MDS in Adult Family Care Homes: MDS-ALS

CASE MIX TEAM
Revised May 2015

MDS-ALS Training: Agenda

- History of MDS-ALS
- Purpose
- Definitions
- Schedule of Assessments
- Case Mix Index, RUG groups
- MDS-ALS Assessment Tool
- Corrections
- Quality Indicators

Training Requirement

MaineCare Benefits Manual, Chapter II, Section 2.07-1.A.4.a:

Only staff trained in completion of the MDS-ALS *by the Department* may conduct or coordinate assessments.

History of MDS-ALS

Who, What, Where, Why and, When...

of Case Mix

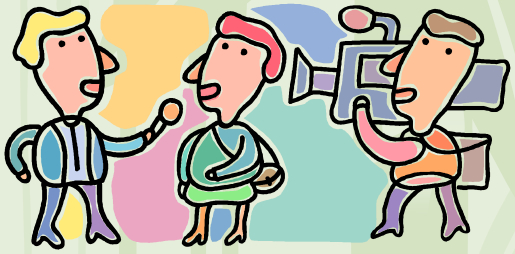
So… Who completes the MDS-ALS?

…The MDS Coordinator

with help from:

- ✓The resident
- ✓Facility staff
- ✓Family
- ✓Clinical records

Assessors Responsibilities



- Conduct interviews
- Read the manual
- Attend training
- Accuracy and timeliness
- Maintain confidentiality
- Edit and submit all MDS/ALS
- Review submission reports

And… What is Case Mix?

Case Mix is a system of reimbursement that pays facilities according to the amount of time spent providing care to residents.

Residents are grouped according to the amount of time needed to provide their care

And… Where is the assessment done?

MDS-ALS assessment is completed in the facility

- All residents
- Regardless of payer source

The MDS-ALS cannot be completed if the resident is not in the facility. For example, if in the hospital or on a therapeutic leave

And… Why do we need to do MDS-ALS Assessments?

1. To provide information to guide staff in developing a realistic individualized Service Plan.
2. To place a resident into a payment group within the Case Mix System.
3. To provide information that determines the Quality Indicators.
4. To show an accurate picture of the resident's condition, the type and amount of care needed

And… When are assessments done?

Type of Assessment	When Completed	Schedule
Admission Assessment	Initial Admission	By the end of the 30th day after admission, as represented by the S2b date. Admission is day #1.
Semi Annual Assessment	Within 180 days of last comprehensive MDS-RCA	Within 7 days of assessment date entered in (A5), as represented by the S2b date.
Annual Assessment	Within 180 days of last MDS-RCA assessment	Within 7 days of assessment date entered in (A5), as represented by the S2b date.
Significant Change Assessment	Only if significant change has occurred	Assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred.
Other	When required by Case Mix Nurse	Within 7 calendar days of Case Mix Nurse visit as represented by S2b date
Discharge Tracking Form	When a resident is discharged, transferred or deceased	Completed within 7 days of the event
MDS-ALS Face Sheet (Section AA through AD of the MDS-ALS form)	Provides key information to uniquely identify each resident and to track the resident in the automated system	Completed only once, at the time of admission to a facility.

Timeliness

MaineCare Benefits Manual, Chapter II, Section 2.07-1.A.8:

"The Department will sanction providers who fail to accurately complete assessments in a timely manner."

Accuracy

Documentation is required to support the time periods and information coded on the MDS-ALS. (MBM, chapter II, Section 2.07-1.A.4.c)

Penalty for Falsification: The Department may sanction a provider whenever the provider willfully and/or knowingly certifies (*or causes another individual to certify*) a material and false statement in an assessment. This may be in addition to any other penalties provided by statute.

Case Mix

Payment Groups

Payment Items

Documentation Requirements

Sanctions

RUGS

Case Mix Quality Assurance Review

About every 6 months, a Case Mix nurse reviews a sample of MDS-ALS assessments and resident records to check the accuracy of the MDS-ALS assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS-ALS may lead to an error.

Poor Documentation could mean…

Lower payment than the facility could be receiving, OR

Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

Never do an inaccurate assessment to match inaccurate documentation

If, after interviewing staff and interviewing/observing the resident, you feel that the documentation is inaccurate, write a note in the record to explain and code the MDS/ALS accurately

Sanctions:

2%	Error rate 34% or greater and less than 37%
5%	Error rate 37% or greater and less than 41%
7%	Error rate 41% or greater and less than 45%
10%	Error rate 45% or greater
10%	If requested reassessments not completed within 7 days

Case Mix Resident Classification Groups and Weights

There are a total of 8 case mix classification or RUG (Resource Utilization Groups) groups, including one default group used when a resident cannot be classified into one of the other classification groups.

RUG Groups

RUG Code	ALS Score	ADL Score	IADL Score	Weight	Rate
AV2	ALS 7-9	ADL 7-28		1.657	$71.68
AV1	ALS 7-9	ADL 0-6		1.210	$52.34
AH2	ALS 5-6	ADL 7-28		1.360	$58.83
AH1	ALS 5-6	ADL 0-6		1.027	$44.43
AM2	ALS 2-4		IADL 12-18	0.924	$39.97
AM1	ALS 2-4		IADL 10-11	0.804	$34.78
AL1	ALS 2-4		IADL 0-9	0.551	$23.84
BC1	Unclassified			0.551	$23.84

Documentation Guidelines

ALS	FIELD	COMMENTARY
B3	Cognitive Skills for Daily Decision Making	Documentation must be found in the record of the resident's ability to actively make decisions regarding tasks of daily living in the last 7 days.
E1a-r	Indicators of Depression	Evidence & observations of these indicators must be present in the resident's record within the last 30 days..
G5ac G5ag	Assist. with phoning Assist. with arranging transport.	Evidence within the record of the resident involvement in the activity. Document the level of independence that best represents the client's functioning & the type of assistance provided over 30 days.
H4	Use of incontinent supplies	Evidence within the record of resident's management of incontinence supplies within the last 14 days. (pads, briefs, ostomy, catheter)
O5f	Administration of OTC medications	Evidence within the record that the resident DID NOT administer OTC meds within the last 7 days.
O6	Medication Preparation & Administration	Evidence in the record that the resident prepared/administered NONE, SOME or ALL of their medications within the last 7 days.
P10	Physicians Order Changes	Include the number of DAYS that the Physician or authorized assistant changed the residents written, telephoned, or faxed orders within the last 14 days. DOES NOT INCLUDE: admission orders, return admission orders or orders without change.

