



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 24, 2016

██████████
The Grand Pavilion for Rehabilitation and Nursing at Rockville Centre
(aka Rockville Operating, LLC)
41 Maine Avenue
Rockville Centre, New York 11570

Re: MDS Final Audit Report
Audit #: 13-4658
Provider ID#: ██████████

Dear ██████████

This is the final audit report of findings with regard to the Office of the Medicaid Inspector General's (OMIG) Minimum Data Set (MDS) audit of The Grand Pavilion for Rehabilitation and Nursing at Rockville Centre (aka Rockville Operating, LLC) for the census period ending January 25, 2012. In accordance with 18 NYCRR §517.6, this final audit report represents the OMIG's final determination on issues found during OMIG's review.

We received your response to our draft audit report dated November 25, 2015. Your comments have been considered (see Attachment D) and the findings in the final audit report remain identical to the draft audit report.

The Medicaid overpayment of \$103,360.36 was calculated using the number of Medicaid days paid for the rate period July 1, 2012 through December 31, 2012 and the change in the direct component of your Medicaid rate as calculated by the Department of Health's Bureau of Long Term Care Reimbursement (BLTCR). The calculation of this overpayment is detailed in Attachment A. BLTCR will adjust your Medicaid rates for the relevant rate period to reflect the change in the direct component. The findings explanation, regulatory references, and applicable adjustment can be found in the attachments following Attachment A.

The Provider has the right to challenge this action and determination by requesting an administrative hearing within 60 days of the date of this notice. If the Provider wishes to request a hearing, the request must be submitted in writing to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

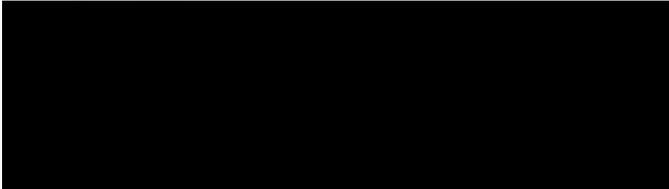
Questions regarding the request for a hearing should be directed to Office of Counsel, at ██████████

In accordance with 18 NYCRR 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Should you have any questions regarding the above, please contact [REDACTED].



Division of Medicaid Audit
Office of the Medicaid Inspector General



OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE GRAND PAVILION FOR REHABILITATION AND NURSING AT ROCKVILLE CENTRE
AUDIT # 13-4658
CALCULATION OF AUDIT IMPACT

RATE TYPE	DECREASED IN DIRECT COMPONENT OF RATE*	MEDICAID DAYS	IMPACT
Part B Eligible/Part B D Eligible	\$4.84	21,254	\$102,869.36
Non-Medicare/Part D Eligible	\$4.91	100	\$491.00
Total			<u>\$103,360.36</u>

*Rounded to nearest 1/100th New York State Department of Health Bureau of Managed Long Term Care Rate Setting / FFS

