symptom to assess with fluid, fiber, mobility, and medication context within this nutrition assessment context
- C. a sign of acute fat depletion within this nutrition assessment context
- D. a laboratory result within this nutrition assessment context

225. During a bedside examination, bilateral ankle edema is present. How should this finding be handled in the NFPE record?

- A. a reliable indicator of improved muscle stores within this nutrition assessment context
- B. proof of adequate protein intake within this nutrition assessment context
- C. a fluid-related finding that can mask weight loss within this nutrition assessment context
- D. a finding that rules out malnutrition within this nutrition assessment context

226. During a bedside examination, sacral edema is present. How should this finding be handled in the NFPE record?

- A. a marker of increased subcutaneous fat within this nutrition assessment context
- B. proof of normal hydration within this nutrition assessment context
- C. a finding that always reflects infection within this nutrition assessment context
- D. a dependent fluid finding requiring position-aware inspection within this nutrition assessment context

227. During a bedside examination, ascites is present. How should this finding be handled in the NFPE record?

- A. an accurate estimate of visceral fat within this nutrition assessment context
- B. proof of improved oral intake within this nutrition assessment context
- C. a replacement for physical examination within this nutrition assessment context
- D. abdominal fluid accumulation that can obscure body-weight trends within this nutrition assessment context

228. During a bedside examination, handgrip weakness is present. How should this finding be handled in the NFPE record?

- A. a diagnosis of malnutrition by itself within this nutrition assessment context
- B. a substitute for a complete NFPE within this nutrition assessment context
- C. a functional finding that should be measured consistently when used within this nutrition assessment context
- D. proof of normal muscle reserves within this nutrition assessment context

229. During a bedside examination, reduced sit-to-stand performance is present. How should this finding be handled in the NFPE record?

- A. a functional cue that can support concern about strength and mobility within this nutrition assessment context
- B. a direct measure of serum protein within this nutrition assessment context
- C. proof of a vitamin deficiency within this nutrition assessment context
- D. a finding unrelated to nutrition status within this nutrition assessment context

230. During a bedside examination, fatigue during meals is present. How should this finding be handled in the NFPE record?

- A. proof that calorie needs are low within this nutrition assessment context
- B. a functional barrier that may reduce ability to meet needs within this nutrition assessment context
- C. a direct measure of edema within this nutrition assessment context
- D. a reason to omit meal observation within this nutrition assessment context

231. During a bedside examination, dentures that do not fit is present. How should this finding be handled in the NFPE record?

- A. a direct diagnosis of nutrient deficiency within this nutrition assessment context
- B. proof that appetite is normal within this nutrition assessment context
- C. an oral-mechanical barrier that may limit food texture choices within this nutrition assessment context
- D. a sign of adequate chewing ability within this nutrition assessment context

232. During a bedside examination, missing teeth is present. How should this finding be handled in the NFPE record?

- A. proof of inadequate protein stores within this nutrition assessment context
- B. a factor that may affect chewing and food selection within this nutrition assessment context
- C. a direct diagnosis of dysphagia within this nutrition assessment context
- D. a finding unrelated to intake within this nutrition assessment context

233. During a bedside examination, mouth pain is present. How should this finding be handled in the NFPE record?

- A. a symptom that can limit oral intake and needs cause assessment within this nutrition assessment context
- B. evidence of normal food tolerance within this nutrition assessment context
- C. a direct measure of fat mass within this nutrition assessment context
- D. a sign that supplements are unnecessary within this nutrition assessment context

234. During a bedside examination, visible edema with weight gain is present. How should this finding be handled in the NFPE record?

- A. proof of successful nutrition repletion within this nutrition assessment context
- B. evidence that muscle mass increased within this nutrition assessment context
- C. a reason to stop assessing intake within this nutrition assessment context
- D. a situation in which scale weight may not reflect improved tissue stores within this nutrition assessment context

235. During a bedside examination, unintentional weight loss history is present. How should this finding be handled in the NFPE record?

- A. a finding to dismiss if BMI is high within this nutrition assessment context

- B. a high-priority trend to quantify by time frame and usual weight within this nutrition assessment context
- C. proof of one specific deficiency within this nutrition assessment context
- D. a reason to avoid physical assessment within this nutrition assessment context

236. During a bedside examination, reduced intake for several days is present. How should this finding be handled in the NFPE record?