DOCUMENTATION for ADL Scores

ALS	FIELD	COMMENTARY
G1aa G1ba G1ca G1da G1ea G1fa G1ga	Bed mobility Transfer Locomotion Dressing Eating Toilet use Personal hygiene	All areas must be documented for all shifts within the last 7 days. Self Performance score only.

DOCUMENTATION for IADL & Bathing Scores

ALS	FIELD	COMMENTARY
G2	Bathing(SP)	Evidence about how the resident takes a full body bath. Code for most dependent within the last 7 days.
G5aa G5ab G5ad G5ae G5af G5ah G5ai	Arrange Shopping Shopping Manage Finances Manage cash/allow Prepares Snacks Light Housework Laundry	IADLs done with help or done by others. Evidence within the record of the level of independence that best represents the clients functioning and the type of assistance provided over 30 days.

Submitting the MDS-ALS

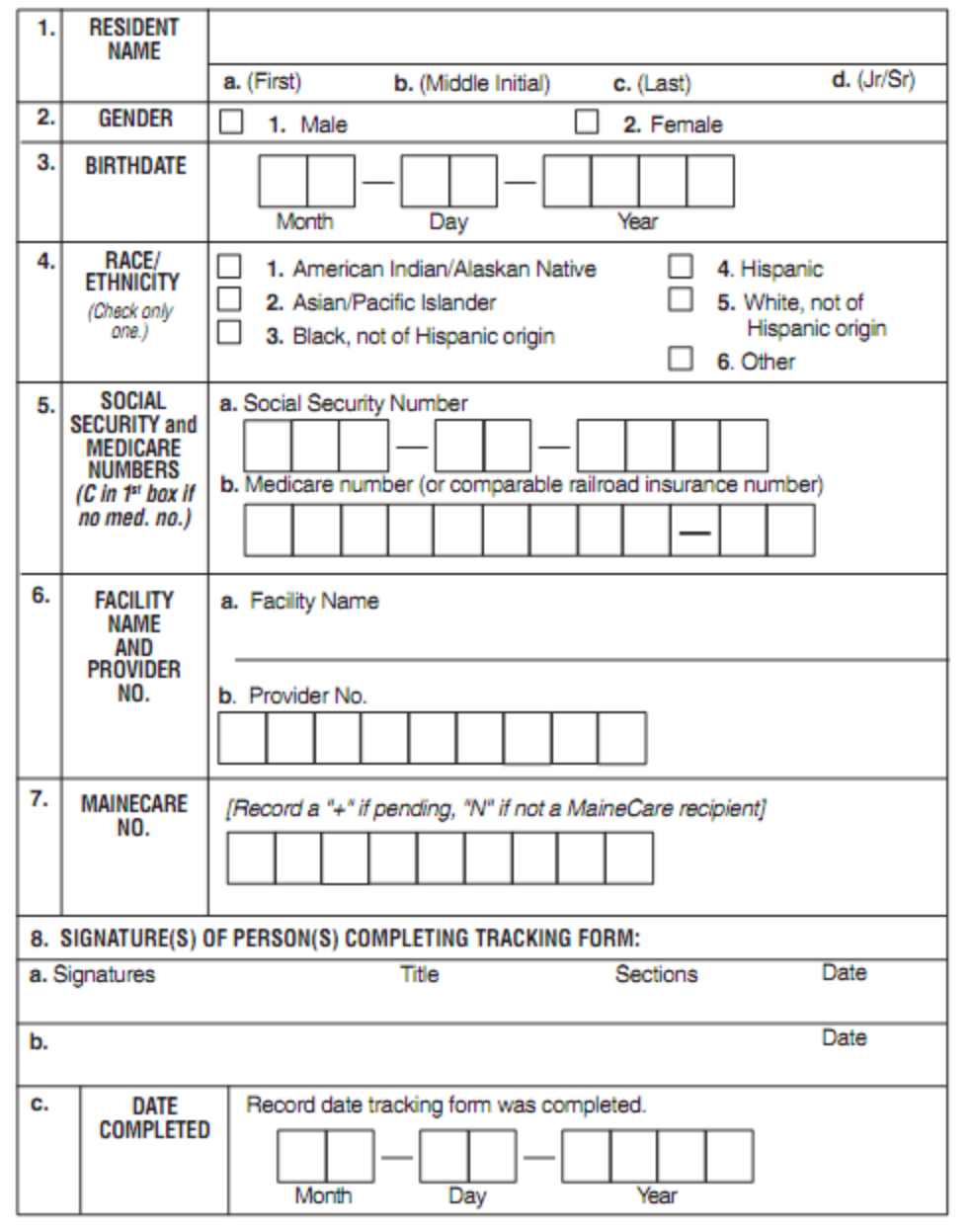
Completed MDS-ALS assessments are submitted within **30** days of completion to:

Catherine Gunn-Thiele
Muskie School of Public Service
PO Box 9300
Portland, Me. 04104-9300
Office Phone: 780-5576

MDS-ALS Assessment Tool

Section by Section

Section AA: Identification Information.



1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	☐ 1. Male ☐ 2. Female
3.	BIRTHDATE	Month — Day — Year
4.	RACE/ ETHNICITY *(Check only one.)*	☐ 1. American Indian/Alaskan Native ☐ 2. Asian/Pacific Islander ☐ 3. Black, not of Hispanic origin ☐ 4. Hispanic ☐ 5. White, not of Hispanic origin ☐ 6. Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS *(C in 1st box if no med. no.)*	a. Social Security Number — — b. Medicare number (or comparable railroad insurance number) —
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name b. Provider No.
7.	MAINECARE NO.	*[Record a "+" if pending, "N" if not a MaineCare recipient]*
8.	SIGNATURE(S) OF PERSON(S) COMPLETING TRACKING FORM:	
a.	Signatures	Title Sections Date
b.		Date
c.	DATE COMPLETED	Record date tracking form was completed. Month — Day — Year

Face Sheet: Background Information

Completed at the time of the resident's initial admission to the facility.

