

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

Section	Page	MDS- RCA Section	Item	Change	Date of change
	Title page		Document Title	Date change to September 2020	8/20/20
			Footers updated on all pages	Footer updated to " <i>Revised Sept 2020</i> "	8/20/20
			All references to "MDS-ALS"	All references to "MDS-ALS" have been changed to "MDS" as the information applies to the MDS for both residential care facilities and adult family care homes	8/20/20
1.1	8		Background and overview	Contact the MDS Helpdesk for more information at 207-624-4095 or via email at MDS3.0.dhhs@maine.gov .	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

1.2	9		Assessor Responsibilities (previously named section 1.3)	<p>Your general responsibilities as an assessor include:</p> <ul style="list-style-type: none"> • reading the training materials; • attending a case mix sponsored training session; This is recommended for residential care facilities (MDS-RCA) and required for adult family care homes (MDS- ALS) in accordance with the MaineCare Benefits Manual. • completing the assigned number of resident assessments in a thorough, efficient and timely manner; • maintaining confidentiality; • editing all completed MDSs for typographical errors and incorrect responses to assure accurate data entry of information into provider software; • submitting all MDS materials, including assessments, tracking forms, discharges, and corrections as instructed and in a timely manner; NOTE: adult family care homes do not utilize or submit tracking forms or corrections. <p>It is the responsibility of the facility staff assessor to complete the MDS in a thorough and accurate manner. One MDS must be completed and submitted for each resident.</p>	8/20/20
1.25	9-11		Facility Responsibilities	Updated information regarding change of ownership; see table on page 11	8/20/20
1.4			Assessment Schedule	Removed from training manual; refer to MaineCare Benefits Manual for schedule of assessments	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

2.1	12		The Importance of Maintaining Confidentiality	You, as the interviewer, need to be aware of relevant laws, regulations, and project rules about confidentiality. This will better prepare you to reassure respondents about the confidentiality of the information that is collected. In addition, you have a responsibility to keep any information you collect totally confidential and not to discuss any home, resident, or staff person by name with anyone other than staff at the Muskie School of Public Service that is the States' designated MDS data-collector or the Department of Health and Human Services. For example, someone may question you about other homes that are participating or about residents' responses. If you respond, "I'm sorry, but that is confidential information, and I am not permitted to discuss it," you will not only be in compliance with the rules and laws but will also provide additional evidence of the sincerity of the facility's confidentiality assurances.	8/20/20
3	15			All references to "client" have been changed to "resident".	8/20/20
4	19	AA	Medicare number	This field may be left blank if there are not enough spaces to accommodate the new numbering system.	8/20/20
5	21	AB	ID/DD	Previous references to MR (mental retardation) have been changed to ID (intellectual disability).	8/20/20
6			Functional Assessment	For Sections A through S	8/20/20
6	33	A2	Medicare number	This field may be left blank if there are not enough spaces to accommodate the new numbering system.	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	35	A3	Significant change in status assessment	<p>3. Significant change in status assessment – A comprehensive reassessment prompted by a “major change” that is not self-limited, that impacts two or more areas of the resident's clinical status, and requires revision of the service plan. The assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. “Self-limiting” means the condition will normally resolve itself without further intervention or by staff implementing standard interventions within 14 days.</p> <p>A Significant Change assessment is warranted if there is a consistent pattern of change with two or more areas of decline or improvement of the resident's clinical status. Documentation of the identification of an event or situation that may lead to completion of a significant change assessment must be in the resident's clinical record. This note will serve as the beginning of the observation period to determine if there are changes in the resident's condition that meet the definition of “significant change” (i.e. a major change that is not self-limiting, impacts two or more areas of the resident's clinical status, and requires revision of the service plan) to ensure the change in the resident's needs is being addressed. A single note in the clinical record on or around the assessment date (item A5) indicating the resident had a significant change without documentation of the qualifying</p>	8/20/20
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
Adult Family Care Homes