- A. proof that malnutrition is present without assessment within this nutrition assessment context
- B. a normal pattern that needs no follow-up within this nutrition assessment context
- C. a direct measure of body composition within this nutrition assessment context
- D. a history that should be integrated with symptoms and physical findings within this nutrition assessment context

237. During a bedside examination, severe fat loss at multiple sites is present. How should this finding be handled in the NFPE record?

- A. a pattern that supports concern when combined with the clinical history within this nutrition assessment context
- B. a diagnosis based only on a single site within this nutrition assessment context
- C. evidence of fluid overload within this nutrition assessment context
- D. proof of normal nutrition status within this nutrition assessment context

238. During a bedside examination, severe muscle loss at multiple sites is present. How should this finding be handled in the NFPE record?

- A. a single numeric laboratory value within this nutrition assessment context
- B. a normal consequence of one missed meal within this nutrition assessment context
- C. a pattern requiring documentation by site and severity within this nutrition assessment context
- D. evidence that edema is absent within this nutrition assessment context

239. During a bedside examination, unilateral limb size difference is present. How should this finding be handled in the NFPE record?

- A. a finding that requires comparison and clinical context before interpretation within this nutrition assessment context
- B. definite generalized muscle wasting within this nutrition assessment context
- C. proof of symmetric fat loss within this nutrition assessment context
- D. a conclusion that needs no further assessment within this nutrition assessment context

240. During a bedside examination, contractures is present. How should this finding be handled in the NFPE record?

- A. proof of inadequate dietary protein within this nutrition assessment context
- B. a direct marker of edema severity within this nutrition assessment context
- C. a finding that makes NFPE impossible within this nutrition assessment context
- D. a factor that may complicate positioning and visual comparison within this nutrition assessment context

241. During a bedside examination, darkly pigmented skin is present. How should this finding be handled in the NFPE record?

- A. a reason to omit skin assessment within this nutrition assessment context
- B. a characteristic that can affect visual assessment and requires careful technique within this nutrition assessment context
- C. proof of dehydration within this nutrition assessment context
- D. a direct estimate of fat stores within this nutrition assessment context

242. During a bedside examination, patient discomfort during palpation is present. How should this finding be handled in the NFPE record?

- A. a reason to continue without consent within this nutrition assessment context
- B. proof that tissue loss is severe within this nutrition assessment context

- C. a signal to pause, explain, and use a respectful modified approach within this nutrition assessment context
- D. a requirement to abandon all assessment within this nutrition assessment context

243. During a bedside examination, limited ability to reposition is present. How should this finding be handled in the NFPE record?

- A. a practical constraint requiring adaptation of the examination sequence within this nutrition assessment context
- B. evidence that nutrition assessment is unnecessary within this nutrition assessment context
- C. proof of fluid overload within this nutrition assessment context
- D. a direct diagnosis of sarcopenia within this nutrition assessment context

244. During a bedside examination, medical tubing near an assessment site is present. How should this finding be handled in the NFPE record?

- A. a reason to remove the tubing within this nutrition assessment context
- B. a cue to protect equipment and select another safe observation approach within this nutrition assessment context
- C. proof that the site is normal within this nutrition assessment context
- D. a sign that edema cannot be assessed within this nutrition assessment context

245. During a bedside examination, recent surgery is present. How should this finding be handled in the NFPE record?

- A. proof of nutrient deficiency within this nutrition assessment context
- B. a reason to use no clinical judgment within this nutrition assessment context
- C. evidence that intake history is irrelevant within this nutrition assessment context
- D. a context that may alter appearance, tolerance, and interpretation of findings within this nutrition assessment context

246. During a bedside examination, pressure injury is present. How should this finding be handled in the NFPE record?

- A. proof that the patient is overfed within this nutrition assessment context
- B. a direct measurement of muscle mass within this nutrition assessment context
- C. a skin finding that should be described and coordinated with the care team within this nutrition assessment context
- D. a reason to avoid nutrition screening within this nutrition assessment context

247. During a bedside examination, frail older adult appearance is present. How should this finding be handled in the NFPE record?

- A. proof that muscle loss is always normal aging within this nutrition assessment context
- B. a reason to skip an NFPE within this nutrition assessment context
- C. a definitive diagnosis of malnutrition within this nutrition assessment context
- D. a cue to assess trends and function without assuming cause from age alone within this nutrition assessment context

248. During a bedside examination, obesity with poor intake is present. How should this finding be handled in the NFPE record?

