Documentation Requirements for MDS-ALS for Adult Family Care Homes

One of the important functions of the MDS-ALS assessment is to generate an updated, accurate picture of the resident's health status.

This document is to help with the understanding of the what case mix team will be looking for to verify the MDS coding. this document is not to minimize the need to refer to the manual for all coding instructions. When you find conflicting reports about a resident's functioning in a particular area, seek additional information to clarify the issue and, when possible, resolve the apparent conflict. When a conflict remains, use your best judgment in reaching a decision.

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. Clarification notes written after the S2b (completion) date will not be accepted as supporting documentation for case mix review purposes.

MaineCare Benefits Manual Chapter II, Section 2.07-1A.1 Assessments for Service Planning:

A person trained in the use of the MDS-ALS must conduct the initial assessment within 30 days of admission. Providers must use the Department-approved tool (MDS-ALS) according to the instructions in the training manual for the MDS-ALS tool.

MaineCare Benefits Manual Chapter II, Section 2.07-1A.3 Reassessments:

After the initial assessment, the member shall receive an assessment using MDS-ALS at least once every six months, or sooner in the event of a significant change, either an improvement or decline, in his or her functional status. The assessments will be sequenced from the date in Section S.2.B. of the MDS-ALS, assessment completion date. Providers must complete subsequent assessments within 180 days from the date in S.2.B. Providers must complete significant change assessments within 14 days after determination is made of a significant change in resident status as defined in the training manual for the MDS-ALS tool. Providers must complete a resident tracking form within 7 days of the discharge, transfer or death. The provider must maintain all completed assessments within the previous 12 months in the member’s active record.

MaineCare Benefits Manual Chapter II, Section 2.07-1A.4.c Accuracy of Assessments:

The Department requires documentation to support the time periods and information coded on the MDS-ALS.

MDS-ALS Item	Field	Commentary
B3	Cognitive Skills for Daily Decision-Making	Clinical record must include documentation of the resident's actual performance in making everyday decisions about tasks or activities of daily living within the 7 day look back period. The documentation must include specific examples of resident behaviors and ability to make decisions to support the coding selected.
E1a-r	Indicators of Depression	Documentation in the clinical record to support the frequency of indicators coded on the MDS and as reported or observed in the last 28 days (or since admission if less than 28 days), Refer to the manual for the for specific coding requirements for the loss of interest items E1o and E1p.
G5ac G5ag	Assistance with telephone use; Assistance with arranging transportation	Staff daily documentation must include documentation within the 30-day look-back period must show the level of resident "self- performance" and staff involvement for each Item for the days the activity occurred. Documentation in the clinical record must support the level of independence that *best represents* the resident's functioning Evidence based on review of staff documentation over the last 30 days.
H4	Use of incontinent supplies	Documentation within the record of resident's management of incontinence supplies (pads, briefs, ostomy and/or catheter supplies) within the 14-day look back. 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.
O5f	Administration of OTC medications	Documentation within the 7-day look-back period must show that the resident DID NOT self-administer any OTC meds.
O6	Medication preparation and administration by the resident	Documentation must include a current physician order for resident self-administered medications AND Documentation within the 7-day look-back must show all medications that were PREPARED and ADMINISTERED by the resident.

P10	Physician order change days	Code the number of days there were changes in the physician's orders during the 14-day look back period. Written, telephone, fax or consultation orders for new or altered treatment. Does NOT include admission orders, re-entry orders, clarifying, or renewal orders without changes. Do NOT count orders received prior to the date of admission or re-entry.

Documentation for ADL Scores

MDS-ALS item	Field	Commentary
G1aa G1ba G1ca G1da G1ea G1fa G1ga	Bed mobility Transfer Locomotion Dressing Eating Toilet use Personal hygiene	Documentation to support the total picture of the resident's ADL self-performance over the 7-day look back period, 24 hours per day, with all shifts present. Only self-performance counts toward the ADL score. Refer to the MDS Training manual for coding of G1eA, Eating-Supervision.

Documentation for IADL and Bathing Score

MDS-ALS Item	Field	Commentary
G2	Bathing (self-performance)	Documentation within the 7-day look-back period must show the resident's self-performance and support provided each time bathing (full body bath) occurred. Apply the code number that reflects the maximum amount of assistance, on the MDS Form.
G5aa G5ab G5ad G5ae G5af G5ah G5ai	Arrange shopping Shopping Manage finances Manage cash Prepare snacks Light housekeeping Laundry	Staff daily documentation must include documentation of resident "self-performance" and staff involvement for each Item for the days the activity occurred, within the 30-day look-back period. Documentation in the clinical record must support the level of independence that *best represents* the resident's functioning; documentation is based on review of staff documentation over the last 30 days.