				<p>characteristics does not meet the requirements for a significant change.</p> <p>The MDS assessment must be completed at item S2b with revision of the service plan no later than 14 days after the identification of the event or situation that lead to completion of the significant change assessment.</p> <p>The next assessment would be due 180 days from the S2b date of the significant change assessment.</p>	
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	42	B3	Cognitive Skills for Daily Decision-Making	<p>Process: Review the clinical record. Consult family and caregiver staff. Observe the resident. <i>The inquiry should focus on whether the resident is actively making these decisions, and not whether staff believes the resident might be capable of doing so. A resident who makes a poor decision is still making a decision.</i></p> <p>Remember the intent of this item is to record what the resident is doing (performance). When a staff member has taken decision-making responsibility away from the resident regarding tasks of everyday living, or the resident is unable to participate in decision-making, the resident should be considered to have impaired performance in decision-making. This item is especially important for further assessment and care planning in that can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence. When coding, identify the most representative level of function, not necessarily the highest. Staff must use clinical judgment to decide if a single observation provides sufficient information on the resident's <i>typical</i> level of function. There must be documentation to support all coding on the MDS. The look back period for this item is seven days.</p> <p>The clinical record must include documentation of the resident's <i>actual</i> performance in making everyday decisions about tasks or activities of daily living within the look back period. The</p>	8/20/20
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020

