



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

THOMAS R. MEYER
Acting Medicaid Inspector General

February 5, 2015

[REDACTED]
Metropolitan Jewish Geriatric Center
4915 10th Avenue
Brooklyn, New York 11219

Re: Metropolitan Jewish Geriatric Center
Medicaid PRI Audit #09-4649
NPI Number: [REDACTED]
Provider Number: [REDACTED]

Dear [REDACTED]:

This is the final audit report of findings with regard to the Office of the Medicaid Inspector General's ("OMIG") Patient Review Instruments ("PRI") audit of Metropolitan Jewish Geriatric Center ("Facility") for the audit period January 1, 2005 through December 31, 2006. In accordance with 18 NYCRR Section 517.6, this final audit report represents the OMIG's final determination on issues raised in the draft audit report.

In your response to the revised draft audit report dated February 20, 2014, you identified specific audit findings with which you disagreed. Your comments have been considered (see Attachment A-1) and the report has been either revised accordingly and/or amended to address your comments (See Attachment A-2). Consideration of your comments resulted in an overall reduction of \$1,726,011 to the total Medicaid overpayment shown in the revised draft audit report.

The findings applicable to the July 1, 2006 through March 31, 2009 Medicaid rates resulted in a Medicaid overpayment of \$1,558,890 as detailed in Attachment A-2. This overpayment is subject to Department of Health ("DOH") and Division of Budget ("DOB") final approval. While not anticipated, any difference between the calculated overpayment and the final DOH and DOB amount will be resolved with the Facility by the OMIG Bureau of Collections Management. The finding explanation, regulatory reference, and applicable adjustment can be found in the exhibits following Attachment A-2.

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below.

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #09-4649
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]

You have the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. You may not request a hearing to raise issues related to rate setting or rate setting methodology. In addition, you may not raise any issue that was raised or could have been raised at a rate appeal with your rate setting agency. You may only request a hearing to challenge specific audit adjustments which you challenged in a response to the draft audit report.

If you wish 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, New York 12204

Questions regarding the request for a hearing should be directed to the Office of Counsel, at [REDACTED].

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 a signed authorization permitting that person to represent you along with your hearing request. At the hearing, you may call witnesses and present documentary evidence on your behalf.

Should you have any questions regarding the above, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]

Sincerely,

[REDACTED]
Division of Medicaid Audit
Office of the Medicaid Inspector General

[REDACTED]
Attachments:

ATTACHMENT A-1 – Analysis of Provider Response
ATTACHMENT A-2 - Calculation of Medicaid Overpayment
ATTACHMENT B - Change in RUG Counts for PRIs submitted on July 24, 2006 and October 12, 2006
ATTACHMENT C - Detailed Findings by Sample Number
ATTACHMENT D - Detailed Findings by Disallowance

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

████████████████████
Metropolitan Jewish Geriatric Center
4915 10th Avenue
Brooklyn, New York 11219-3301

PROVIDER ID # ██████████

AUDIT #09-4649

AMOUNT DUE: \$1,558,890

AUDIT

TYPE

PROVIDER

RATE

PART B

OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

████████████████████
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #09-4649
Albany, New York 12237-0048

5. If the provider number shown above is incorrect, please enter the correct number below.

[]

CORRECT PROVIDER NUMBER

METROPOLITAN JEWISH GERATRIC CENTER AUDIT #09-4649

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

Facility Objections to Decubitus Level Findings:

Sample #168 – Finding: Disallow Decubitus Level – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #557 – Finding: Disallow Decubitus Level – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #558 – Finding: Disallow Decubitus Level – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Stasis Ulcer Findings:

Sample #305– Finding: Disallow Stasis Ulcer – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Parental Feeding Findings:

Sample #161– Finding: Disallow Parental Feeding

Facility Comment: The medical record shows the patient was evaluated by MD on 7/21/06 for abdominal distention. Lab work was ordered, GT- feeding was ordered on hold, IV fluids were ordered and administered 7/21/06 – 7/23/06. The PRI assessor had the flexibility to choose any PRI date up until the end of the PRI period on 7/24/06, it is reasonable to assume that the date of the PRI had been changed to reflect the patient's change in status, however is not reflected on the PRI due to a data entry error.

OMIG Response: The documentation submitted by the facility supports care given to the resident outside the ATP. The ATP – Applicable Time Period is the 28 day "look back" period used to complete a PRI - the four weeks prior to the PRI completion. All of the data entered on the PRI is dependent on documentation in the medical record for this 28 day (4 weeks) look back period, which ends on the day the PRI is completed. The NYSDOH Division of Health Care Financing clarification sheet: Patient Review Instrument 5/99, page 33 states "All PRI submissions should be checked for accuracy once the data have been submitted electronically and accepted. The facility is given an additional seven days to make corrections. Enter the correct data, re-run the edit checks, re-encrypt and resubmit the ENTIRE file. This must be done by the update date provided in the acceptance message. NO CORRECTIONS WILL BE ALLOWED AFTER THE UPDATE DATE."

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

Facility Objections to Chemotherapy Findings:

Sample #299 – Finding: Disallow Chemotherapy

Facility Comment: The resident had a diagnosis of Breast Carcinoma in Situ for which she received radiation therapy. The physician orders demonstrate that the resident was sent for consultation on the 7/18/06, 7/20/06 and again on 7/26/06. On 7/21/06 the primary physician ordered. Tamoxifen po daily x 5 years for breast cancer. The PRI assessor had the flexibility to choose any PRI date up until the end of the PRI period on 7/24/06, it is reasonable to assume that the date of the PRI had been changed to reflect the patient's change in status, however is not reflected on the PRI due to a data entry error.

OMIG Response: The documentation submitted by the facility supports care given to the resident outside the ATP (6/22/06 - 7/19/06) and may not be counted. The ATP – Applicable Time Period is the 28 day “look back” period used to complete a PRI - the four weeks prior to the PRI completion. All of the data entered on the PRI is dependent on documentation in the medical record for this 28 day (4 weeks) look back period, which ends on the day the PRI is completed. The NYS DOH Division of Health Care Financing clarification sheet: Patient Review Instrument 5/99, page 33 states. “All PRI submissions should be checked for accuracy. Once the data have been submitted electronically and accepted, the facility is given an additional seven days to make corrections. Enter the correct data, re-run the edit checks, re-encrypt, and resubmit the ENTIRE file. This must be done by the update date provided in the acceptance message. NO CORRECTIONS WILL BE ALLOWED AFTER THE UPDATE DATE.”

