



Office of the  
Medicaid Inspector  
General

ANDREW M. CUOMO  
Governor

DENNIS ROSEN  
Medicaid Inspector General

August 23, 2016

[REDACTED]  
Heritage Commons Residential Health Care  
1019 Wicker Street  
Ticonderoga, New York 12883

Re: MDS Final Audit Report  
Audit #: 14-4555  
Provider ID#: [REDACTED]

Dear [REDACTED]

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 Heritage Commons Residential Health Care for the census period ending January 25, 2013. In accordance with 18 NYCRR §517.6, this final audit report represents the OMIG's final determination on issues found during OMIG's review.

Since you did not respond to our draft audit report dated August 3, 2016, the findings in the final audit report remain identical to the draft audit report.

The Medicaid overpayment of \$29,338.61 was calculated using the number of Medicaid days paid for the rate period July 1, 2013 through December 31, 2013 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 [REDACTED]

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].

[REDACTED]

Division of Medicaid Audit  
Office of the Medicaid Inspector General

[REDACTED]

OFFICE OF THE MEDICAID INSPECTOR GENERAL  
HERITAGE COMMONS RESIDENTIAL HEALTH CARE  
AUDIT 14-4555  
CALCULATION OF AUDIT IMPACT

RATE TYPE	DECREASED IN DIRECT COMPONENT OF RATE*	MEDICAID DAY	IMPACT
Part B Eligible/Part B D Eligible	\$2.83	10,367	\$29,338.61
Non-Medicare/Part D Eligible	\$2.87	0	\$0.00
Total			<u>\$29,338.61</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  
 HERITAGE COMMONS RESIDENTIAL HEALTH CARE  
 AUDIT #14-4555  
 ERRORS BY SAMPLE NUMBER

Sample #	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	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 swallowing/nutritional status	Disallow special treatments, procedures	Disallow restorative nursing programs	Disallow Dementia Add On	Disallow BMI Add On		
1	BA1	BA1	0.47	0.47														
2	CC1	PD1	0.98	0.72	1	1	1		1	1	1							
3	CC1	CC1	0.98	0.98														
4	PD1	PD1	0.72	0.72		1	1				1							
5	PE1	PE1	0.79	0.79				1	1									
6	CB1	CB1	0.86	0.86		1	1				1							
7	CC1	CB1	0.98	0.86	1	1	1	1	1	1								
8	PA2	PA1	0.48	0.46									1					
9	IB1	IB1	0.78	0.78							1			1				
10	PD1	PD1	0.72	0.72		1	1				1							
11	PE1	PD1	0.79	0.72	1	1		1	1									
12	CC1	PD1	0.98	0.72	1	1	1	1	1	1		1						
13	SSB	SSA	1.06	1.03		1	1	1			1							
14	RLB	PD1	1.15	0.72		1	1				1		1					
15	PE1	PD1	0.79	0.72		1	1	1	1	1								
16	IA1	IA1	0.61	0.61														
17	PC2	PC1	0.67	0.66		1	1			1		1			1			
18	CB1	PD1	0.86	0.72		1	1			1		1						
19	PE1	PD1	0.79	0.72		1	1	1		1								
20	RLB	PD1	1.15	0.72		1	1			1		1	1					
Totals					4	14	5	13	3	6	13	2	1	2	2	4	1	1

**OFFICE OF THE MEDICAID INSPECTOR GENERAL  
HERITAGE COMMONS RESIDENTIAL HEALTH CARE  
AUDIT #14-4555  
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 4 instances, documentation did not support resident required total assist every time. 2, 7, 11, 12

**Bed Mobility Support Provided**

In 7 instances, documentation did not support resident was a 2+ person physical help at least once. 2, 7, 11, 12, 13, 14, 18

In 7 instances, documentation did not support resident was a one person physical help at least once. 4, 6, 10, 15, 17, 19, 20

**Transfer Self-Performance**

In 5 instances, documentation did not support resident required total assist every time. 7, 12, 13, 15, 19

**Transfer Support Provided**

In 6 instances, documentation did not support resident was a 2+ person physical help at least once. 2, 7, 12, 13, 15, 19

In 7 instances, documentation did not support resident was a one (1) person physical help at least once. 4, 6, 10, 14, 17, 18, 20

Eating Self-Performance

In 3 instances, documentation did not support resident required total assist every time. 5, 11, 12

Toilet Use Self-Performance

In 6 instances, documentation did not support resident required total assist every time. 2, 5, 7, 11, 12, 15

Toilet Use Support Provided

In 4 instances, documentation did not support resident was a 2+ person physical help at least once. 2, 7, 15, 19

In 9 instances, documentation did not support resident was a one person physical help at least once. 4, 6, 10, 12, 13, 14, 17, 18, 20

Active Disease Diagnosis

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 the diseases coded relate to the resident's functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death. MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xvii)  
MDS Manual 3.0 I0100-I8000*

In 1 instance, documentation did not support hemiplegia as a physician documented diagnosis in the past 60 days. 2

In 1 instance, documentation did not support Dementia as a physician documented diagnosis in the past 60 days. 9

**Swallowing/Nutritional Status**

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 of conditions that could affect the residents' ability to maintain adequate nutrition and hydration. MDS 3.0 manual guidelines will be followed when examining the medical records.

*42 CFR §483.20 (b) (xvii)*  
*MDS 3.0 Manual K0100-0700*

In 1 instance documentation did not support a resident weight in the past 30 days. 17

**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. 18

In 1 instance, documentation did not support oxygen therapy during the look back period. 12

**Skilled Therapy**

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 qualified therapist, in conjunction with the physician and nursing staff, is responsible for determining the necessity for and the frequency and duration of the therapy provided to residents. Rehabilitation (i.e., via Speech-Language Services, and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy helps the residents to attain or maintain their highest level of well-being and improve their quality of life. MDS 3.0 manual guidelines will be followed when reviewing the documentation provided by the facility.

*42 CFR §483.20 (b) (xvii)*  
*MDS 3.0 Manual 00400-0500*

Physical Therapy

In 2 instances, documentation did not support medical necessity for therapy and/or therapy was not reasonable for resident condition. 14, 20

Restorative Nursing Programs

In 1 instance, documentation did not support resident participated in a nursing rehabilitation program. 14

In 3 instances, documentation did not support measurable goals and/or periodic evaluation of the nursing rehabilitation program. 8, 17, 20

Dementia Add-on

In 1 instance, documentation did not support the diagnosis of Alzheimer's/dementia required for the add-on. 9

*10 NYCRR §86-2.40 (z)(1)*

BMI Add-on

In 1 instance, documentation does not support resident BMI was less than 35%. 17

*10 NYCRR §86-2.40 (z)(2)*

**RUGS-II Classifications Overturned**

In 12 instances, the RUG classifications were overturned.

2, 7, 8, 11, 12, 13, 14, 15, 17, 18, 19, 20

*10 NYCRR §86-2.10, Volume A-2*