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 THE GRAND PAVILION FOR REHABILITATION AND NURSING AT ROCKVILLE CENTRE
 AUDIT #13-4658
 FINDINGS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS								
					DISALLOW BED MOBILITY SELF PERFORMANCE	DISALLOW BED MOBILITY SUPPORT PROVIDED	DISALLOW TRANSFER SELF PERFORMANCE	DISALLOW TRANSFER SUPPORT PROVIDED	DISALLOW EATING SELF PERFORMANCE	DISALLOW TOILET USE SELF PERFORMANCE	DISALLOW TOILET USE SUPPORT PROVIDED	DISALLOW SPECIAL TREATMENTS, PROCEDURES	
1	CA2	CA2	0.84	0.84	1		1				1		
2	CB1	CA1	0.86	0.77	1		1						
3	CC1	IA1	0.98	0.61	1		1		1		1		
4	IB1	CA1	0.78	0.77	1		1						
5	SSC	CA2	1.12	0.84	1		1		1		1		
6	CB2	CA2	0.91	0.84	1		1						
7	IB1	CA1	0.78	0.77	1		1						
8	SSB	CA2	1.06	0.84	1	1	1						
9	PE1	IA1	0.79	0.61	1		1		1		1		
10	CC1	CA1	0.98	0.77	1		1		1		1		
11	RHC	RMA	1.40	1.17	1		1						
12	CA2	CA2	0.84	0.84	1		1						
13	IB1	CA1	0.78	0.77			1						
14	PD1	PA1	0.72	0.46	1		1						
15	CC1	CA1	0.98	0.77	1		1		1		1		
16	CC1	CA1	0.98	0.77	1		1		1		1		1
17	SSC	CA2	1.12	0.84	1		1		1		1		
18	IB1	CA1	0.78	0.77	1		1						
19	CA1	CA1	0.77	0.77	1		1						
20	SSB	CA2	1.06	0.84	1		1						
21	PD2	PA2	0.73	0.48	1		1						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 THE GRAND PAVILION FOR REHABILITATION AND NURSING AT ROCKVILLE CENTRE
 AUDIT #13-4658
 FINDINGS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS							
					DISALLOW BED MOBILITY SELF PERFORMANCE	DISALLOW BED MOBILITY SUPPORT PROVIDED	DISALLOW TRANSFER SELF PERFORMANCE	DISALLOW TRANSFER SUPPORT PROVIDED	DISALLOW EATING SELF PERFORMANCE	DISALLOW TOILET USE SELF PERFORMANCE	DISALLOW SPECIAL TREATMENTS, PROCEDURES	
22	SSC	IB1	1.12	0.78	1	1	1		1	1		
23	CC2	CA2	1.12	0.84	1		1		1	1		
24	RMB	RMA	1.22	1.17	1		1			1		
25	SSC	CA2	1.12	0.84	1		1	1	1	1	1	
26	RHC	RMA	1.40	1.17	1		1			1		
27	SSC	CA1	1.12	0.77	1		1		1	1		
28	RMX	RMA	1.96	1.17	1	1	1	1	1	1	1	1
TOTALS					27	3	28	2	12	28	2	1

**OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE GRAND PAVILION FOR REHABILITATION AND NURSING AT ROCKVILLE CENTRE
AUDIT #13-4658
MDS DETAILED FINDINGS**

MDS FINDINGS**SAMPLE SELECTION****Functional Status-ADL Self-Performance and Support**

If the provider is unable to produce the supporting documentation for the patient, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.

Documentation must indicate an assessment was done to evaluate the need for assistance with activities of daily living (ADL's), altered gait and balance, and decreased range of motion (ROM). MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xvii)
MDS Manual 3.0 G0100-0900*

Bed Mobility Self-Performance

In 11 instances, documentation did not support resident required total assist every time.

3, 5, 8, 9, 10, 15, 16, 17, 22, 25, 27

In 6 instances, documentation did not support resident required weight bearing assist three or more times.

6, 11, 20, 23, 26, 28

In 10 instances, documentation did not support resident required non weight bearing assist three or more times.

1, 2, 4, 7, 12, 14, 18, 19, 21, 24

Bed Mobility Support Provided

In 2 instances, documentation did not support resident was a 2+ person physical help at least once.

8, 22

In 1 instance, documentation did not support resident was a one person physical help at least once.

28

Transfer Self-Performance

In 10 instances, documentation did not support resident required total assist every time.

3, 5, 8, 9, 10, 16, 17, 20, 22, 27

In 9 instances, documentation did not support resident required weight bearing assist three or more times. 2, 11, 13, 15, 21, 23, 25, 26, 28

In 9 instances, documentation did not support resident required non weight bearing assist three or more times. 1, 4, 6, 7, 12, 14, 18, 19, 24

Transfer Support Provided

In 1 instance, documentation did not support resident was a 2+ person physical help at least once. 25

In 1 instance, documentation did not support resident was a one (1) person physical help at least once. 28

Eating Self-Performance

In 8 instances, documentation did not support resident required total assist every time. 3, 5, 10, 16, 17, 22, 25, 27

In 3 instances, documentation did not support resident required weight bearing assist three or more times. 9, 15, 23

In 1 instance, documentation did not support resident required supervision one or more times. 28

Toilet Use Self-Performance

In 12 instances, documentation did not support resident required total assist every time. 3, 5, 8, 9, 10, 15, 16, 17, 20, 22, 23, 27

In 8 instances, documentation did not support resident required weight bearing assist three or more times. 2, 6, 11, 13, 14, 25, 26, 28

In 8 instances, documentation did not support resident required non weight bearing assist three or more times. 1, 4, 7, 12, 18, 19, 21, 24

Toilet Use Support Provided

In 1 instance, documentation did not support resident was a 2+ person physical help at least once. 25

In 1 instance, documentation did not support resident was a one person physical help at least once. 28

Special Treatments, Procedures, and Programs

If the provider is unable to produce the supporting documentation for the patient, the service will be disallowed and the Case Mix will be adjusted. A repayment schedule will be developed.