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

Facility Objections to Dialysis Findings:

Sample #497 – Finding: Disallow Dialysis – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Eating Level of Care Findings:

Sample #102 – Finding: Disallow Eating Level 2 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #202 – Finding: Disallow Eating Level 2

Facility Comment: The documentation in the medical record-care plans, and Nursing Notes, support Level 2 with eating. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. Nurse's note dated 6/28/06, state patient needs extensive assist with meals/eating - help of weight bearing support and full staff assist part of the time.

OMIG Response: The additional documentation submitted by the facility was reviewed. The monthly nurse's note is not signed, the MDS submitted as support for eating level of care does not include the documentation to support the MDS, and there are no CNA accountability records to review. The care plan submitted is not signed, has no goals for eating and has no evaluation of progress.

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

Sample #239 – Finding: Disallow Eating Level 3 -

Facility Comment: The documentation in the medical record-care plans, and Nursing Notes, support Level 3 with eating. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. Care Plans for ADL'S (eating) was initiated on 1/11/06 – reflects need for total assist with eating. MDS – ARD 6/29/06 reflects resident need for total assist with eating. CNA accountability record showed need of staff to spoon feed on May/June and June/July. Nurse's note also states the patient was confused to make decisions and needed continual presence and help to finish meal.

OMIG Response: The additional documentation submitted was reviewed and indicated that nurse's monthly note dated 6/27/06 is not signed. The care plan submitted has no signature or initials as to who wrote it; there are no goals for eating or directions, and there is no evaluation during the ATP. There are two CNA accountability records with overlapping dates, one 5/30/06 – 7/3/06 , the other 6/27/06 – 7/31/06, the plan of care is stated feeds self, spoon feed in dining room. The MDS submitted dated 6/29/06 reflects a 7 day look back which does not cover the ATP. Continual help with eating qualifier not supported by documentation.

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

Sample #244 – Finding: Disallow Eating Level 3

Facility Comment: The documentation in the medical record-care plans, and Nursing Notes, support Level 3 with eating. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. Care Plans for ADL'S (eating) was initiated on 2/14/06 – reflects need for extensive assist with eating. As per nursing notes from 7/3/06, the patient needs extensive assist with meals/eating of one staff. The patient was confused and unable to make decisions regarding meal consumption.

OMIG Response: The additional documentation submitted was reviewed and indicated that nurse's monthly note dated 7/3/06 is not signed. The care plan submitted has no signature or initials as to who wrote it; there are no goals for eating or directions, and there is no evaluation during the ATP. Previously reviewed CNA accountability records June/July and July/August indicate feeds self with tray set up, there is also a nutrition note that states resident is a self-feed with tray set up. The MDS submitted dated 8/9/06 reflects a 7 day look back which does not cover the ATP. Continual help with eating qualifier not supported by documentation.

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

Sample #558 – Finding: Disallow Eating Level 5 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Transfer Level Findings:

Sample #41 – Finding: Disallow Transfer Level 3

Facility Comment: The documentation in the medical record-care plans, Nurse's notes, and CNA Accountability record, support a level 3 transfer. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. The Care Plan for ADL'S (transfer) was initiated on 9/27/05 – reflects the need for one assist with transfer, was reviewed on 6/13/06. Care Plans, for elimination reflect resident is incontinent. MDS with ARD of 8/31/06 reflects resident requires transfer 1 assist. Nurse's note 6/21/06 states patient needs limited assist with transfer, 6/29/06 note

states need of extensive assist. Rehabilitation screen on 6/20/06 supported residents of minimal assist of one staff with transfer, able to ambulate 50-60 feet with rolling walker and contact guard.

OMIG Response: Additional documentation submitted by the facility was reviewed, the toileting documentation does not support transfer status. Nurse's progress note 6/29/06 does not indicate transfer status. The 6/21/06 nurses note indicates limited assist is required (level 2 transfer). Assessments for pain, behavior, and falls risk have no information to support transfer status. The care plans submitted relate to ADL's and elimination. There is no documentation to support transfer status. The documentation from physical therapy indicates minimal assist in transfer, ambulates with rolling walker and contact guard. The MDS with an ARD of 8/31/06 reflects a 7 day look back which does not cover the ATP. The documentation submitted supports level 2 for transfer.

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

Sample #102– Finding: Disallow Transfer Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #202 – Finding: Disallow Transfer Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #491 – Finding: Disallow Transfer Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #497– Finding: Disallow Transfer Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #538 – Finding: Disallow Transfer Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #557 – Finding: Disallow Transfer Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #558 – Finding: Disallow Transfer Level 4 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Toileting Findings:

Sample #41 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided”. There is a Nurse's note on 6/29/06 which states resident is incontinent and is assisted with toileting q3 hours and prn.

OMIG Response: Additional documentation submitted by the facility was reviewed. Toileting schedule sheet covering 7/1/06 – 7/31/06 has many blanks during the days of ATP (6/20/06 – 7/17/06), there is no documentation for the dates 6/20/06 – 6/30/06. There is a weekly nurse's note dated 6/29/06 which states that the resident is incontinent and is assisted with toileting every three hours. The CNA accountability record for ATP period 6/20/06 – 7/1/06 toileting schedule are blank. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #102– Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There is a nurse's note on 6/27/06 which states patient needs extensive assist of one with toileting. Patient was placed on a toileting schedule which was beneficial. As per toileting sheets, patient was toileted every 2 to 4 hours, is incontinent and is assisted with toileting every three hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for ATP period 6/20/06 – 7/1/06 toileting schedule are blank. A separate toileting schedule documentation sheet has blanks for the ATP period. A nurses note dated 6/27/06 states resident requires extensive assist of one staff with toileting. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #105 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #111 – Finding: Disallow Toileting Level –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There is a nurse's note on 6/28/06 which states resident is incontinent and requires extensive assistance with toileting.

OMIG Response: Additional documentation submitted by the facility was reviewed. The toileting schedule record for ATP period 6/20/06 – 7/1/06 has many blanks; there is no schedule for July. A nurse's note dated 6/28/06 states resident requires extensive assist of one staff with toileting. The MDS with an ARD of 6/16/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #202 – Finding: Disallow Toileting Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #204 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There is a nurse's note on 7/7/06 which states resident is incontinent and requires extensive assistance with toileting.