Section AB: Demographic Information

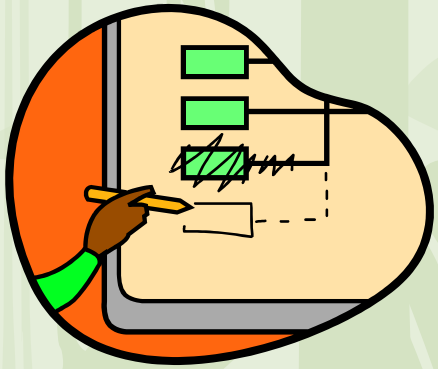
Section AC: Customary Routine

Section AD: Face Sheet Signatures and dates

Section A: Identification and Background information

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	SOCIAL SECURITY and MEDICARE NUMBERS *(C in 1st box if no med. no.)*	a. Social Security Number ___ — ___ — ____ b. Medicare number (or comparable railroad insurance number) ____ — __
3.	FACILITY NAME AND PROVIDER NO.	a. Facility Name _____ b. Provider No. ____
4.	MAINECARE NO.	*[Record a "+" if pending, "N" if not a MaineCare recipient]* ____
5.	ASSESSMENT DATE	*Last day of observation period* __ — __ — ____ Month Day Year
6.	REASON FOR ASSESSMENT	*(Check primary reason for assessment)* ☐ 1. Admission assessment ☐ 2. Annual assessment ☐ 3. Significant change in status assessment ☐ 4. Semi-Annual ☐ 5. Other *(specify)* _____

When to complete a Significant Change MDS-ALS assessment:



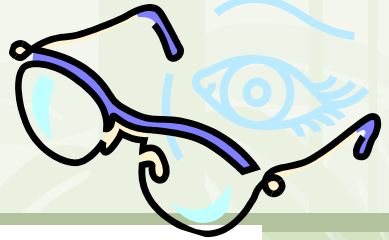
- Resident has experienced a "major change"
- Not self-limited
- Impacts more than one area of the resident's clinical status
- Requires review and/or changes to the service plan
- Improvement or decline
- Completed by the end of the 14th day following the documented determination

Section B: Cognitive Patterns

1.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK—seems/appears to recall after 5 minutes ☐ 0. Memory OK ☐ 1. Memory problem b. Long-term memory OK—seems/appears to recall long past ☐ 0. Memory OK ☐ 1. Memory problem
2.	MEMORY/ RECALL ABILITY	*(Check all that resident was normally able to recall during **last 7 days**)* ☐ a. Current season ☐ d. That he/she is in a facility/home ☐ b. Location of own room ☐ e. NONE OF ABOVE are recalled ☐ c. Staff names/faces
3.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING *(Check only one.)*	*(Made decisions regarding tasks of daily life)* ☐ 0. *INDEPENDENT*—decisions consistent/reasonable ☐ 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only ☐ 2. *MODERATELY IMPAIRED*—decisions poor; cues/ supervision required ☐ 3. *SEVERELY IMPAIRED*—never/rarely made decisions
4.	COGNITIVE STATUS *(Check only one.)*	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days). ☐ 0. No change ☐ 1. Improved ☐ 2. Declined

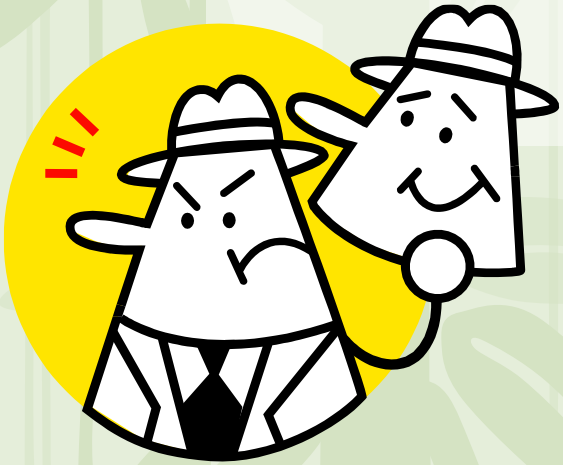
SECTION C. COMMUNICATION/HEARING PATTERNS

1.	**HEARING** *(Check only one.)*	*(With hearing appliance, if used)* ☐ 0. *HEARS ADEQUATELY*—normal talk, TV, phone ☐ 1. *MINIMAL DIFFICULTY* when not in quiet setting ☐ 2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly ☐ 3. *HIGHLY IMPAIRED*–absence of useful hearing
2.	**COMMUNICATION DEVICES/ TECHNIQUES**	*(Check all that apply during last 7 days.)* ☐ a. Hearing aid, present and used ☐ b. Hearing aid, present and not used regularly ☐ c. Other receptive communication techniques used (e.g., lip reading) ☐ d. *NONE OF ABOVE*
3.	**MAKING SELF UNDERSTOOD** *(Check only one.)*	*(Expressing information content—however able)* ☐ 0. *UNDERSTOOD* ☐ 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts ☐ 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests ☐ 3. *RARELY/NEVER UNDERSTOOD*
4.	**ABILITY TO UNDERSTAND OTHERS** *(Check only one.)*	*(Understanding information content—however able)* ☐ 0. *UNDERSTANDS* ☐ 1. *USUALLY UNDERSTANDS*—may miss some part / intent of message ☐ 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication ☐ 3. *RARELY/NEVER UNDERSTANDS*



SECTION D. VISION PATTERNS

1.	**VISION** *(Check only one.)*	*(Ability to see in adequate light and with glasses if used)* ☐ 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books ☐ 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books ☐ 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects ☐ 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects ☐ 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	**VISUAL APPLIANCES**	a. Glasses, contact lenses ☐ 0. No ☐ 1. Yes b. Artificial eye ☐ 0. No ☐ 1. Yes



SECTION E. MOOD and BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)* 0. Not exhibited in last 30 days 1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month). 2. This type of behavior exhibited daily or almost daily (6, 7 days/week)

VERBAL EXPRESSIONS OF DISTRESS

____ a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."

____ b. Repetitive questions—e.g., "Where do I go; What do I do?"

____ c. Repetitive verbalizations—e.g., calling out for help, ("God help me")

____ d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received

____ e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone"

____ f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

____ g. Recurrent statements that something terrible is about to happen —e.g., believes he or she is about to die, have a heart attack

____ h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

____ i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

(continued next page)

Section E: Mood and Behavior Patterns (cont.)