- A. proof that fat stores ensure adequate nutrition within this nutrition assessment context
- B. a situation where body size does not exclude malnutrition risk within this nutrition assessment context
- C. a reason to ignore weight change within this nutrition assessment context
- D. evidence that an NFPE has no value within this nutrition assessment context

249. During a bedside examination, facial asymmetry is present. How should this finding be handled in the NFPE record?

- A. proof of bilateral temporal wasting within this nutrition assessment context
- B. a direct measure of edema within this nutrition assessment context

- C. a reason to compare sides and avoid overcalling generalized loss within this nutrition assessment context
- D. evidence of adequate fat stores within this nutrition assessment context

250. During a bedside examination, visible wound drainage is present. How should this finding be handled in the NFPE record?

- A. a clinical concern to report and integrate with nutrition support planning within this nutrition assessment context
- B. proof of a specific vitamin deficiency within this nutrition assessment context
- C. a direct measure of food intake within this nutrition assessment context
- D. a finding unrelated to healing needs within this nutrition assessment context

Practice Exam 5: Answer Key and Explanations

- 1. B** — Loss of muscle mass in the temporal region is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.
- 2. C** — Hollowing beneath the eyes from subcutaneous fat loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.
- 3. D** — Reduced subcutaneous fat in the cheeks is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.
- 4. A** — Reduced muscle or fat stores over the upper chest is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.
- 5. B** — Visible bony shoulder contours from tissue loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not

establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

6. C — Loss of muscle between the metacarpals is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

7. B — Loss of muscle at the base of the thumb is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

8. D — Reduced posterior shoulder muscle or fat stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

9. A — Loss of muscle bulk in the anterior thigh is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

10. C — Loss of calf muscle mass is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

11. A — Reduced posterior upper-arm subcutaneous fat is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

12. C — Possible depletion of fat and muscle stores over the thorax is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

13. B — A skin integrity finding requiring nutrition and hydration context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

14. D — A finding that may support concern for dehydration is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but

does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

15. B — A nonspecific finding interpreted with the full assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

16. C — A cue to consider anemia and correlate with laboratory data is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

17. A — An oral finding that warrants diet and clinical correlation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

18. D — A lip finding that may prompt review of nutrient intake and absorption is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

19. C — A symptom that can reduce intake and should be assessed further is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

20. A — A swallowing concern requiring prompt interdisciplinary follow-up is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

21. D — A barrier to intake that should be characterized and addressed is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

22. B — A symptom that may limit meal volume and total intake is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

23. A — A symptom that can affect hydration, absorption, and nutrient losses is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides

useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

24. B — A symptom to assess with fluid, fiber, mobility, and medication context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

25. C — A fluid-related finding that can mask weight loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

26. D — A dependent fluid finding requiring position-aware inspection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

27. B — Abdominal fluid accumulation that can obscure body-weight trends is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

28. C — A functional finding that should be measured consistently when used is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

29. D — A functional cue that can support concern about strength and mobility is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

30. A — A functional barrier that may reduce ability to meet needs is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

31. D — An oral-mechanical barrier that may limit food texture choices is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

32. A — A factor that may affect chewing and food selection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but

does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

33. C — A symptom that can limit oral intake and needs cause assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

34. B — A situation in which scale weight may not reflect improved tissue stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

35. C — A high-priority trend to quantify by time frame and usual weight is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

36. B — A history that should be integrated with symptoms and physical findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

37. D — A pattern that supports concern when combined with the clinical history is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

38. A — A pattern requiring documentation by site and severity is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

39. C — A finding that requires comparison and clinical context before interpretation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

40. B — A factor that may complicate positioning and visual comparison is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides

useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

41. A — A characteristic that can affect visual assessment and requires careful technique is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

42. D — A signal to pause, explain, and use a respectful modified approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

43. A — A practical constraint requiring adaptation of the examination sequence is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

44. D — A cue to protect equipment and select another safe observation approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

45. B — A context that may alter appearance, tolerance, and interpretation of findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

46. C — A skin finding that should be described and coordinated with the care team is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

47. B — A cue to assess trends and function without assuming cause from age alone is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

48. D — A situation where body size does not exclude malnutrition risk is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

49. C — A reason to compare sides and avoid overcalling generalized loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

50. A — A clinical concern to report and integrate with nutrition support planning is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