OMIG Response: Additional documentation submitted by the facility was reviewed. The toileting schedule record for ATP period 6/14/06 – 7/11/06 has many blanks. A nurse's note dated 7/7/06 states resident requires extensive assist of one staff with toileting. The MDS with an ARD of 6/6/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #219 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #228 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There is a nurse's note on 6/20/06 which states resident is incontinent and requires limited assistance with toileting, the MDS with ARD of 7/6/06 supports a toileting program. The care plan reviewed 4/18/06 shows patient needs extensive assist with toileting and is incontinent and has a toileting schedule of every 3 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The toileting schedule record for ATP period 6/16/06 – 7/13/06 has many blanks; and in some instances the time period exceeds 4 hours between toileting care. A nurse's note dated 6/20/06 states resident requires limited assist of one staff with toileting. The MDS with an ARD of 7/6/06 reflects only a 7 day look back of the 28 day ATP period, and does not include documentation used to score MDS. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #244 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #270– Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". The MDS with ARD 8/4/06 reflects that resident is incontinent and receives extensive assist with toileting / assist of two. There is a nurse's note on 7/18/06 which states resident was able to ambulate 100 feet with RW and contact guard is incontinent, assisted with toileting every 2-4 hours & prn at night.

OMIG Response: Additional documentation submitted by the facility was reviewed. The toileting accountability record for ATP period 6/27/06 – 7/24/06 has many blanks and periods of over 4 hours intervals on toileting schedule. A nurse's note dated 7/18/06 states resident able to ambulate 100' with RW and contact guard requires extensive assist of two staff with toileting. The MDS with ARD 8/4/06 reflects a 7 day look back period which is outside the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #273 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #275 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #276 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI

instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". The MDS with ARD 8/15/06 reflects the resident requires total assistance with toileting. There is a nurse's note on 7/11/06 which states resident needs extensive assist with toileting and transfer.

OMIG Response: Additional documentation submitted by the facility was reviewed. The toileting schedule record for ATP period 6/27/06 – 7/24/06 has many blanks. A nurse's note dated 7/11/06 states resident requires extensive assist of one staff with toileting and is not signed. The MDS with an ARD of 8/15/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #312 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There are nurse's notes on 6/12/06 and 7/10/06 which state resident is incontinent and requires extensive assistance with toileting; a care plan dated 1/3/06 with evaluation on 6/14/06 stating no change voiding freely. MDS with ARD date of 6/12/06 and 9/2/06 indicate toileting program. CNA accountability sheets are signed every 2-4 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 4 hours, and some are missing times. Nurse's notes dated 6/12/06 and 7/10/06 indicates extensive assist/one staff and no individualized scheduled toileting program. Plan of care dated 1/3/06 and reviewed 6/14/06 indicates resident is incontinent and has diaper change every two- four hours, there is no specific times indicated for the individualized plan and does not state toileting program. The MDS's with ARD's of 6/12/06 and 9/2/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #314 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There are nurse's notes on 6/28/06 and 7/17/06 which state resident is incontinent and requires extensive assistance with toileting; a care plan dated 7/12/06 with

evaluation on 7/12/06 stating free of UTI's. MDS with ARD date of 7/28/06 indicate toileting program. CNA accountability sheets are signed every 2-4 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 4 hours, and some are missing times. Nurse's notes dated 6/28/06 and 7/17/06 indicates extensive assist/one staff and no individualized scheduled toileting program. Plan of care dated 7/12/06 and reviewed 7/12/06 indicates resident is incontinent and requires total assist of 1has, diaper change every two- four hours, there is no specific times indicated for the individualized plan and does not state toileting program. The MDS with ARD of 7/28/06 reflect a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #317 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There are nurse's notes on 7/19/06 which state resident is incontinent and requires extensive assistance with toileting; a care plan dated 6/14/06. MDS with ARD date of 8/28/06 toileting program q3h and prn. CNA accountability sheets are signed every 2-4 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 4 hours, and some are missing times. Nurse's notes dated 7/19/06 indicates extensive assist one staff and individualized scheduled toileting program. Plan of care dated 3/14/06 and reviewed 6/14/06 indicates resident is incontinent and requires assist of 1, toileting every three hours and prn, there is no specific times indicated for the individualized plan and does not state toileting program. The MDS with ARD of 8/28/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #322 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". As per nurse's note on 7/13/06 which state resident is incontinent and requires total assistance of 1 staff with toileting. A care plan dated 6/28/06; with no evaluation. MDS with ARD date of 6/21/06 and 9/22/06 indicate toileting program. CNA accountability sheets are signed every 2-4 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 4 hours, and some are missing times. Nurse's note dated 7/13/06 indicates total assist/one staff and toilet q2-4 hours; there is no individualized scheduled toileting program. Plan of care dated 6/28/06 has no evaluation; indicates resident is incontinent and has toilet/diaper change every two- four hours, there is no specific times indicated for the individualized plan and does not state toileting program. The MDS's with ARD's of 6/21/06 and 9/22/06 reflects a 7 day look back which covers only one of the 28 days of the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #330 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #332 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided". There are nurse's notes on 6/15/06 and 7/13/06 which state resident is incontinent and requires total assistance with toileting. A care plan dated 9/6/05 with evaluation on 6/6/06 stating toilet q3 hours and prn 6:30am – 6:30pm. MDS with ARD date of 5/26/06 and 8/7/06 indicate toileting program, total assistance. CNA accountability sheets are signed every 2-4 hours

OMIG Response: Additional documentation submitted by the facility was reviewed. The explanation from facility uses an S instead of M for first name initial material has been identified as belonging to sample 332. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 3 hours some over 4 hours, and some are missing times and signatures (initials). Nurse's notes dated 6/15/06 and 7/13/06 indicates total assistance/one staff and individualized scheduled toileting program. Plan of care dated 9/6/05 and reviewed 6/6/06 indicates resident is incontinent and requires total assist of 1, has diaper change every two- four hours, there is no specific times indicated for the individualized plan and does not state toileting program. The MDS's with ARD's of 5/26/06 and 8/7/06 reflect a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include "the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided". The documentation and medical record support level 4 toileting.

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

Sample #334 – Finding: Disallow Toileting Level 5 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #338 – Finding: Disallow Toileting Level 5 –Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #375 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided”. There are nurse’s note’s on 6/19/06 and 7/17/06 which state resident is incontinent and requires limited/extensive assistance with toileting. A care plan dated 1/12/06 with evaluation on 2/21/06 stating incontinent, toilet every 3 hours. MDS with ARD date of 5/11/06 indicate toileting program. CNA accountability sheets are signed every 2-4 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 4 hours, and some are missing times and initials. Nurse’s notes dated 6/19/06 and 7/17/06 indicates extensive assist-total assist/one staff and no individualized scheduled toileting program/brief change. Plan of care dated 1/12/06 and reviewed 2/21/06 indicates resident is incontinent and requires limited assist of 1has, toileted every three hours, there are no specific times indicated for the individualized plan and does not state toileting program. The MDS with ARD of 5/11/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided”. The documentation and medical record support level 4 toileting.