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)* 0. Not exhibited in last 30 days 1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month). 2. This type of behavior exhibited daily or almost daily (6, 7 days/week)
		SLEEP-CYCLE ISSUES ____ j. Unpleasant mood in morning ____ k. Insomnia/change in usual sleep pattern **SAD, APATHETIC, ANXIOUS APPEARANCE** ____ l. Sad, pained, worried facial expressions—e.g., furrowed brows ____ m. Crying, tearfulness ____ n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking **LOSS OF INTEREST** ____ o. Withdrawal from activities of interest—e.g., no interest in long-standing activities or being with family/friends ____ p. Reduced social interaction **INDICATORS OF MANIA** ____ q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc. ____ r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	**SENSE OF INITIATIVE/ INVOLVEMENT** *(Check all that apply.)*	☐ a. At ease interacting with others ☐ b. At ease doing planned or structured activities ☐ c. At ease doing self-initiated activities ☐ d. Establishes own goals ☐ e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) ☐ f. Accepts invitations into most group activities ☐ g. *NONE OF ABOVE*
2.	**UNSETTLED RELATION-SHIPS** *(Check all that apply.)*	☐ a. Covert/open conflict with or repeated criticism of staff ☐ b. Unhappy with roommate ☐ c. Unhappy with residents other than roommate ☐ d. Openly expresses conflict/anger with family/friends ☐ e. Absence of personal contact with family/friends ☐ f. Recent loss of close family member/friend ☐ g. Does not adjust easily to change in routines ☐ h. *NONE OF ABOVE*
3.	**LIFE-EVENTS HISTORY** *(Check all that apply.)*	Events in past 2 years ☐ a. Serious accident or physical illness ☐ b. Health concerns for other person ☐ c. Death of family member or close friend ☐ d. Trouble with the law ☐ e. Robbed/physically attacked ☐ f. Conflict laden or severed relationship ☐ g. Loss of income leading to change in lifestyle ☐ h. Sexual assault/abuse ☐ i. Child custody issues ☐ j. Change in marital/partner status ☐ k. Review hearings (e.g., forensic, certification, capacity hearing) ☐ l. *NONE OF ABOVE*

ADL SELF-PERFORMANCE

Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last **7** days.

SECTION G. PHYSICAL FUNCTIONING

1. (A) ADL SELF-PERFORMANCE

0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days

1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times.

3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:

— Weight-bearing support

— Full staff performance during part (but not all) of last 7 days

4. TOTAL DEPENDENCE—Full staff performance of activity during last 7 days

8. ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS

(B) **ADL SUPPORT CODES** *(CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD)* **during last 7 days; code regardless of person's self-performance classification.**

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. Activity did not occur during entire 7 days

		A SELF-PERFORMANCE	B SUPPORT
a.	**BED MOBILITY**– How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER** – How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	**LOCOMOTION** – How resident moves to and returns from other locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
d.	**DRESSING** – How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
e.	**EATING** – How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
f.	**TOILET USE** – How resident uses the toilet room (or commode, bed- pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	**PERSONAL HYGIENE** – How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

(A) ADL SELF-PERFORMANCE

0. ***INDEPENDENT***—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. ***SUPERVISION***—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. ***LIMITED ASSISTANCE***—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times.
3. ***EXTENSIVE ASSISTANCE***—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. ***TOTAL DEPENDENCE***—Full staff performance of activity during last 7 days
8. ***ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS***

(B) **ADL SUPPORT CODES** *(CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD)* **during last 7 days; code regardless of person's self-performance classification.**

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. Activity did not occur during entire 7 days

	A	B
	SELF-PERFORMANCE	SUPPORT

G2. Bathing Self -Performance

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Check for most dependent*** *in self-performance* during last 7 days.

- ☐ **0.** Independent—No help provided
- ☐ **1.** Supervision—Oversight help only
- ☐ **2.** Physical help limited to transfer only
- ☐ **3.** Physical help in part of bathing activity
- ☐ **4.** Total dependence
- ☐ **8.** Activity itself did not occur during entire 7 days

G5. IADL Self-Performance

a.	Resident arranged for shopping for clothing, snacks, other incidentals.	
b.	Resident shopped for clothing, snacks, or other incidentals.	
c.	Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	
d.	Resident managed finances including banking, handling checkbook, or paying bills.	
e.	Resident managed cash, personal needs allowance.	
f.	Resident prepared snacks, light meals.	
g.	Resident used phone.	
h.	Resident did light housework such as making own bed, dusting, or taking care of belongings.	
i.	Resident sorted, folded, or washed own laundry.	

Note: this section has a **14-day** look back period.

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident's PERFORMANCE OVER ALL SHIFTS)

0. *CONTINENT*—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed			
b.	BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed			
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a.	Diarrhea	c.
		Constipation	b.	Fecal impaction	d.
				Resident is independent	e.
				NONE OF ABOVE	f.
3.	APPLIANCES and PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.
		Bladder retraining program	b.		
		External (condom) catheter	c.	Pads/briefs used	g.
		Indwelling catheter	d.	Enemas/irrigation	h.
		Intermittent catheter	e.	Ostomy present	i.
				NONE OF ABOVE	j.

4. USE OF INCONTINENCE SUPPLIES
(Check only one.)

Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days.

- ☐ 0. Always continent
- ☐ 1. Resident incontinent and able to manage incontinence supplies independently.
- ☐ 2. Resident incontinent and receives assistance with managing incontinence supplies.
- ☐ 3. Resident incontinent and does not use incontinence supplies.

H4. Use of Incontinence Supplies

0. Always Continent

1. Resident incontinent and able to manage supplies independently.

2. Resident incontinent and receives assistance with managing supplies.

3. Resident incontinent and does not use incontinence supplies. For example, resident refuses to use the supplies or hides their soiled garments.

POP QUIZ !

0 - Continent – Complete control

1 - Usually Continent – Bladder, incontinent episodes occur once a week or less. Bowel incontinent episodes occur less than once a week.

2 - Occasionally Incontinent – Bladder incontinent episode occur two or more times a week but not daily. Bowel incontinent episodes occur once a week.

3 - Frequently Incontinent – Bladder, tended to be incontinent daily, but some control present (e.g., on day shift) Bowel, 2-3 times a week.

4 - Incontinent – Bladder incontinent episodes occur multiple times daily. Bowel incontinence is all (or almost all) of the time.

A. Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.

B. Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet.

C. Although she is generally continent of urine, every once in a while (about once in two weeks) Mrs. T doesn't make it to the bathroom in time after receiving her daily diuretic pill

D. Late in the day when she is tired, Mrs. A sometimes (but not all days) has more episodes of urinary incontinence.

Section I: Diagnosis

All diseases and conditions must have physician documented diagnosis in the clinical record.

Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan.

Section J covers Health Conditions and Possible Medication Side Effects…

A lot of territory!