51. A — Loss of muscle mass in the temporal region is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

52. D — Hollowing beneath the eyes from subcutaneous fat loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

53. B — Reduced subcutaneous fat in the cheeks is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

54. C — Reduced muscle or fat stores over the upper chest is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

55. A — Visible bony shoulder contours from tissue loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

56. D — Loss of muscle between the metacarpals is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

57. B — Loss of muscle at the base of the thumb is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

58. D — Reduced posterior shoulder muscle or fat stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

59. C — Loss of muscle bulk in the anterior thigh is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

60. B — Loss of calf muscle mass is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

61. C — Reduced posterior upper-arm subcutaneous fat is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

62. A — Possible depletion of fat and muscle stores over the thorax is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

63. A — A skin integrity finding requiring nutrition and hydration context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

64. C — A finding that may support concern for dehydration is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

65. B — A nonspecific finding interpreted with the full assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

66. D — A cue to consider anemia and correlate with laboratory data is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

67. D — An oral finding that warrants diet and clinical correlation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

68. B — A lip finding that may prompt review of nutrient intake and absorption is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

69. C — A symptom that can reduce intake and should be assessed further is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

70. A — A swallowing concern requiring prompt interdisciplinary follow-up is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

71. A — A barrier to intake that should be characterized and addressed is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

72. D — A symptom that may limit meal volume and total intake is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

73. C — A symptom that can affect hydration, absorption, and nutrient losses is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

74. B — A symptom to assess with fluid, fiber, mobility, and medication context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and

severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

75. A — A fluid-related finding that can mask weight loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

76. D — A dependent fluid finding requiring position-aware inspection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

77. C — Abdominal fluid accumulation that can obscure body-weight trends is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

78. C — A functional finding that should be measured consistently when used is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

79. B — A functional cue that can support concern about strength and mobility is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

80. D — A functional barrier that may reduce ability to meet needs is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

81. B — An oral-mechanical barrier that may limit food texture choices is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

82. A — A factor that may affect chewing and food selection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

83. B — A symptom that can limit oral intake and needs cause assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides

useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

84. C — A situation in which scale weight may not reflect improved tissue stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

85. A — A high-priority trend to quantify by time frame and usual weight is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

86. D — A history that should be integrated with symptoms and physical findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

87. B — A pattern that supports concern when combined with the clinical history is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

88. A — A pattern requiring documentation by site and severity is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

89. C — A finding that requires comparison and clinical context before interpretation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

90. D — A factor that may complicate positioning and visual comparison is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

91. C — A characteristic that can affect visual assessment and requires careful technique is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and

severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

92. D — A signal to pause, explain, and use a respectful modified approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

93. A — A practical constraint requiring adaptation of the examination sequence is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

94. B — A cue to protect equipment and select another safe observation approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

95. B — A context that may alter appearance, tolerance, and interpretation of findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

96. A — A skin finding that should be described and coordinated with the care team is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

97. C — A cue to assess trends and function without assuming cause from age alone is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

98. D — A situation where body size does not exclude malnutrition risk is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

99. D — A reason to compare sides and avoid overcalling generalized loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides

useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

100. B — A clinical concern to report and integrate with nutrition support planning is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

101. C — Loss of muscle mass in the temporal region is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

102. A — Hollowing beneath the eyes from subcutaneous fat loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

103. C — Reduced subcutaneous fat in the cheeks is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

104. A — Reduced muscle or fat stores over the upper chest is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

105. D — Visible bony shoulder contours from tissue loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

106. B — Loss of muscle between the metacarpals is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

107. B — Loss of muscle at the base of the thumb is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

108. A — Reduced posterior shoulder muscle or fat stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but

does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

109. D — Loss of muscle bulk in the anterior thigh is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

110. C — Loss of calf muscle mass is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

111. A — Reduced posterior upper-arm subcutaneous fat is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

112. D — Possible depletion of fat and muscle stores over the thorax is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

113. C — A skin integrity finding requiring nutrition and hydration context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

114. B — A finding that may support concern for dehydration is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

115. A — A nonspecific finding interpreted with the full assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

116. D — A cue to consider anemia and correlate with laboratory data is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

117. B — An oral finding that warrants diet and clinical correlation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence,

but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

118. C — A lip finding that may prompt review of nutrient intake and absorption is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