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

Sample #394 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided”. There are nurse’s notes on 6/27/06 and 7/7/06 which state resident is incontinent and requires extensive assistance with toileting. A care plan dated 10/19/05 with evaluation on 7/12/06 stating incontinent, remind to toilet every 3 hours. MDS with ARD date of 7/6/06 indicate toileting program. CNA accountability sheets are signed every 2-4 hours.

OMIG Response: Additional documentation submitted by the facility was reviewed. The CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July are present, several entries are over 4 hours, and some are missing times and initials. Nurse’s notes dated 6/27/06 and 7/7/06 indicates extensive assist / one staff and no individualized scheduled toileting program/ brief change. Plan of care dated 10/19/05 and reviewed 7/12/06 indicates resident is incontinent, is reminded to use toilet every 3 hours and pm, there are no specific times indicated for the individualized plan and does not state toileting program. The MDS with ARD of 7/6/06 reflects a 7 day look back which covers 7 days of the 28 day ATP period. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided”. The documentation and medical record support level 4 toileting.

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

Sample #414 – Finding: Disallow Toileting Level 5 –

Facility Comment: The documentation in the medical record – care plans, nursing notes, CNA accountability record and MDS support level 5 toileting. The very nature of the care plan and the fact they must be developed by an RN imply that the information contained is based on the nursing process. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance was provided”. There are nurse’s notes on 6/22/06 and 7/27/06 which state resident is incontinent and requires limited assistance of 1 staff with toileting; a care plan dated 3/26/06 with evaluation on 6/27/06 stating usually continent, toilet every 2-4 hours. MDS with ARD date of 9/18/06 usually continent of bladder indicate toileting program. (CNA accountability sheets are included but not commented on by facility.)

OMIG Response: Additional documentation submitted by the facility was reviewed. Previously submitted CNA accountability record for June and July 2006 has no entries for toileting schedule. A separate patient toileting schedule for June and July was submitted, many entries are over 4 hours, and some are missing times and initials. Does not support constant supervision or physical assistance required for toileting. Nurse’s notes dated 6/22/06 and 7/27/06 indicates extensive assist/one staff and no individualized scheduled toileting program/brief change. Plan of care dated 3/26/06 and reviewed 6/27/06 indicates resident is continent and requires limited assist of 1, has, continue toileted every 2-4 hours, there are no specific times indicated for the individualized plan and does not state toileting program. The MDS with ARD of 9/18/06 reflects a 7 day look back which does not cover the ATP. PRI instructions/clarifications state the toileting schedule must include “the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided, must be present in each instance assistance was provided”. The documentation and medical record support level 4 toileting.

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

Sample #491 – Finding: Disallow Toileting Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #497– Finding: Disallow Toileting Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #538 – Finding: Disallow Toileting Level 3– Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #557 – Finding: Disallow Toileting Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #558 – Finding: Disallow Toileting Level 4 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Disruptive, Infantile or Socially Inappropriate Behavior Findings:

Sample #273 – Finding: Disallow Disruptive, Infantile or Socially Inappropriate Behavior Level 4: Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #274 – Finding: Disallow Disruptive, Infantile or Socially Inappropriate Behavior Level 4: Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample #276 – Finding: Disallow Disruptive, Infantile or Socially Inappropriate Behavior Level 4: Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Facility Objections to Physical Therapy Findings

Sample #4– Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample # 5– Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in final report.

Sample # 9 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample # 11- Finding: Disallow PT Level 3 –

Facility Comment: The MD order for the PT evaluation was unable to be located. The possibility exists that this document was lost during the audit process. The PT evaluation dated 6/8/06 has an MD signature demonstrating the MD was in agreement of this evaluation.

OMIG Response: While auditors were onsite there were a number of documents not available for the audit team to review. This physicians order for PT was one of them, on 3/22/11 the facility sent additional documentation, but they were not able to locate the physicians order at that time as well. PRI instructions/clarifications state: "There must be an order for restorative therapy." Documentation supports level 4 PT.

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

Sample #22 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #23 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #28 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #38 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #42 – Finding: Disallow PT Level 3 –

Facility Comment: In detailed findings auditor stated resident on hospice and therefore had no positive potential for significant improvement. Base line is documented 4/10/06: ambulation 75 -100 feet with rolling walker and contact guard and close supervision, bed mobility- independent, bed to WC transfer – CG , sit to stand – supervision. The residents’ hospice status (breast cancer) does not preclude her from being able to improve her ambulation or transfer status. The resident has a right to improve the quality of her life by being able to maneuver in bed independently, transfer and ambulate to her baseline. Based on 6/19 assessed status vs. her 4/10 baseline status, the resident made significant gains in ambulation and transfers by 7/5/06 able to ambulate 30 feet x3 and transfers with minimal assist. Had the resident not been provided therapy solely based on her diagnosis the quality of her life would surely have been poor.

OMIG Response: The NYS DOH Division of Health Care Financing, Instructions for PRI state “Restorative therapy level 3 documentation qualifiers. There is positive potential for improved functional status within a short predictable period of time, therapy notes and progress notes should support that patient has this potential is improving”. The facility indicated that the 4/10/06 discharge summary from PT is a base line. The PRI ATP dated 7/17/06 has a look back period of 28 days. The documentation in the medical record available at the time of in facility record review has daily nurse’s notes which indicate the resident was in a much weakened status, poor appetite, oxygen continuously, confused intermittently “related to diagnosis of breast cancer with metastasis to the brain, resident on hospice with palliative care, and multiple notes of keeping resident comfortable offering emotional support. Resident pain level from 6/20/06 – 7/17/06 the range of ATP, increased from 0 to 1-2-3 over the 28 day period. There is a note on 7/14/06 stating condition unchanged, palliative care given, make comfortable. 6/19/06 PT evaluation states able to march in place, bed mobility moderate assist, and transfer moderate assist, ambulation minimum assist. On 7/5/06 PT notes state improvement, bed mobility moderate assist (same as 6/19/06), transfer minimum assist (nurse’s notes state extensive assist of 1 requires), ambulation minimum assist (same) PT discharge on 7/28/06 shows decline in transfer status. The resident should be afforded opportunity to maintain function, review of new documents and previously submitted documentation indicate **level 2** maintenance level PT. The NYS DOH Division of Health Care Financing, instructions for PRI state Maintenance Therapy level 2 – therapy is provided to maintain or retard deterioration of current functional/ ADL status. Residents’ diagnosis of breast cancer with metastasis to the brain do indicate a declining functional state and is documented in the medical record.

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

Sample #44– Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #45 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample # 47 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #48 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #54 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #63 – Finding: Disallow PT Level 3 -Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #65 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #68 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #76 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #80 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #84 – Finding: Disallow PT Level 3 –

Facility Comment: New admissions of less than four weeks can be marked for restorative therapy if there is a Physician, Nurse Practitioner, or appropriately cosigned Physician order for therapy and the patient receiving it. PT TX logs attached prove that the resident did receive therapy 5 days a week for a total of 2.5 hours. Documentation shows significant improvement.