The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specific time periods. MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xv)
MDS 3.0 Manual O0100-0300, O0600-0700*

In 1 instance, documentation did not support the number of days with MD exams during the look back period. 16

In 1 instance, documentation did not support the number of days with MD orders during the look back period. 16

RUGS-II Classifications Overturned

In 25 instances, the RUG classifications were overturned. 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28

10 NYCRR §86-2.10, Volume A-2

OFFICE OF THE MEDICAID INSPECTOR GENERAL
THE GRAND PAVILION FOR REHABILITATION AND NURSING
AT ROCKVILLE CENTRE
AUDIT #13-4658

All OMIG disallowances were accepted by the Facility except for those shown below. The following details the disposition of the draft report disallowances after consideration of the Facility's draft audit report response comments.

Sample #2

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD): 01/16/12.
The 7-Day Look Back Period: 01/16/12 – 01/10/12.

Documentation submitted and reviewed:

MDS Section G dated 1/16/12, Nursing Assistant Accountability Record dated January 2012, Rockville Nursing Center Interdisciplinary Care Plan dated 12/2/11 and updated 4/4/12, 5/24/12, 5/31/12.

The CNA Accountability Record is a check list format documenting ADL Self Performance Levels. There is no documentation on every shift that indicated what care was provided, nor is there evidence of an interview conducted by a licensed staff with the nursing assistant.

Resident Care Plans are unacceptable sources of documentation to support ADL levels claimed on the MDS. They are the final product as a result of data collection to complete the MDS.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only.
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support the MDS manual Chapter 4: Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #3

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and "nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care". The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page1, created by RN. If there is a care level change the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures' acknowledges that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):12/21/11

The 7-Day Look Back Period: 12/21/11 – 12/15/11

Documentation submitted and reviewed:

MDS Section G dated 12/21/11, Nursing Assistant Accountability Record dated December 2011, Rockville Nursing Center Interdisciplinary Care Plan dated 09/20/11 and updated 12/14/11, 3/12/12, 5/21/12, and the PT/OT Rehabilitation screen dated 9/30/11.

The CNA Accountability Record is a check list format documenting ADL Self-Performance Levels. There is no documentation on every shift that indicated what care was provided, nor is there evidence of an interview conducted by a licensed staff with the nursing assistant. To be a level 4, Total assist, the event must have been total care every time care was provided.

Resident Care Plans are unacceptable sources of documentation to support ADL levels claimed on the MDS. They are the final product as a result of data collection to complete the MDS.

The rehabilitation – PT/OT Screen is dated three months prior to the ARD. The screen is a snapshot in time. The MDS is seeking the actual care given in a specific time period. Section G is for the care giver and does not require or expect therapy intervention.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual' ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA): Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #5

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):01/23/12.

The 7-Day Look Back Period: 01/23/12 – 01/17/12.

Documentation submitted and reviewed:

MDS Section G dated 01/23/12, Nursing Assistant Accountability Record dated January 2012, Rockville Nursing Center Interdisciplinary Care Plan dated 03/11/11 and updated 04/26/11, 5/27/11, 8/12/11, 8/24/11, 9/6/11 and 9/20/11. Also another care plan was dated 4/12/12/ and updated 6/29/12, 8/7/12 and 9/14/12 which was after the ARD. There was a medex with the tube feeding listed, and an interdisciplinary alteration in nutritional status care plan dated 1/30/12 and updated 4/13/12, 6/30/12, 9/17/12 and 10/11/12 which was outside the ARD.

Physician's orders dated 1/4/12 show an order for the tube feed, and a nutritional assessment dated 1/30/12 also outside the ARD. The listed documentation does not indicate that the tube feed required total care.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #8

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation. ADL support provided for bed mobility was not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed

daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interview the staff and observe resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):12/09/11.

The 7-Day Look Back Period: 12/09/11-12/03/11.