119. A — A symptom that can reduce intake and should be assessed further is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

120. B — A swallowing concern requiring prompt interdisciplinary follow-up is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

121. C — A barrier to intake that should be characterized and addressed is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

122. D — A symptom that may limit meal volume and total intake is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

123. C — A symptom that can affect hydration, absorption, and nutrient losses is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

124. D — A symptom to assess with fluid, fiber, mobility, and medication context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

125. B — A fluid-related finding that can mask weight loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

126. A — A dependent fluid finding requiring position-aware inspection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

127. C — Abdominal fluid accumulation that can obscure body-weight trends is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

128. B — A functional finding that should be measured consistently when used is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

129. A — A functional cue that can support concern about strength and mobility is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

130. D — A functional barrier that may reduce ability to meet needs is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

131. C — An oral-mechanical barrier that may limit food texture choices is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

132. B — A factor that may affect chewing and food selection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

133. D — A symptom that can limit oral intake and needs cause assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

134. A — A situation in which scale weight may not reflect improved tissue stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and

severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

135. C — A high-priority trend to quantify by time frame and usual weight is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

136. A — A history that should be integrated with symptoms and physical findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

137. D — A pattern that supports concern when combined with the clinical history is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

138. B — A pattern requiring documentation by site and severity is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

139. B — A finding that requires comparison and clinical context before interpretation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

140. D — A factor that may complicate positioning and visual comparison is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

141. A — A characteristic that can affect visual assessment and requires careful technique is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

142. C — A signal to pause, explain, and use a respectful modified approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides

useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

143. C — A practical constraint requiring adaptation of the examination sequence is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

144. A — A cue to protect equipment and select another safe observation approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

145. B — A context that may alter appearance, tolerance, and interpretation of findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

146. D — A skin finding that should be described and coordinated with the care team is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

147. A — A cue to assess trends and function without assuming cause from age alone is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

148. B — A situation where body size does not exclude malnutrition risk is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

149. D — A reason to compare sides and avoid overcalling generalized loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

150. C — A clinical concern to report and integrate with nutrition support planning is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It

provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

151. C — Loss of muscle mass in the temporal region is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

152. A — Hollowing beneath the eyes from subcutaneous fat loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

153. D — Reduced subcutaneous fat in the cheeks is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

154. B — Reduced muscle or fat stores over the upper chest is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

155. D — Visible bony shoulder contours from tissue loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

156. A — Loss of muscle between the metacarpals is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

157. C — Loss of muscle at the base of the thumb is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

158. B — Reduced posterior shoulder muscle or fat stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

159. D — Loss of muscle bulk in the anterior thigh is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not

establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

160. A — Loss of calf muscle mass is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

161. B — Reduced posterior upper-arm subcutaneous fat is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

162. C — Possible depletion of fat and muscle stores over the thorax is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

163. B — A skin integrity finding requiring nutrition and hydration context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

164. C — A finding that may support concern for dehydration is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

165. D — A nonspecific finding interpreted with the full assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

166. A — A cue to consider anemia and correlate with laboratory data is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

167. A — An oral finding that warrants diet and clinical correlation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

168. C — A lip finding that may prompt review of nutrient intake and absorption is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and

severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

169. B — A symptom that can reduce intake and should be assessed further is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

170. D — A swallowing concern requiring prompt interdisciplinary follow-up is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

171. C — A barrier to intake that should be characterized and addressed is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

172. A — A symptom that may limit meal volume and total intake is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

173. B — A symptom that can affect hydration, absorption, and nutrient losses is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

174. D — A symptom to assess with fluid, fiber, mobility, and medication context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

175. B — A fluid-related finding that can mask weight loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

176. C — A dependent fluid finding requiring position-aware inspection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

177. A — Abdominal fluid accumulation that can obscure body-weight trends is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides

useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

178. D — A functional finding that should be measured consistently when used is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

179. D — A functional cue that can support concern about strength and mobility is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

180. B — A functional barrier that may reduce ability to meet needs is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

181. A — An oral-mechanical barrier that may limit food texture choices is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

182. C — A factor that may affect chewing and food selection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

183. B — A symptom that can limit oral intake and needs cause assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

184. C — A situation in which scale weight may not reflect improved tissue stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

185. D — A high-priority trend to quantify by time frame and usual weight is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

186. A — A history that should be integrated with symptoms and physical findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