OMIG Response: While auditors were onsite there were a number of documents not available for the audit team to review. This physicians order for PT was one of them, on 3/22/11 the facility sent additional documentation, but they were not able to locate the Physicians order at that time as well. PRI instructions/clarifications state: "There must be an order for restorative therapy." Documentation supports level 4 PT. No Physician's order is available for review.

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

Sample #85 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #88– Finding: Disallow PT Level 3 –

Facility Comment: New admissions of less than four weeks can be marked for restorative therapy if there is a Physician, Nurse Practitioner, or appropriately cosigned Physician order for therapy and the patient receiving it. PT TX logs attached prove that the resident did receive therapy 5 days a week for a total of 2.5 hours. Documentation shows significant improvement.

OMIG Response: While auditors were onsite there were a number of documents not available for the audit team to review. This physicians order for PT was one of them, on 3/22/11 the facility sent additional documentation, but they were not able to locate the Physicians order at that time as well. PRI instructions/clarifications state: "There must be an order for restorative therapy". Documentation supports level 4 PT. No Physician's order is available for review.

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

Sample #90 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #95 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #99 – Finding: Disallow PT Level 3 –

Facility Comment: New admissions of less than four weeks can be marked for restorative therapy if there is a Physician, Nurse Practitioner, or appropriately cosigned Physician order for therapy and the patient receiving it. PT TX logs attached prove that the resident did receive therapy 5 days a week for a total of 2.5 hours.

OMIG Response: While auditors were onsite there were a number of documents not available for the audit team to review. This physicians order for PT was one of them, on 3/22/11 the facility sent additional documentation, but they were not able to locate the Physicians order at that time as well. PRI instructions/clarifications state: "There must be an order for restorative therapy." Documentation supports level 4 PT. No Physician's order is available for review.

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

Sample #102 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #104– Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #105 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #108 – Finding: Disallow PT Level 3 –

Facility Comment: "In order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week." The PRI date was imputed in error – the correct date was 7/17/06. PT TX logs attached prove that the resident did receive therapy 5 days a week for a total of 2.5 hours. Documentation shows significant improvement.

OMIG Response: New York State Department of Health Division of Health Care Financing clarification sheet – Patient Review Instrument – states “All PRI submissions should be checked for accuracy. Once the data have been submitted electronically and accepted, the facility is given an additional seven days to make corrections. This must be done by the update date provided in the acceptance message. No corrections will be allowed after the update date.” The error for data entry was discovered after the seven day period and cannot be allowed.

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

Sample #116 – Finding: Disallow PT Level 3 –Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #120 – Finding: Disallow PT Level 3 –Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #479 – Finding: Disallow PT Level 3 –Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #491 – Finding: Disallow PT Level 3 –

Facility Comment: Detailed audit findings stated that the wrong chart was submitted for review upon request from auditors. Attached, please find all the supporting documentation to support the facilities RUG choice. PT logs, physician orders, evaluation and progress note submitted.

OMIG Response: While auditors were onsite there were no documents available for the audit team to review. The facility sent additional documentation which was reviewed. The PT logs do not support 5 days/week, 2.5 hours. Week 1 of ATP, 4 days, 2 hours 5minutes, indicated on PT logs; week 3, 4 days, 2 hours, indicated on PT logs. New York State Department of Health Division of Health Care Financing Patient Review Instrument directions state “In order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week.”

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

Sample #515 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #522 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #536 – Finding: Disallow PT Level 3 –

Facility Comment: In the detailed audit report, the auditor comments that the resident missed more than 2 days of therapy during ATP- upon review of the documentation – the resident did not miss more than 2 days of treatment, the resident was provided treatment on Saturday 2 x during ATP. PT TX logs attached prove that the resident did receive therapy 5 days a week for a total of 2.5 hours.

OMIG Response: The PT logs do not support 5 days/week, 2.5 hours. Week 1 of ATP, 3 days, 1 hour. 35 minutes, indicated on PT logs; the resident received 18 of 20 required treatments during ATP, Saturday treatments may be counted once only. New York State Department of Health Division of Health Care Financing Patient Review Instrument directions state "In order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week."

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

Sample #544 – Finding: Disallow PT Level 3 –

Facility Comment: New admissions of less than four weeks can be marked for restorative therapy if there is a Physician, Nurse Practitioner, or appropriately cosigned Physician order for therapy and the patient receiving it. Positive potential is clearly assessed and documented by therapist, patient received evaluation and at least one treatment.

OMIG Response: Patient was admitted on 10/12/06 date of ATP, received evaluation and one treatment PT states positive potential – ambulation poor tolerance for endurance 120' with supervision, documentation in medical record state family refusing to have resident on therapy unit (6th floor) family walking with resident in hallway, has impaired hearing, confusion and poor English skills, medical record indicates family will take resident home in morning, resident discharged 10/13/06. The medical record strongly indicated poor potential for improved functional status within a short predictable period of time.

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

Sample #548 – Finding: Disallow PT Level 3 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #554– Finding: Disallow PT Level 3 –

Facility Comment: "In order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week. PT logs for Sept/Oct 2006 prove that the resident received the required 5 days/week for a total of 2.5 hours during the ATP.

OMIG Response: The PT logs do not support 5 days/week, 2.5 hours. Week 3 of ATP, 4 days, 2 hours 7minutes, indicated on PT logs; week 4 of ATP, 4 days, 2 hours 10 minutes indicated on PT logs. New York State Department of Health Division of Health care financing Patient Review Instrument directions state "In order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week."

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

Sample #555 – Finding: Disallow PT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Facility Objections to Occupational Therapy Findings:

Sample # 8 – Finding: Disallow OT Level 3 –

Facility Comment: PT D/C summary from 3/31/06 assesses the resident to require minimum assist with bed mobility and sit stand transfers. Resident was referred to OT secondary to a decline in ADL performance. The residents' positive potential is based on the decline from the resident's baseline status to the current reduced status.