Adult Family Care Homes

				documentation must include specific examples of resident behaviors and ability to make decisions to support the coding selected.	
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	42	B3	Cognitive Skills for Daily Decision-Making	<p>Coding: Check the numbered box that is the <i>most representative</i> level of function, not necessarily the highest. Staff must use clinical judgment to decide if a single observation provides sufficient information on the resident's typical level of function.</p> <p>0. Independent – The resident's decisions were consistent and reasonable (reflecting lifestyle, culture, values); the resident organized daily routine and make decisions in a consistent, reasonable, and organized fashion.</p> <p>1. Modified Independence – The resident organized daily routine and made safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations. If there have been no new tasks or situations within the look back, this choice cannot be coded.</p> <p>2. Moderately Impaired – The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and conducting daily routines.</p> <p>3. Severely Impaired – The resident's decision-making was severely impaired; the resident never made independent decisions. If the resident does not respond to reminders, cues, or supervision, the resident is dependent on others for everyday decision-making.</p>	8/20/20
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	48	E1	Indicators of Depression, Anxiety, Sad Mood	Intent: To record the frequency of indicators observed and reported <i>in the last 28 days</i> (or <i>since admission if less than 28 days</i>), irrespective of the assumed cause of the sign or symptom (behavior).	8/20/20
6	50	E	Coding clarification	For E1o and E1p, there must be documentation in the clinical record of the coder's rationale for coding a change.	8/20/20
6	50	E1	Indicators of Depression, Anxiety, Sad Mood	Process: Review daily staff documentation, consult with or interview staff across all shifts for the time frame of the observation. Daily staff documentation for all shifts is the preferred method to support the coding of these indicators. When daily documentation is not utilized, the results of the consultations and/or interviews must be documented in the resident's record to support the entire time frame. <i>If the loss of interest items (E1o. and E1p) have occurred during the look back period but is not a change in the usual pattern for the resident, this information could be referenced in the monthly summary or other areas of documentation in the resident's clinical record.</i> Evaluation of staff documentation will allow the facility to be aware of changes in the resident's behavior.	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	51	E1	Indicators of Depression, Anxiety, Sad Mood	<p>Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 28 days. Remember; code regardless of what you believe the cause to be. For E1o and E1p, there must be documentation in the clinical record of the coder's rationale for coding a change. (9/1/20)</p> <p>CODING:</p> <p>0. Indicator exhibited less than one day <i>each</i> week in last 28 days</p> <p>1. Indicator exhibited one to five <i>days</i> per week during the past 28 days. Behavior must have occurred at least one day every week.</p> <p>2. Indicator exhibited daily or almost daily (6 to 7 <i>days</i> each week) during the past 28 days or the average of the four weeks is 6.0 or greater.</p> <p>NOTE: <u>Average</u> is defined as the total of the values for each week in the look back period divided by number of weeks in the look back period.</p> <p>See page 51 of the training manual to view a sample posting of the E1 calculator. Please contact the MDS help desk to request a copy of the look back calculator that includes the E1 calculator</p>	8/20/20
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	53	E4h	Dangerous non-violent behavior	h. Dangerous non-violent behavior - e.g., falling asleep while smoking, leaving walker behind when walking, taking oxygen off when in use, not calling for help when transferring. There must be documentation to support the coding of this item. (additional examples added)	8/20/20
6	60	G1	f. Toileting	f. Toilet Use – How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.	8/20/20
6	60	G1	g. Personal Hygiene	g. Personal Hygiene – How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands and perineum. A partial bath or partial sponge bath is included in personal hygiene. This item does not include a shower or full bath of any type.	8/20/20
6	63	G1	Coding of Self-Performance for Supervision	1. Supervision – Oversight, encouragement, or cueing provided three or more times during last seven days –OR- supervision one or two times plus physical assistance provided only one or two times during last seven days.	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	63	G1	Coding of Self-Performance for Supervision	Supervision of eating involves direct supervision of the resident. Oversight of all residents in the dining room cannot be coded as supervision for the individual resident. The service plan must describe the need for supervision, i.e. related to risk of choking, the resident needs direct cueing in order to eat, etc.	8/20/20
6	63	G1	Coding of Self-Performance for Limited Assistance	Limited Assistance – Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance on three or more occasions –OR- limited assistance one or two times plus weight-bearing support provided only one or two times during last seven days.	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	64	G1	Coding of Self-Performance of ADL (clarification of rule of three for activities occurring three or more times at different levels)	<p>There will be times when no single type or level of assistance is provided to the resident three or more times during a seven-day period. If the activity occurred three or more times, but at different levels, the higher levels can be converted to the next lower level. If the next lower level, including the converted values, occurred three or more times, code the lower level on the MDS.</p> <p>Example: A resident required supervision 18 times, limited assistance two times, and extensive assistance one time during the seven-day look-back period. Convert the extensive level to limited assistance (next lower level). Now the lower level of limited assistance has occurred three times and can be coded on the MDS.</p>	8/20/20
6	70	G2	Bathing	<p>Definition: Bathing – How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair. This does not include a partial bath or sponge bath. <i>Cleansing of parts of the body, rather than a full-body cleansing, would be included in personal hygiene (G1.g)</i></p>	
6	72	G5A	IADL Self-Performance	<p>Definition: IADL Self-Performance – Measures what the resident actually did (not what he or she might be capable of doing) each time the activity occurred within each IADL category over the last 30 days according to a performance-based scale.</p>	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	73	G5A	IADL Self-Performance	Under Process : Staff documentation should capture whether the activity occurred each shift, the resident's level of self-performance and the level of staff supported provided.	8/20/20
6	74	G5A	IADL Self-Performance	This is the documentation on the MDS by the MDS coordinator that reflects the resident's self-performance over the 30-day look back period. Staff documentation would capture whether the activity occurred each shift, the resident's level of self-performance and the level of staff support provided.	8/20/20
6	81	H4.	Use of Incontinence Supplies	Intent: To determine and record the <i>resident's ability to manage</i> incontinence supplies, including pads, briefs, an ostomy, or a catheter, in the last 14 days. To "manage supplies" means to change the pad or brief, empty catheter and/or ostomy bag; it does not refer to ordering supplies or putting them away when supplies arrive.	8/20/20
