Change Table for *MDS-ALS and RCA Manual*, Effective 9/1/2020
Residential Care Facilities

Section	Page	MDS-RCA Section	Item	Change	Date of change
	Title page		Document Title	Date change to September 2020	9/1/20
			Footers updated on all pages	Footer updated to "*Revised Sept 2020*"	9/1/20
			All references to "MDS-RCA"	All references to MDS-RCA have been changed to MDS as the information applies to the MDS for both residential care facilities and adult family care homes	9/1/20
1.1	8		Background and overview	Material incorporated from MDS-ALS manual that is pertinent to the MDS process	9/1/20
1.2	9		Assessor Responsibilities	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.	9/1/20
1.25	9-11		Facility Responsibilities	Information added regarding new facilities, transfer or residents, facility closing, facility change in level of care and change of ownership	9/1/20

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.	9/1/20
4	19	AA	Medicare number	This field may be left blank if there are not enough spaces to accommodate the new numbering system.	9/1/20
5	21	AB	ID/DD	Previous references to MR (mental retardation) have been changed to ID (intellectual disability).	9/1/20
6	33	A2	Medicare number	This field may be left blank if there are not enough spaces to accommodate the new numbering system.	9/1/20
6	51	E	Coding clarification	For E1o and E1p, there must be documentation in the clinical record of the coder's rationale for coding a change.	9/1/20

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)	9/1/20
6	54-55	E4	Behavior symptoms	Clarification that Column A is Frequency, Column B is Alterability, and Column C is History	9/1/20
6	72	G5A	IADL Self-Performance	**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.	9/1/20
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.	9/1/20
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.	9/1/20

6	81	H4.	Use of Incontinence Supplies	Intent: To determine and record the *resident's ability to manage* 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.	9/1/20
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	9/1/20
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. *A resident's repetitive delusions should be referenced on the service plan.*	9/1/20
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). *The degree of the burn must be documented in the record by a physician or a registered nurse.*	9/1/20

6	104	O4a	Days received the following medications	Medications include prescriptions for antipsychotics (such as Haldol), antianxiety (such as Ativan), hypnotics (such as Restoril), and antidepressants (such as Elavil), diuretics (such as Lasix), dementia treatment (Aricept *or any dementia treatment drug*), and injectable Insulins.	9/1/20
6	105	O5	Self-administered medications	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 *self-administer* 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.	9/1/20
6	105	O6	Medication preparation and administration	Process: Documentation is required in the clinical record, monthly summary, or the medication administration record to support the coding.	9/1/20
6	106	O8	Misuse of Medication	Process: ***Misuse of medication can involve substances other than narcotics or opioids.*** 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?	9/1/20

6	110	P2	Intervention Program for Mood, Behavior, Cognitive Loss	**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	9/1/20
6	112	P3	Need for ongoing monitoring	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.	9/1/20
6	115	P10	Physician Orders	**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. *Do not count visits or orders prior to the date of admission or reentry*.	9/1/20

6	118	S3	Case Mix Group	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. 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. *If you are an adult family care home and not using an approved vendor software, the case mix or Resource Utilization Group (RUG) will be on the final validation report.* (the last sentence is not applicable to residential care facilities)	9/1/20
7	121	D1.5	Medicare numbers	This field may be left blank if there are not enough spaces to accommodate the new numbering system.	9/1/20