OMIG Response: A review of the medical record and the additional documentation submitted by the facility during ATP dates, assesses the resident by nursing and physician staff as frail, elderly female, tube feedings via peg tube, dementia with agitation and verbally abusive to staff at times. Also noted resident sleeps at long intervals during the day; during the ATP resident was on contact droplet precautions. The CT evaluation and treatment plan makes no mention of the residents' medical issues. 7/11/06 -OT reports resident is making progress with moderate assist in bed mobility and grooming, nursing staff report extensive – total care. The medical record clearly does not compare to the OT evaluations and notations. Finding stands

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

Sample #10 – Finding: Disallow OT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #28 – Finding: Disallow OT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #49 – Finding: Disallow OT Level 3 -- Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #57 – Finding: Disallow OT Level 3 –

Facility Comment: The residents' positive potential for improvement is clear based upon review of the documentation which shows that resident's baseline was fully functional in 11/2005; when he began a long hospitalization; the residents' positive potential is based on his baseline status of independent. The resident demonstrated significant progress through the ATP as the documentation shows. 6/26/06 OT – transfers maximum 2 assist, grooming minimum assist, 7/6/06 standing 2-3 minutes without assist. 7/12/06 stands 5 minutes without assist. Overall resident quality life greatly improved.

OMIG Response: Review of the additional documentation submitted by the facility and the medical record indicate that there was not significant improvement over the ATP with residents functioning, nurse's notes document resident transfers with maximum assist of 2 persons, trach was removed, dressings by staff to stoma, tube feedings; resident was hospitalized for TBI – there is no indication in the physician's notes to suggest a positive prognosis. OT states 7/12/06 making slow progress able to stand 2-3 minutes, not supported by nursing notes. Medical record supports OT level 2.

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

Sample #62 – Finding: Disallow OT Level 3 –

Facility Comment: This resident was referred to OT s/p a right upper extremity shoulder fracture. Resident presented with reduced Rom and MS throughout the right use as well as significant edema. Significant functional improvement was gained. The resident quality of life and dignity was significantly improved by her ability to perform ADL's such as grooming and eating without requiring the burden of care givers to provide full assistance.

OMIG Response: Resident admitted to facility 5/16/06, refused offer of OT and PT at that time. X-ray on 7/19/06 shows calcific tendonitis of right shoulder. Per OT documentation little progress made during ATP; OT reports resident went from minimum assist with eating to a contact guard for eating with set up; nursing staff documentation indicates resident receiving continuous assistance with meals and 2 assist with transfers. There was a team meeting to modify ROM program for resident to be medicated prior to therapy, nursing staff at this time also provided ROM twice daily, documented on accountability record. Per OT logs on progress sheets resident attended 15 sessions during ATP, minimum requirement is 5 days/week at 2.5 hours. Week 1 attended 1 day/30minutes; week 2 attended 4 days/2hours. Medical record supports level 2 OT.

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

Sample #65 – Finding: Disallow OT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #74 – Finding: Disallow OT Level 3 - - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #90 – Finding: Disallow OT Level 3- Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #483 – Finding: Disallow OT Level 3 –

Facility Comment: Positive potential is clearly present based on the residents' prior to hospitalization level of compared to the assessed decline level as documented on the OT initial evaluation. 9/8/06 dressing improves from dependent to maximum assist, grooming improves from moderate/maximum assist to modified independent for face washing and hair combing. These consist and significant improvements throughout the ATP reduce the burden on the caregiver as well as increase the independence of the resident.

OMIG Response: The document used to assess prior level of function does not have the residents' name, a date or staff signature. Resident was admitted to facility s/p CVA, now with ESRD, receiving hemodialysis. The medical record documents on a near daily basis throughout the ARD how weak the resident is, feedings via peg tube refusing medications by mouth and pureed snacks by mouth. 10/6/06 evaluation by OT states grooming has improved from maximum assist to min/moderate assist; nursing note same day states resident remains unchanged receives total care for ADL's. The medical record clearly documents the ongoing deteriorating condition of the resident and the high level of care given; medical record supports level 2 for OT.

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

Sample #497 – Finding: Disallow OT Level 3 - - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #516– Finding: Disallow OT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #522 – Finding: Disallow OT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #540 – Finding: Disallow OT Level3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #544 – Finding: Disallow OT Level 3 –

Facility Comment: New admissions of less than four weeks can be marked for restorative therapy if there is a Physician, Nurse Practitioner, or appropriately cosigned Physician order for therapy and the patient receiving it. Positive potential is clearly assessed and documented by therapist, patient received evaluation and at least one treatment.

OMIG Response: Patient was admitted on 10/12/06 date of ATP, received evaluation and one treatment. OT states positive potential – ambulation poor tolerance for endurance 120' with supervision, documentation in medical record state family refusing to have resident on therapy unit (6th floor) family walking with resident in hallway, has impaired hearing, confusion and poor English skills, medical record indicates family will take resident home in morning, resident discharged 10/13/06. The medical record strongly indicated poor potential for improved functional status within a short predictable period of time.

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

Sample #548 – Finding: Disallow OT Level 3 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Facility Objections to Number of Physician Visits:

Sample #22 – Finding: Disallow Physician Visits –

Facility Comment: Requirement met as evidenced by: 7/2/06 the MD documented evaluation of the patient's right eye redness, Vigamox eye drops ordered for 10 days; 7/3/06 physician progress note documents patient had low grade fever – diagnosed with periorbital cellulitis, sent to hospital for CT of head. 7/3/06 physician visit for pain left foot, x-ray ordered; 7/6/06 returned to facility MD reviewed treatment plan ordered by ER.

OMIG Response: Physician visits 7/2/06; 7/3/06; 7/3/06 meet PRI criteria for unstable and changing condition; visit on 7/6/06 is a review of medical treatment by ER with no change in condition, documented as stable and unchanged. Medical record supports 3 physician visits.

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

Sample #225 – Finding: Disallow Physician Visits –

Facility Comment: Requirement met as evidenced by: 6/15/06 physician progress notes show evaluation post fall; on; 6/16/06 physician progress note shows evaluation of questionable fracture of 5th finger right hand; 6/17/06 physician progress note reflects patients' ecchymosis around both eyes. Sent to ER and returned. MD evaluated ER visit; 6/23/06 seen by orthopedic to evaluate non-displaced fracture of 5th finger right hand. 7/11/06 Physician monthly progress note, with notation of fall and fracture. Documentation supports 5 physician visits.

OMIG Response: The NYS DOH Division of Health Care Financing clarification sheet: Patient Review Instrument "count only those visits during which the physician, nurse practitioner or physician assistant personally examines the resident to address an unstable condition." Also in most cases a fracture would cause medical instability. However, a fracture, such as a fracture finger, may not cause medical instability." Physician visits on 6/15/06 – post fall assessment; 6/17/06 follow up from fall, evaluation eye and 6/23/06 orthopedic evaluation meet PRI requirements. Physician note of 6/16/06 evaluation of x-ray – resident was not seen by physician, therefore does not meet PRI requirements; and 7/11/06 physician's monthly note is not a visit to review an unstable condition, note relates summary of events of past month. Medical record supports 3 visits.