6	84	I	z. Quadriplegia	z. Quadriplegia - Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury. Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition	8/20/20
6	85	I	ww. Explicit Terminal Prognosis	Primary Physician has documented in the record that the resident is terminally ill and, in his/her clinical experience, not expected to have more than 6 months to live. This judgment must be substantiated with a well-documented disease, diagnosis and deteriorating clinical course	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	86	I2	Other Current Diagnoses	Coding - Enter the description of the diagnoses on the lines provided. <i>It is not necessary to enter an ICD code as it not used to calculate quality measures or RUG groups.</i>	8/20/20
6	87	J1	e. Delusions	e. Delusions – Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., that he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned). Documentation must include a description of the delusions and evidence that the resident’s delusion was false. <i>A resident’s repetitive delusions should be referenced on the service plan.</i>	8/20/20
6	92	J7	Accidents	Definition: a. Fell in the past 30 days. b. Fell in the past 31-180 days c. Hip fracture – in last 180 days. d. Other fracture in last 180 days – Any fracture other than a hip fracture within the last 180 days.	8/20/20
6	97	M1	b. Burns	b. Burns (second or third degree) – Includes burns from any cause (e.g., heat, and/or chemicals) in any state of healing and treatments received within the 7-day look back period. This category does not include first degree burns (changes in skin color only). <i>The degree of the burn must be documented in the record by a physician or a registered nurse.</i>	9/1/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	98	M2	Ulcers	<p>NOTE: If eschar and necrotic tissue are covering and preventing adequate staging of a pressure ulcer, the assessor will document and code the pressure ulcer as a Stage IV until the eschar has been debrided (surgically or mechanically) to allow staging. These instructions must be followed for MDS coding purposes until they are revised. Although the AHCPR and NPUAP system for staging pressure ulcers indicates that the presence of eschar precludes accurate staging of the ulcer, the facility must use these directions in order to code the MDS, but not necessarily to render treatment. Documentation must accurately reflect findings from assessments that were conducted.</p> <p>For the MDS assessment, staging of ulcers should be coded in terms of what is seen during the look back period. For example, a healing stage 3 that has the appearance of a stage 2 pressure ulcer must be coded as a “2” for purposes of the MDS assessment.</p> <p>Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.</p>	8/20/20
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Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	104	O3	Injections	<p>Due to potential systemic and/or local complications from injections, it is important that staff ask the resident about the following situations:</p> <ul style="list-style-type: none"> • Actual administration is being done • Any difficulties with the administration procedure • Any distressing signs or symptoms that could be attributed to the medication • Any signs or symptoms of problems at the injection site <p>There must be documentation to support that communication between resident and staff occurred, even if there were no complications.</p>	8/20/20
6	105	O5	Self-administered medications	<p>Process: Self-administration requires an assessment of the resident's safety to self-administer and a physician's order that would allow for resident's to have medications at the bedside and to self-administer. Document if the client did or did not <i>self-administer</i> any over-the-counter meds in the provider notes, monthly summaries, or the assessment tool. This would mean that the facility provided no assistance, over-sight, or cuing to the client.</p>	8/20/20
6	105	O6	Medication preparation and administration	<p>Process: Documentation is required in the clinical record, monthly summary, or the medication administration record to support the coding.</p>	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	106	O8	Misuse of Medication	<p>Process: <i>Misuse of medication can involve substances other than narcotics or opioids.</i> Does the resident take more or less than the medication prescribed? Do they run out of medication earlier than is expected? Do they take medications for purposes other than what the medication is intended, e.g., cough medicine to relax or to get high? Do they use inhaler correctly, incorrect administration can lead to too much or too little medication being delivered? Does a resident who uses a nicotine patch also smoke cigarettes or use another form of tobacco?</p>	8/20/20
6	109	P1b	Respiratory therapy	<p>d. Respiratory therapy – Included are coughing, deep breathing, nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional, such as a registered nurse or respiratory therapist. Does not include hand-held medication dispensers (e.g., inhalers). Count only the time that the qualified professional spends with the resident.</p>	8/20/20
6	110	P2	Intervention Program for Mood, Behavior, Cognitive Loss	<p>Intent: To record all interventions and strategies used in the last 7 days (unless a different time frame is specified). The service plan should clearly identify the following information: 1. the problem, situation, or challenge being addressed, 2. the goal of the program, and 3. Approaches to be used</p>	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	112	P3b	New Treatment	<p>Intent: P3b. New Treatment: To record specific monitoring required by the resident for possible serious, untoward side effects related to a new medication or for effectiveness of a newly prescribed treatment.</p> <p>Serious or untoward side effects:</p> <ul style="list-style-type: none"> • May result in death • May be life threatening • May lead to hospital admission or evaluation • May require intervention to prevent disability or permanent damage • May be an allergic or other systemic reaction <p>If the resident has been placed on a <i>new</i> medication, administered by any route, that requires special monitoring for serious side effects or drug interactions, it may be coded in this area. An increase or decrease in the dosage of a medication is not a new medication.</p> <p>If the resident has a <i>newly prescribed</i> treatment that must be assessed for effectiveness, it could be coded in this area.</p>	8/20/20
6	112	P3	Need for ongoing monitoring	<p>If more than one person is responsible code for the highest level. If both a licensed staff nurse and other facility staff are monitoring, code licensed staff nurse. If both home health nurse and other staff are monitoring, code home health nurse.</p>	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	112	P3	Need for ongoing monitoring	<p>Process: The need for on-going monitoring of an acute condition (unstable, fluctuating, medically complex) or new treatment/medication must be documented by the physician or a Registered Nurse, including a description of what monitoring is required. <i>Review the resident's clinical record. Clinical records must contain documentation by the person coded as being responsible for the monitoring to show that monitoring has occurred during the look back period</i></p>	8/20/20
6	115	P10	Physician Orders	<p>Physician Orders - Includes written, telephone, fax or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. <i>Do not count visits or orders prior to the date of admission or reentry.</i></p>	8/20/20
6	116	P11	Abnormal Lab Values	<p>Definition: Abnormal is being defined as out of normal range according the reporting laboratory.</p>	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