187. C — A pattern that supports concern when combined with the clinical history is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

188. D — A pattern requiring documentation by site and severity is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

189. B — A finding that requires comparison and clinical context before interpretation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

190. A — A factor that may complicate positioning and visual comparison is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

191. B — A characteristic that can affect visual assessment and requires careful technique is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

192. A — A signal to pause, explain, and use a respectful modified approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

193. D — A practical constraint requiring adaptation of the examination sequence is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

194. C — A cue to protect equipment and select another safe observation approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

195. C — A context that may alter appearance, tolerance, and interpretation of findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

196. B — A skin finding that should be described and coordinated with the care team is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

197. A — A cue to assess trends and function without assuming cause from age alone is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

198. D — A situation where body size does not exclude malnutrition risk is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

199. A — A reason to compare sides and avoid overcalling generalized loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

200. C — A clinical concern to report and integrate with nutrition support planning is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

201. D — Loss of muscle mass in the temporal region is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

202. B — Hollowing beneath the eyes from subcutaneous fat loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

203. D — Reduced subcutaneous fat in the cheeks is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

204. C — Reduced muscle or fat stores over the upper chest is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

205. A — Visible bony shoulder contours from tissue loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

206. B — Loss of muscle between the metacarpals is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

207. C — Loss of muscle at the base of the thumb is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

208. B — Reduced posterior shoulder muscle or fat stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

209. A — Loss of muscle bulk in the anterior thigh is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

210. D — Loss of calf muscle mass is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

211. C — Reduced posterior upper-arm subcutaneous fat is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

212. A — Possible depletion of fat and muscle stores over the thorax is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

213. D — A skin integrity finding requiring nutrition and hydration context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

214. B — A finding that may support concern for dehydration is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

215. D — A nonspecific finding interpreted with the full assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

216. A — A cue to consider anemia and correlate with laboratory data is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

217. B — An oral finding that warrants diet and clinical correlation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

218. C — A lip finding that may prompt review of nutrient intake and absorption is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

219. B — A symptom that can reduce intake and should be assessed further is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

220. C — A swallowing concern requiring prompt interdisciplinary follow-up is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

221. A — A barrier to intake that should be characterized and addressed is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

222. D — A symptom that may limit meal volume and total intake is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

223. A — A symptom that can affect hydration, absorption, and nutrient losses is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

224. B — A symptom to assess with fluid, fiber, mobility, and medication context is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

225. C — A fluid-related finding that can mask weight loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

226. D — A dependent fluid finding requiring position-aware inspection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

227. D — Abdominal fluid accumulation that can obscure body-weight trends is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

228. C — A functional finding that should be measured consistently when used is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

229. A — A functional cue that can support concern about strength and mobility is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

230. B — A functional barrier that may reduce ability to meet needs is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

231. C — An oral-mechanical barrier that may limit food texture choices is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

232. B — A factor that may affect chewing and food selection is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

233. A — A symptom that can limit oral intake and needs cause assessment is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

234. D — A situation in which scale weight may not reflect improved tissue stores is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

235. B — A high-priority trend to quantify by time frame and usual weight is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

236. D — A history that should be integrated with symptoms and physical findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

237. A — A pattern that supports concern when combined with the clinical history is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It

provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

238. C — A pattern requiring documentation by site and severity is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

239. A — A finding that requires comparison and clinical context before interpretation is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

240. D — A factor that may complicate positioning and visual comparison is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

241. B — A characteristic that can affect visual assessment and requires careful technique is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

242. C — A signal to pause, explain, and use a respectful modified approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

243. A — A practical constraint requiring adaptation of the examination sequence is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

244. B — A cue to protect equipment and select another safe observation approach is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

245. D — A context that may alter appearance, tolerance, and interpretation of findings is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It

provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

246. C — A skin finding that should be described and coordinated with the care team is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

247. D — A cue to assess trends and function without assuming cause from age alone is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

248. B — A situation where body size does not exclude malnutrition risk is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

249. C — A reason to compare sides and avoid overcalling generalized loss is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.

250. A — A clinical concern to report and integrate with nutrition support planning is the best interpretation. Interpret it with intake history, weight trend, symptoms, function, and medical context. It provides useful evidence, but does not establish a diagnosis alone. Document site, symmetry, and severity when applicable. Then compare it with assessment data and communicate concerns to the care team.