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

Sample #244 – Finding: Disallow Physician Visits –

Facility Comment: Requirement met as evidenced by: 6/27/06 physician progress notes show evaluation post fall; on 7/3/06 physician progress note documents patient complained discomfort right shoulder, diagnosed arthritis –x-ray, labs and Tylenol ordered 7/7/06 physician evaluated patient's labs and made order changes. 7/9/06 patient was evaluated post fall; 7/11/06 Physician progress note reflects increase pain right shoulder. 7/13/06 Physician progress note reflects evaluation of labs and patient's condition. Documentation supports 5 physician visits.

OMIG Response: The NYS DOH Division of Health Care Financing clarification sheet: Patient Review Instrument "count only those visits during which the physician, nurse practitioner or physician assistant personally examines the resident to address an unstable condition." Physician visits on 6/27/06 – post fall assessment-meets PRI requirement; 7/3/06 physician monthly visit progress note documents patient complained discomfort right shoulder, diagnosed arthritis –x-ray, labs and Tylenol ordered patient stable does not meet requirements; 7/7/06 physician evaluated patient's labs and made order changes- patient was not seen by physician; 7/9/06 patient was evaluated post fall – meets requirement; 7/11/06 Physician progress note f/u of fall, condition stable; 7/13/06 physician progress note reflects evaluation of labs with med changes, resident was not seen – does not meet requirement for PRI; Medical record supports 3 visits.

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

Sample #252– Finding: Disallow Physician Visits –

Facility Comment: Requirement met as evidenced by: 6/23/06 physician progress notes show evaluation of the patient with agitation, Haldol ordered; 6/24/06 physician progress note evaluates patient's left hand open skin tear- treatment ordered; 6/28/06 physician evaluated patient with agitation ordered psychiatry consult; 7/9/06 patient was evaluated post fall; 7/10/06 PT & OT consults ordered. Documentation supports 5 physician visits.

OMIG Response: The NYS DOH Division of Health Care Financing clarification sheet: Patient Review Instrument "count only those visits during which the physician, nurse practitioner or physician assistant personally examines the resident to address an unstable condition. Excludes Psychiatry visits." Physician visits on 6/23/06 evaluation patient with agitation meets requirement; 6/24/06 – Physician order not seen;

6/28/06 psychiatry visit – does not meet requirements; 6/29/06 reviewed psychiatrist note patient not seen- does not meet PRI requirements. Physician note of 7/16/06 post fall evaluation meets PRI requirements; and 7/11/06 order only for PT & OT resident not seen. Medical record supports 2 visits.

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

Sample #297 – Finding: Disallow Physician Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #308 – Finding: Disallow Physician Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Facility Objections to Primary Medical Problem

Sample #102 – Finding: Disallow Primary Medical Problem - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #168 – Finding: Disallow Primary Medical Problem - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #202– Finding: Disallow Primary Medical Problem - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #558 – Finding: Disallow Primary Medical Problem - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 METROPOLITAN JEWISH GERIATRIC CENTER
 AUDIT #09-4649
 CALCULATION OF MEDICAID OVERPAYMENT

<u>Service</u>	<u>Effective Period</u>	<u>Part B Non-Elig.</u>		<u>Part B-Elig</u>		<u>Difference</u>	<u>Medicaid Days</u>	<u>Medicaid Impact</u>
		<u>From</u>	<u>To</u>	<u>From</u>	<u>To</u>			
NF	07/01/06 - 09/30/06	281.63	276.02	276.40	270.79	5.61	31676	\$ 177,702
NF	10/01/06 - 12/31/06	284.31	278.76	279.08	273.53	5.55	31053	172,344
NF	01/01/07 - 03/31/07	296.29	290.64	290.93	285.28	5.65	29858	168,698
NF	04/01/07 - 06/30/07	294.71	289.09	289.38	283.76	5.62	29340	164,891
NF	07/01/07 - 08/31/07	287.04	281.42	281.71	276.09	5.62	16961	95,321
NF	09/01/07 - 12/31/07	287.04	281.42	281.71	276.09	5.62	30864	173,456
NF	01/01/08 - 03/31/08	294.93	289.20	289.48	283.75	5.73	21872	125,327
NF	04/01/08 - 06/30/08	288.76	283.07	283.35	277.66	5.69	22066	125,556
NF	07/01/08 - 12/31/08	295.92	290.23	290.51	284.82	5.69	41337	235,208
NF	01/01/09 - 03/31/09	300.30	294.45	294.78	288.93	5.85	20579	120,387
TOTAL MEDICAID OVERPAYMENT								<u>\$ 1,558,890</u>

NOTES: Impact of the Dementia Per Diem Calculation handled as per diem disallowance on Schedule VII (Schedule E)

Rate Setting Name: MJG Nursing Home Company Inc

OFFICE OF THE MEDICAID INSPECTOR GENERAL
METROPOLITAN JEWISH GERIATRIC CENTER
CHANGE IN RUG CATEGORIES
JULY 24, 2006

RUG CATEGORY	CHANGE IN RUG CATEGORY			ADJUSTED
	REPORTED	INCREASE	DECREASE	
BA	0			0
BB	7		4	3
BC	3		1	2
CA	3			3
CB	30	5		35
CC	47		16	31
CD	21		5	16
PA	7	4		11
PB	11	4		15
PC	103	34		137
PD	31		6	25
PE	25	4		29
RA	2	2		4
RB	123		16	107
SA	3	1		4
SB	54		6	48
TOTAL	470	54	54	470

Dementia Patient Per Diem Calculation

CA	0			0
BA	0			0
PA	0			0
PB	2		2	0
TOTAL	2	0	2	0

OFFICE OF THE MEDICAID INSPECTOR GENERAL
METROPOLITAN JEWISH GERIATRIC CENTER
CHANGE IN RUG CATEGORIES
OCTOBER 12, 2006

RUG CATEGORY	CHANGE IN RUG CATEGORY			
	REPORTED INCREASE	DECREASE	ADJUSTED	
BA	0			0
BB	8		5	3
BC	3		1	2
CA	0			0
CB	32	1		33
CC	43		13	30
CD	23		4	19
PA	6	3		9
PB	12	4		16
PC	103	37		140
PD	27		5	22
PE	20	4		24
RA	7	3		10
RB	148		20	128
SA	4	2		6
SB	48		6	42
TOTAL	484	54	54	484

Dementia Patient Per Diem Calculation

CA	0			0
BA	0			0
PA	0			0
PB	3		3	0
TOTAL	3	0	3	0

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 REVIEW OF PATIENT REVIEW INSTRUMENT
 METROPOLITAN JEWISH GERATRIC CENTER
 AUDIT #09-4649