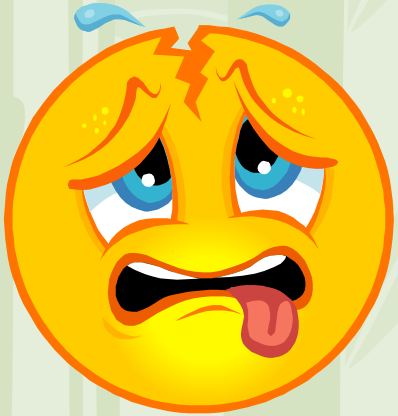
- J1. Problem conditions
- J2. Extrapyramidal signs and symptoms
- J3 and 4. Pain Symptoms and location
- J5 and 6. Pain interference and management
- J7. Accidents
- J8. Fall risk

Section J. Health Conditions and Possible Medication Side Effects

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*

- ☐ a. Inability to lie flat due to shortness of breath
- ☐ b. Shortness of breath
- ☐ c. Edema
- ☐ d. Dizziness/vertigo
- ☐ e. Delusions
- ☐ f. Hallucinations
- ☐ g. Hostility
- ☐ h. Suspiciousness
- ☐ i. Headache
- ☐ j. Numbness/tingling
- ☐ k. Blurred vision
- ☐ l. Dry mouth
- ☐ m. Excessive salivation or drooling
- ☐ n. Change in normal appetite
- ☐ o. Other *(specify)* _____
- ☐ p. *NONE OF ABOVE*



Section K: Oral and Nutritional Status

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS *(Check all that apply.)*	☐ a. Mouth is "dry" when eating a meal ☐ b. Chewing Problem ☐ c. Swallowing Problem ☐ d. Mouth Pain ☐ e. *NONE OF ABOVE*
2.	HEIGHT AND WEIGHT	*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice–e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* a. HT (in.) ☐☐ b. WT (lb.) ☐☐☐
3.	WEIGHT CHANGE	a. **Unintended weight loss–5% or more in last 30 days; or 10% or more in last 180 days** ☐ 0. No ☐ 1. Yes b. **Unintended weight gain–5% or more in last 30 days; or 10% or more in last 180 days** ☐ 0. No ☐ 1. Yes
4.	NUTRITIONAL PROBLEMS OR APPROACHES *(Check all that apply.)*	☐ a. Complains about the taste of many foods ☐ b. Regular or repetitive complaints of hunger ☐ c. Leaves 25% of food uneaten at most meals ☐ d. Therapeutic diet ☐ e. Mechanically altered (or pureed) diet ☐ f. Noncompliance with diet ☐ g. Eating disorders ☐ h. Food allergies *(specify)* _____ ☐ i. Restrictions *(specify)* _____ ☐ j. *NONE OF ABOVE*

Section L: Oral / Dental Status

SECTION L. ORAL/DENTAL STATUS

1.	**ORAL STATUS AND DISEASE PREVENTION** *(Check all that apply.)*	☐ a. Has dentures or removable bridge ☐ b. Some/all natural teeth lost–does not have or does not use dentures (or partial plates) ☐ c. Broken, loose or carious teeth ☐ d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes ☐ e. Daily cleaning of teeth/dentures or daily mouth care–by resident or staff ☐ f. Resident has difficulty brushing teeth or dentures ☐ g. *NONE OF ABOVE*

Section M: Skin Condition

SECTION M. SKIN CONDITION

1.	**SKIN PROBLEMS** *(Check all that apply.)*	Any troubling skin conditions or changes in the **last 7 days?** ☐ a. Abrasions (scrapes) or cuts ☐ b. Burns (2nd or 3rd degree) ☐ c. Bruises ☐ d. Rashes, itchiness, body lice ☐ e. Open sores or lesions ☐ f. Other *(specify)* _____ ☐ g. *NONE OF ABOVE*	
2.	**ULCERS** *(Due to any cause.)*	(Record the number of ulcers at each ulcer stage–regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9=9 or more.) Requires full body exam. **a.** Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. **b.** Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. **c.** Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues–presents as a deep crater with or without undermining adjacent tissue. **d.** Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage
3.	**FOOT PROBLEMS**	**a.** Resident or someone else inspects resident's feet on a regular basis? ☐ 0. No ☐ 1. Yes **b.** One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, enlarged toe in last 7 days? ☐ 0. No ☐ 1. Yes	

Section N: Activity Pursuit Patterns

SECTION N. ACTIVITY PURSUIT PATTERNS

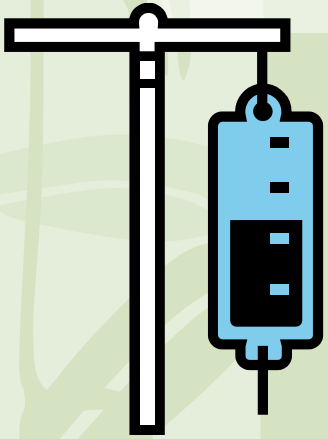
1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: ☐ a. Morning ☐ b. Afternoon ☐ c. Evening ☐ d. Night (Bedtime to A.M.) ☐ e. *NONE OF ABOVE*
2.	AVERAGE TIME INVOLVED IN ACTIVITIES *(Check only one.)*	*(When awake and not receiving treatments or ADL care)* ☐ 1. Most–more than 2/3 of time ☐ 2. Some–from 1/3 to 2/3 of time ☐ 3. Little–less than 1/3 of time ☐ 4. None
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)* ☐ a. Own room ☐ b. Day/activity room ☐ c. Outside facility (e.g., in yard) ☐ d. Away from facility ☐ e. *NONE OF ABOVE*
4.	GENERAL ACTIVITY PREFER-ENCES	*(Check all PREFERENCES whether or not activity is currently available to resident)* ☐ a. Cards/other games ☐ b. Crafts/arts ☐ c. Exercise/sports ☐ k. Gardening or plants ☐ l. Talking or conversing ☐ m. Helping others

Section O: Medications

SECTION O. MEDICATIONS (cont.)

4A.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during the last 7 days; enter "0" if not used. Note–enter "1" for long-acting meds used less than weekly) _____ a. Antipsychotic _____ d. Hypnotic _____ g. Insulin _____ b. Antianxiety _____ e. Diuretic _____ c. Antidepressant _____ f. Aricept
4B.	PRN MEDICATIONS	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? ☐ 0. No ☐ 1. Yes
5.	SELF-ADMINSTERED MEDICATIONS *(Check all that apply.)*	Did resident **self-administer** any of the following in the last 7 days: ☐ a. Insulin ☐ e. Glucosan ☐ b. Oxygen ☐ f. Over-the-counter Meds ☐ c. Nebulizers ☐ g. Other (specify) _____ ☐ d. Nitropatch ☐ h. *NONE OF ABOVE*
6.	MEDICATION PREPARATION ADMINISTRATION	Did resident prepare and administer his/her own medications in last 7 days? *(Check only one.)* ☐ 0. No Meds ☐ 1. Resident prepared and administrated NONE of his/her own medications. ☐ 2. Resident prepared and administrated SOME of his/her own medications. ☐ 3. Resident prepared and administrated ALL of his/her own medications.