Documentation submitted and reviewed:

MDS Section G dated December 9, 2011, nursing notes dated December 7, 8,9, Rockville Center Interdisciplinary Care Plan dated 5/30/11 and updated 6/4/11, 8/26/11 ,9/7/11/, 10/3/11,10/24/11, 11/14/11, 11/30/11, 12/7/11, 12/8/11, and another Care Plan dated 12/8/11, 01/27/12, 02/23/12, 2/23/12, 7/28/12. Also included in review documents was a Rehabilitation Progress note dated 12/6/11, which is outside the ARD, MD orders dated 10/28/11.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #9

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):11/14/11

The 7-Day Look Back Period: 11/14/11-11/08/11

Documentation submitted and reviewed:

MDS Section G dated November 14, 2011, Rockville Center Interdisciplinary Care Plan dated 8/24/11 and updated 11/7/11, 12/9/11, 2/6/12, 4/27/12, Nursing Assistant Accountability Record dated November 2011.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
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- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #10

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):01/20/12.The 7-Day Look Back Period: 01/20/12-01/14/12.

Documentation submitted and reviewed:

Rockville Care Center Interdisciplinary Care Plan dated 11/29/11 and 11/25/11 with updates 12/9/11, 3/16/12, 5/16/12, 6/8/12.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #11

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by

nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):11/12/11.

The 7-Day Look Back Period: 11/12/11 – 11/06/11.

Documentation submitted and reviewed:

MDS Section G dated 11/12/11, Nursing Assistant Accountability Record dated November 2011.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #14

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):12/30/11

The 7-Day Look Back Period: 12/30/11 – 12/24/11

Documentation submitted and reviewed:

MDS Section G dated 12/30/11, Nursing Assistant Accountability Record dated December 2011, Rockville Care Center Interdisciplinary Care Plan dated 7/17/11 and updated 8/29/11, 9/29/11, 12/23/11, 3/22/12.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #15

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record, the individualized CNA Accountability Record is initiated and completed by nurse and "nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care". The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):12/15/11.

The 7-Day Look Back Period: 12/15/11 – 12/09/11.

Documentation submitted and reviewed:

MDS Section G dated 12/15/11, Nursing Assistant Accountability Record dated December 2011, Rockville Care Center Interdisciplinary Care Plan dated 8/26/11, and updated 11/11/11, 12/9/11, 12/12/11, 1/30/1.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #16

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):02/07/12.

The 7-Day Look Back Period: 02/07/12 – 02/01/12.

Documentation submitted and reviewed:

MDS Section G dated 02/07/12, Nursing Assistant Accountability Record dated February 2012, and Rockville Care Center Interdisciplinary Care Plan dated 02/07/12, and updated 4/18/12, 5/1/12, 6/8/12

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only

- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #20

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by

RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):11/21/11.

The 7-Day Look Back Period: 11/21/11 – 11/15/11.

Documentation submitted and reviewed:

MDS Section G dated 11/21/11, Nursing Assistant Accountability Record dated November 2011, and Rockville Care Center Interdisciplinary Care Plan dated 11/15/11 and 11/11/11 and updated 11/22/11, 12/8/11, 2/14/12, 4/24/11, 5/9/12, 7/25/12.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as

the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #21

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss /report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures' acknowledges that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):01/20/12

The 7-Day Look Back Period: 01/20/12 – 01/14/12

Documentation submitted and reviewed:

MDS Section G dated 01/20/12, Nursing Assistant Accountability Record dated January 2012. Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #22

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use, bed mobility support provided, not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and "nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care". The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page1. created by RN. If there is a care level change the CNA will discuss /report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures' acknowledges that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide.

OMIG Response:

MDS Assessment Reference Date (ARD):12/23/11.

The 7-Day Look Back Period: 12/23/11 – 12/17/11.

Documentation submitted and reviewed:

Nursing Assistant Accountability Record dated December 201, and Rockville Care Center Interdisciplinary Care dated 11/8/12 and 1/2/12 which are outside the ARD.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #23

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

“As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care. The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page1 created by RN. If there is a care level change the CNA will discuss /report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures' acknowledges that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide.