6	118	P2	Signatures	<p>The S2b date must be signed as being complete within 7 days of the Assessment date (item A5). When calculating the due date for subsequent assessments, the S2b date is day 1.</p> <p>Clarification notes written after the S2b (completion) date will not be accepted as supporting documentation for a case mix review.</p>	8/20/20
6	118	S3	Case Mix Group	<p>Intent: The Case Mix Group refers to the MaineCare reimbursement system established by the Department of Health and Human Services. The group is calculated from certain items in the MDS that reflects the amount of resources required to care for the resident. Residents are grouped according to their resource use.</p> <p>Coding: After the state or designated agent processes the MDS, the facility will receive a validation report identifying the Case Mix Group for that assessment. The Case Mix Group will be calculated automatically if using an approved vendor software and will also be on the final validation report. <i>If you are an adult family care home and not using an approved vendor software product, the case mix index or Resource Utilization Group (RUG) will be on the final validation report.</i></p>	8/20/20
7	121	D1.5	Medicare numbers	This field may be left blank if there are not enough spaces to accommodate the new numbering system.	8/20/20

Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
 Adult Family Care Homes

8	125	8.2	Final Field Edits	<p>8.2. Final Field Edits</p> <p>As soon as possible after you complete all work on an MDS, you will perform a thorough edit of each MDS section. This final edit must be performed as soon as possible while details are still fresh in your mind and while you have a chance to make needed additions or corrections. Careful attention to detail during the editing process will guarantee an accurate assessment.</p> <p>If you are completing the MDS electronically, it is the responsibility of the Assessor to verify that the data submitted matches the data on the printed form. Any discrepancies must be rectified before submitting the MDS to the state or designated agent.</p>	8/20/20
9	125	9	Semi Annual Assessment	<p>9. SEMI ANNUAL ASSESSMENT</p> <p>A new assessment is required within 180 days of the S2b date of the previous assessment, on an ongoing basis for as long as the resident resides in the facility, according to guidelines and time frames provided by the Department of Health and Human Services. If, at any time, a Significant Change in status assessment is submitted the “clock” will be reset for all subsequent assessments. If you are requested to perform another assessment by a nurse reviewer, the “time clock” will also be reset for all subsequent assessments.</p>	8/20/20
10	126-135	10	Correction of the MDS	<p>This section applies to Residential Care Facility only. It does not apply to Adult Family Care Homes</p>	8/20/20