Section P: Special Treatments and Procedures



SECTION P. SPECIAL TREATMENTS and PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE–*Check treatments or programs received during the last 14 days* [Note–count only post admission treatments]

TREATMENTS

- ☐ a. Chemotherapy or radiation
- ☐ b. Oxygen therapy
- ☐ c. Dialysis

PROGRAMS

- ☐ d. Alcohol/drug treatment program
- ☐ e. Alzheimer's/dementia special care unit
- ☐ f. Hospice care
- ☐ g. Home health
- ☐ h. Home care
- ☐ i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)
- ☐ j. Case management
- ☐ k. Day treatment program
- ☐ l. Sheltered workshop/employment
- ☐ m. Job training
- ☐ n. Transportation
- ☐ o. Psychological rehabilitation
- ☐ p. Formal education
- ☐ q. *NONE OF ABOVE*

b. THERAPIES–*Record the number of days each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. a day)*

(Note-count only post admission therapies)
(A) = # of days administered for 15 minutes or more
Check B if therapy was received at home or in facility
Check C if therapy was received out-of-home or facility

	Days (A)	ON SITE (B)	OFF SITE (C)
a. Speech-language pathology and auditory services			
b. Occupational therapy			
c. Physical therapy			
d. Respiratory therapy			
e. Psychological therapy (by any licensed mental health professional)			

Section P: Special Treatments and Procedures (cont.)

2.	INTER-VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	*(Check all interventions or strategies used in the last 7 days unless other time specified–no matter where received)* ☐ **a.** Special behavior symptom evaluation program ☐ **b.** Special behavior management program ☐ **c.** Evaluation by a licensed mental health specialist in last 90 days ☐ **d.** Group therapy ☐ **e.** Resident-specific deliberate changes in the environment to address mood/behavior patterns–e.g., providing bureau in which to rummage ☐ **f.** Reorientation–e.g., cueing ☐ **g.** Validation/Redirection ☐ **h.** Crisis intervention in facility ☐ **i.** Crisis stabilization unit in last 90 days ☐ **j.** Other *(specify)* _____ ☐ **k.** *NONE OF ABOVE*

Section P: Special Treatments and Procedures (cont.)

3.	NEED FOR ON-GOING MONITORING	*(Code for person responsible for monitoring)* 0. No monitoring required 1. RCF nurse 2. RCF Other Staff 3. Home health nurse
		____ a. Acute physical or psychiatric condition - not chronic ____ b. New treatment/medication

Section P: Special Treatments and Procedures

P4. Rehab / Restorative care

P5. Skill Training

P6. Adherence With Treatments/Therapies Programs

P7. General Hospital Stays

P8. Emergency Room (ER) Visit(s)

P9. Physician Visits

Section P: Special Treatments and Procedures

10.	PHYSICIAN ORDERS	In the **last 14 days** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "0" if none)

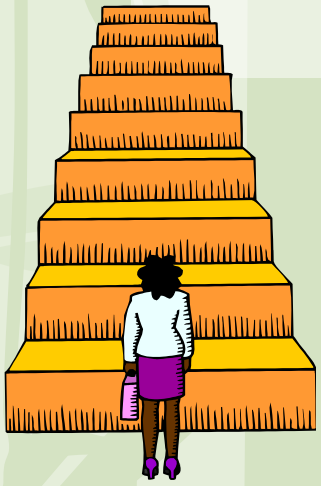
Note: Code the number of **days** the physician changed the resident's orders, not including order renewals without Change or clarification of orders.

Section P: Special Treatments and Procedures

P11. Abnormal Lab Values

P12. Psychiatric Hospital Stay(s)

P13. Outpatient Surgery



Section Q: Service Planning

SECTION Q. SERVICE PLANNING

1.	**RESIDENT GOALS** *(Check all areas in which resident has self-identified goals)*	☐ a. Health promotion/wellness/exercise ☐ b. Social involvement/making friends ☐ c. Activities/hobbies/adult learning ☐ d. Rehabilitation–skilled ☐ e. Maintaining physical or cognitive function ☐ f. Participation in the community ☐ g. Other *(specify)* _____ ☐ h. No goals
2.	**CONFLICT**	a. Any disagreement between resident and family about goals or service plan? ☐ 0. No ☐ 1. Yes b. Any disagreement between resident/family and staff about goals or service plan? ☐ 0. No ☐ 1. Yes

Note: this item refers to
Resident self-identified goals

Section R: Discharge Potential

SECTION R. DISCHARGE POTENTIAL

1.	DISCHARGE POTENTIAL	a. Does resident or family indicate a preference to return to community? ☐ 0. No ☐ 1. Yes b. Does resident have a support person who is positive towards discharge? ☐ 0. No ☐ 1. Yes c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? ☐ 0. No change ☐ 1. Improved ☐ 2. Declined

Section S: Assessment Information and Signatures

SECTION S. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident:	☐ 0. No ☐ 1. Yes
		b. Family:	☐ 0. No ☐ 1. Yes ☐ 2. No Family
		c. Other Non-Staff:	☐ 0. No ☐ 1. Yes ☐ 2. None

2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

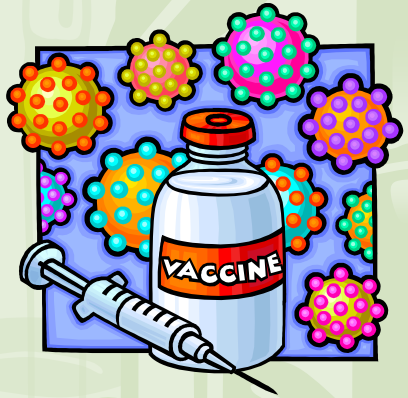
a. Signature of Assessment Coordinator (sign on line above)

b. Date Assessment Coordinator signed as complete ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

c. Other Signatures	Title	Sections	Date
d.			Date
e.			Date

3.	CASE MIX GROUP	☐☐☐☐☐

Section T: Preventive Health



SECTION T. PREVENTIVE HEALTH/HEALTH BEHAVIORS

1.	PREVENTIVE HEALTH	*(Check all the procedures the resident received during the past 12 months)* ☐ a. Blood pressure monitoring ☐ b. Hearing assessment ☐ c. Vision test ☐ d. Dental visit ☐ e. Influenza vaccine ☐ f. Pneumococcal vaccine (ANY time) ☐ g. Breast exam or mammogram ☐ h. Pap smear ☐ i. PSA or rectal exam ☐ j. Other *(specify)* _____

Note: **12 month look back period** for preventive health measures.

Section U: Medications list

SECTION U. MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen.