OMIG Response:

MDS Assessment Reference Date (ARD):12/28/11

The 7-Day Look Back Period: 12/28/11 – 12/22/11

Documentation Submitted and Reviewed: MDS Section G dated 12/28/11, Nursing Assistant Accountability Record dated December 2011, and Rockville Care Center Interdisciplinary Care dated 12/8/11 and updated 1/1/12, 3/4/12, 5/11/12, 5/23/12.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #25

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating , Toilet Use and transfer support provided and toilet use support provided not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab

nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):12/18/11

The 7-Day Look Back Period: 12/18/11 – 12/12/11

Documentation Submitted and Reviewed: Nursing Assistant Accountability Record dated December 2011,

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #26

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):01/07/12

The 7-Day Look Back Period: 01/07/12 – 01/01/12

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only

- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #27

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift,

otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):12/27/11.

The 7-Day Look Back Period: 12/27/11-12/21/11.

Documentation submitted and reviewed:

MDS 3.0 Section G dated 12/27/12, Rockville Center Nursing Assistant Accountability Record dated December 2011, and Rockville Care Center Interdisciplinary Care Plan dated 5/2/11, updated 6/22/11, 8/16/11, 9/12/11, 12/1/11.

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.

Sample #28

Based on information and documentation provided by the facility, the following disallowances were not reversed and will be included in the Final Report:

Item #G0110Aa, G0110Ba, G010Ha, G0110Ia: ADL Self-Performance for Bed Mobility, Transfer, Eating and Toilet Use, bed mobility support provided, transfer support provided, and toilet use support provided not supported by documentation.

Facility Comment:

Facility refers to CNA Accountability Record, MDS Section G and Resident Care Plan as supporting documentation for ADL levels claimed.

Facility statement:

"As indicated by Rockville Center Nursing policy and Procedure Topic: CNA Accountability and Assignment Record the individualized CNA Accountability Record is initiated and completed by nurse and nurse taking orders is responsible to update this record whenever there is a change in residents condition/status/plan of care." The CNA Accountability Record (CNAAR) is signed daily by the CNA to indicate that care levels are congruent with the CNAAR page 1 created by RN. If there is a care level change, the CNA will discuss/report change to the nurse taking orders and changes will then be documented and modified to said CNAAR at the end of shift, otherwise CNA signature will indicate no change. Each shift the CNA signature indicates the daily level of care provided based on page 1 of the CNAAR. In addition, the signatures acknowledge that the care level during the shift will satisfy the MDS requirements for ADLs Rule of Three. As per the RAI manual Chapter 3 Section G, the MDS coordinator and the rehab nurse will review the CNAAR, interviews the staff and observes resident care to ensure that the CNAAR and MDS coincide."

OMIG Response:

MDS Assessment Reference Date (ARD):1/23/12

The 7-Day Look Back Period: 1/23/12 – 1/17/12

Documentation submitted and reviewed:

MDS 3.0 Section G dated 1/23/12, Rockville Care Center Interdisciplinary Care dated 1/12/12 and updated 3/28/12, 4/21/12, 4/30/12, 7/4/12, and 7/10/12

Although the facility has a policy in place, it does not meet the requirements set forth in the MDS 3.0 manual.

The documents provided do not support the Rule of Three, nor do they support total care required every time the ADL occurred.

ASSESSMENT

The ADL Self-Performance documentation does not support the MDS Manual 3.0 coding criteria §G0100-0900 as follows:

- Documentation for ADL Self-Performance must record what the resident actually did, not what he or she might be capable of doing, within each ADL category
- The focus for ADL coding is on the 7-day look back period only
- Full staff performance of an activity with NO participation by Resident is necessary to meet the definition of Level 4/Total Dependence. Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look back period.
- Documentation for ADL Self-Performance should record the level of assistance actually provided to the resident, not the type and level of assistance he or she should receive according to the written plan of care. The level of assistance that is actually provided might differ from what is indicated in the plan.

Documentation does not support the MDS Manual ADL coding instructions

- Direct care staff from each shift caring for the resident must be consulted to learn what the resident does for him/herself during each episode of each ADL activity definition, as well as the type and level of staff assistance provided. Documentation does not support that an interview was conducted with staff at the end of each shift during the 7-day look back period.

Documentation does not support MDS manual Chapter 4 - Care Area Assessment (CAA) Process and Care Planning:

- Completed MDS must be analyzed and combined with other relevant information to develop and individualized care plan.

Disposition: The draft report finding is unchanged and will be included in the final report.