1. List the medication name and the dosage
2. RA (Route of Administration). Use the appropriate code from the following list:

1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other

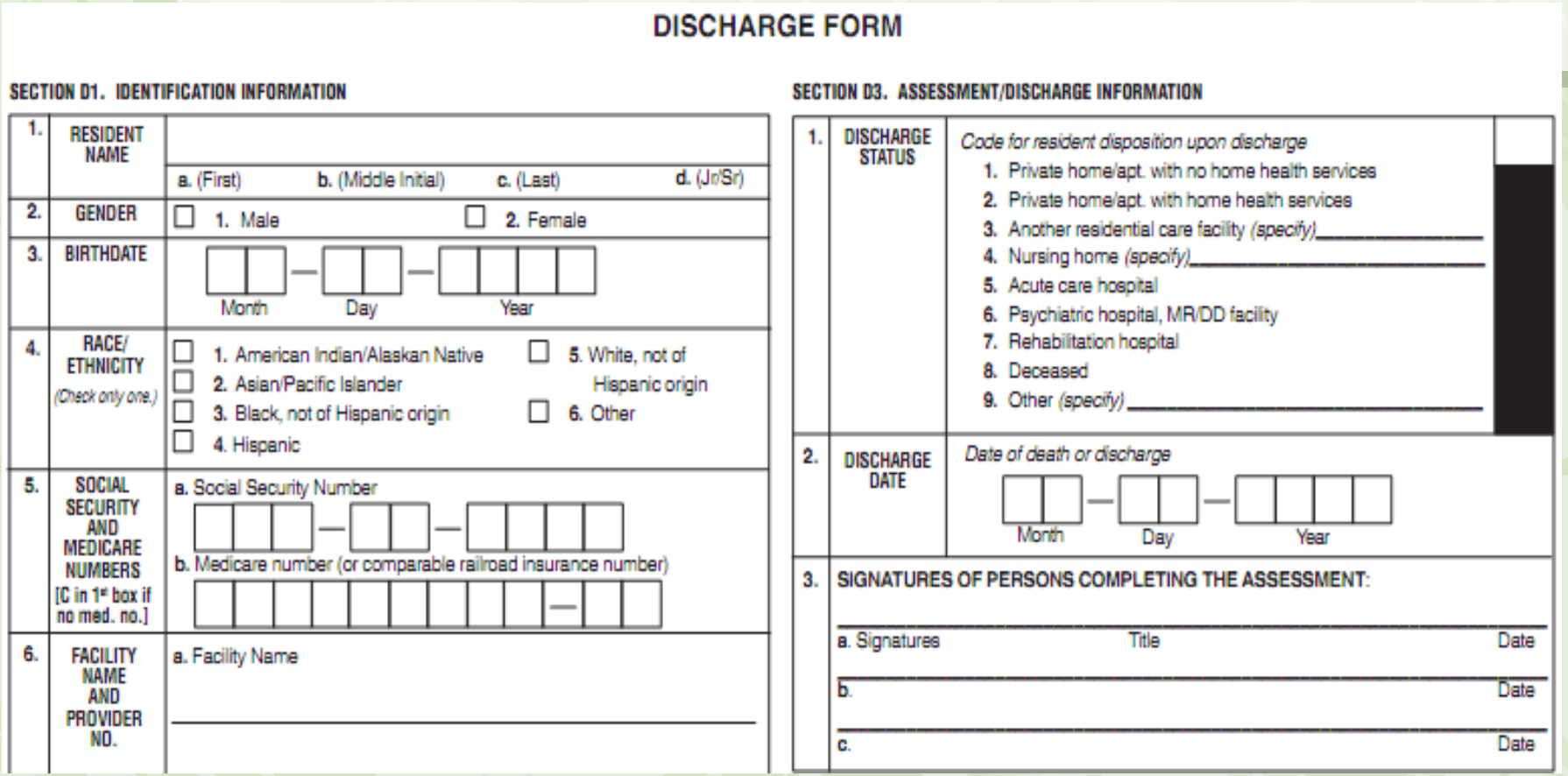
3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the medication was given.

PR = (PRN) as necessary	8H = (q8h) every eight hours	5D = five times a day	5W = five times every week
1H = (qh) every hour	1D = (qd or hs) once daily	1W = (QWeek) once every week	6W = six times every week
2H = (q2h) every two hours	2D = (BID) two times daily	2W = twice every week	1M = (QMonth) once every month
3H = (q3h) every three hours	(includes every 12 hours)	3W = three times every week	2M = twice every month
4H = (q4h) every four hours	3D = (TID) three times daily	QO = every other day	C = continuous
6H = (q6h) every six hours	4D = (QID) four times daily	4W = four times every week	O = other

4. PRN-n (prn — number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

5. DRUG CODE: Enter the National Drug Code (NDC). The last two digits of the 11-digit NDC define package size and have been omitted from the codes listed in the manual Appendix E. If using this Appendix, the NDC should be entered left-justified (the first digit of the code should be entered in the space farthest to the left of the NDC code column). This should result in the last two spaces being left blank.

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes
EXAMPLE: Coumadin 2.5 mg	1	1W		
Digoxin 0.125 mg	1	1D		
Humulin R 25 Units	5	1D		
Robitussin 15cc	1	PR	2	



DISCHARGE FORM

SECTION D1. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	☐ 1. Male ☐ 2. Female
3.	BIRTHDATE	Month Day Year
4.	RACE/ ETHNICITY *(Check only one.)*	☐ 1. American Indian/Alaskan Native ☐ 2. Asian/Pacific Islander ☐ 3. Black, not of Hispanic origin ☐ 4. Hispanic ☐ 5. White, not of Hispanic origin ☐ 6. Other
5.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if no med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name

SECTION D3. ASSESSMENT/DISCHARGE INFORMATION

1.	DISCHARGE STATUS	*Code for resident disposition upon discharge* 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Another residential care facility *(specify)*_____ 4. Nursing home *(specify)*_____ 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other *(specify)*_____
2.	DISCHARGE DATE	*Date of death or discharge* Month Day Year
3.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	a. Signatures Title Date b. Date c. Date

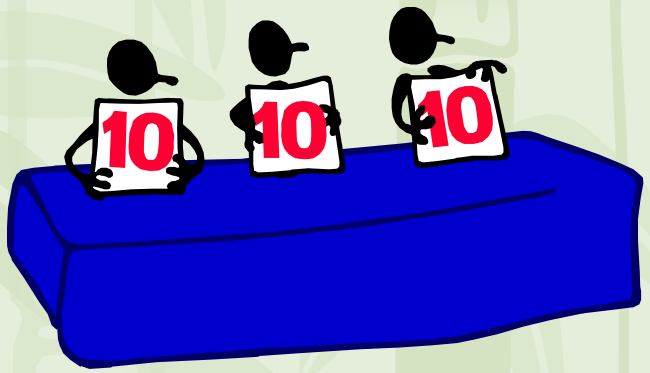
Scoring of the MDS-ALS

3 step process:

1. Calculate ALS (Assisted Living Score)
2. Calculate ADL score
3. Calculate IADL / Bathing (IADL/B) score

Living Assistance Score

Step 1: Calculate Daily Living Skills Score			
Modified Cognitive Skills		If value B3>0 then Score=1, otherwise score =0	
B3	Cognitive skills for daily decision-making		
Indicators of Depression, Anxiety, and/or Sad Mood		Count number of items in Section E1 that are >0. If total count is 0, 1 or 2 then Score = 0; if total count is 3 or more, then score =1 in the shaded score area.	
E1a	Negative statements		
E1b	Repetitive questions		
E1c	Repetitive verbalizations		
E1d	Persistent anger with self or others		
E1e	Self deprecation		
E1f	Expressions of what appear to be unrealistic fears		
E1g	Recurrent statements that something terrible is about to happen		
E1h	Repetitive health complaints		
E1i	Repetitive anxious complaints/concerns		
E1j	mood in morning Unpleasant		
E1k	Insomnia/change in usual sleep pattern		
E1l	Sad, pained, worried facial expressions		
E1m	Crying, tearfulness		
E1n	Repetitive physical movements		
E1o	Withdrawal from activities of interest		
E1p	Reduced social interaction		
E1q	Inflated self-worth		
E1r	Excited behavior, motor excitation		
	Total		
Assistance with use of the telephone or arranging transportation		If value of G5ac or G5ag=1 or 2, Score =1 in the shaded score area, otherwise enter 0 in the shaded area	
G5Ac	Transportation		
G5Ag	Assistance to use telephone		
	Total		
Management of Incontinence Supplies		If H4=0 Score=0; If H4=1, Score=1; If H4=2, Score=2; If H4=3, Score=0	
H4	Ability to manage incontinent supplies		
Self-Administration of Medications		If O5f=1, Score = 0; Otherwise Score = 1;	
O5f	Self-administration of over the counter medications		
Medication Preparation and Administration		If O6=0, Score=1; If O6=1, Score=2; If O6=2, Score=1; If O6=3, Score=0;	
O6	Did resident prepare and administer any of his/her own medications		
Physician's Orders		If value P10>0, Score=1; Otherwise Score=0.	
P10	Number of days physician changed orders		
	Total of all shaded boxes in Step 1, column A. This is the Daily Living Assistance Score		



ADL Score

Step 2: Calculate ADL score			
Activities of Daily Living (ADL)		If response = 0, Score 0; If response = 1, Score 1 If response = 2, Score 2; If response = 3, Score 3 If response = 4, Score 4; If response = 8, Score 4;	
G1Aa	Bed mobility, self-performance		
G1Ba	Transfer, self-performance		
G1Ca	Locomotion, self-performance		
G1Da	Dressing, self-performance		
G1Ea	Eating, self-performance		
G1Fa	Toilet Use, self-performance		
G1Ga	Personal hygiene, self-performance		
	Total all ADL items to calculate ADL score		

IADL / Bathing Score

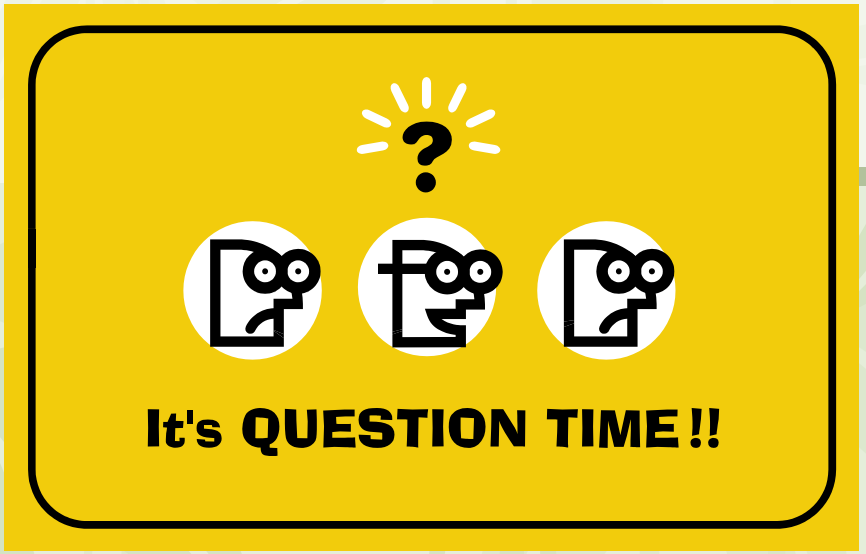
Step 3: Instrumental Activities of Daily Living and Bathing (IADL/B)			
Bathing		If G2 =0, Score=0; If G2 =1, Score=1 If G2 =2, Score=2; If G2 =3, Score=3 If G2 =4, Score=4; If G2 =8, Score=0;	
G2	Bathing, self-performance		
Instrumental Activities of Daily Living		If response = 0, Score=0; If response = 1, Score=1 If response = 2, Score=2; If response = 3, Score=3 If response = 4, Score=4; If response = 8, Score=0;	
G5Aa	Arranging for shopping		
G5Ab	Shopping		
G5Ad	Managing finances		
G5Ae	Managing cash, allowance		
G5Af	Prepares snack		
G5Ah	Light housework		
G5Ai	Laundry		
	Total IADL		
	Total IADL and Bathing (IADL/B)		

Final RUG Score

MaineCare Adult Family Care Home RUG group: Use scores from Living Assistance Score and the higher of ADL and IADL/B scores to determine classification group from chart below.

RUG code

RUG Code	ALS Score	ADL Score	IADL Score	Weight	Rate
AV2	ALS 7-9	ADL 7-28		1.657	$71.68
AV1	ALS 7-9	ADL 0-6		1.210	$52.34
AH2	ALS 5-6	ADL 7-28		1.360	$58.83
AH1	ALS 5-6	ADL 0-6		1.027	$44.43
AM2	ALS 2-4		IADL 12-18	0.924	$39.97
AM1	ALS 2-4		IADL 10-11	0.804	$34.78
AL1	ALS 2-4		IADL 0-9	0.551	$23.84
BC1	Unclassified			0.551	$23.84


It's QUESTION TIME!!

Reminders:

ASK questions!

ASK more questions!

Attend training as needed

Contact Information

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