Sample#	DOB	Initials	PRI Date	RUG Category		RUG Weight		DETAILED FINDINGS																			
				Reported	Derived	Reported	Derived	Disallow Toileting	Disallow Eating	Disallow Physician Visits	Disallow Primary Medical Problem	Disallow Transfer	Disallow Oxygen	Disallow PT Level	Disallow OT Level	Disallow Disruptive Behavior	Disallow Wound Care	Disallow Decubitus Level	Disallow Hallucinations	Disallow Dementia Add-on	Disallow Suctioning	Disallow Physical Aggression	Disallow Verbal Disruption	Disallow Stairs/Lifter	Disallow Dehydration	Disallow Parenteral Feeding	Disallow Chemo Therapy
451	12/11/1947	J.S.	7/17/2006	PB	PB	0.83	0.83																				
452	5/27/1932	V.T.	7/17/2006	PB	PB	0.83	0.83																				
453	4/20/1931	O.B.	7/18/2006	PB	PA	0.83	0.83																				
454	11/23/1928	M.C.	7/18/2006	PB	PA	0.83	0.83																				
455	8/16/1918	S.V.	7/18/2006	PB	PA	0.83	0.83																				
456	9/26/1926	C.T.	7/19/2006	PB	PB	0.83	0.55																				
457	6/8/1937	J.W.	7/19/2006	PB	PB	0.83	0.83																				
458	9/1/1961	W.S.	7/20/2006	PB	PA	0.83	0.83																				
459	12/18/1958	R.S.	7/20/2006	PB	PB	0.83	0.55																				
460	7/10/1957	M.J.	7/20/2006	PB	PB	0.83	0.83																				
461	12/12/1978	S.V.	7/21/2006	PB	PB	0.83	0.83																				
462	5/18/1972	F.A.	7/14/2006	CA	CA	0.83	0.83																				
463	3/17/1961	M.J.	7/20/2006	CA	CA	0.83	0.83																				
464	12/30/1911	H.K.	7/24/2006	CA	CA	0.7	0.7																				
465	8/7/1934	L.M.	7/19/2006	CA	CA	0.7	0.7																				
466	4/26/1932	I.R.	7/19/2006	PA	PA	0.55	0.55																				
467	12/28/1949	S.F.	7/19/2006	PA	PA	0.55	0.55																				
468	11/16/1913	F.Z.	7/24/2006	PA	PA	0.55	0.55																				
469	8/21/1950	R.B.	7/24/2006	PA	PA	0.55	0.55																				
470	8/19/1958	A.E.	7/20/2006	PA	PA	0.55	0.55																				
471	6/6/1905	S.F.	7/21/2006	PA	PA	0.55	0.55																				
472	12/1/1915	N.L.	10/3/2006	PA	PA	0.55	0.55																				
473	12/28/1912	D.L.	10/3/2006	RB	RB	0.55	0.55																				
474	3/17/1917	H.E.	10/3/2006	RB	RB	1.79	1.79																				
475	7/2/1924	A.E.	10/4/2006	RB	RB	1.79	1.79																				
				RB	RB	1.79	1.79																				
				RB	RB	1.79	1.79																				
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METROPOLITAN JEWISH GERIATRIC CENTER DETAILED FINDINGS

PRI FINDINGS**Sample Selection****Decubitus Level Disallowed**

The PRI instructions/clarifications state, *“For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components: 1. A description of the patient’s decubitus, 2. Circumstance or medical condition which led to the decubitus, 3. An active treatment plan.”*

10 NYCRR Section 86-2.30 (II) 16

In 2 instances, documentation did not support a description of the wound as decubitus level 2, 3, or 4.	174, 497
In 2 instances, documentation did not support circumstance or medical condition which led to the decubitus.	174, 497
In 2 instances, documentation did not support an active treatment plan.	174, 497
In 5 instances, documentation did not support a necrosis qualifier.	106, 157, 163, 174, 497

Dehydration

The PRI instructions/clarifications define dehydration as an *“excessive loss of body fluids requiring immediate medical treatment and ADL care.”*

10 NYCRR Section 86-2.30 (II) 17B

In 1 instance, the medical record did not support the definition of dehydration.	484
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Stasis Ulcer

The PRI instructions/clarifications define a stasis ulcer as *“open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.”*

10 NYCRR Section 86-2.30 (II) 17D

In 1 instance, documentation did not support the definition of stasis ulcer. 548

Suctioning - General (Daily)

PRI instructions/clarifications state, *"For medical treatments having a daily frequency requirement, treatments must be provided every day of the four week period."*

10 NYCRR Section 86-2.30 (II) 18B

In 3 instances, documentation did not support the daily frequency requirement for suctioning. 144, 149, 177

Oxygen - (Daily)

PRI instructions/clarifications state *"For medical treatments having a daily frequency requirement, treatments must be provided every day of the four week period."*

10 NYCRR Section 86-2.30 (II) 18C

In 20 instances, documentation did not support the daily frequency requirement for oxygen. 49, 53, 90, 104, 122, 148, 174, 184, 187, 188, 191, 247, 262, 264, 267, 271, 512, 530, 547, 557

Parenteral Feeding

The PRI instructions/clarifications define parenteral feeding as *"intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance."*

10 NYCRR Section 86-2.30 (II) 18F

In 1 instance, the medical record did not support parenteral feeding during the past 28 days. 161

Wound Care

The PRI instructions/clarifications define a wound as a *"subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers."* Additionally, *"decubiti, stasis ulcers, skin tears and feeding tubes are excluded"* from wound care.

10 NYCRR Section 86-2.30 (II) 18G

In 6 instances, documentation did not support wound care due to surgery, trauma, or cancerous lesion during the past 28 days. 9, 13, 100, 257, 497, 527

In 3 instances, wound care for decubiti, stasis ulcers, skin tears and feeding tubes are excluded. 9, 475, 497

Chemotherapy

The PRI instructions/clarifications define chemotherapy as *“treatment of carcinoma through IV and/or oral chemical agents.”*

10 NYCRR Section 86-2.30 (II) 18H

In 1 instance, the medical record did not support the chemotherapy during the past 28 days. 299

Eating

PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 19

Level 2 eating *“requires intermittent supervision and/or minimal physical assistance with minor parts of eating such as cutting food, buttering bread or opening milk cartons.”*

In 6 instances, documentation did not support intermittent supervision and/or minor physical assistance with eating. 74, 202, 391, 407, 491, 497

Level 3 eating continual help *“means that the patient requires a staff person’s continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.”*

In 46 instances, documentation did not support continual help with eating. 14, 28, 33, 37, 39, 41, 45, 48, 49, 58, 63, 66, 68, 80, 97, 111, 227, 239, 244, 250, 291, 328, 341, 343, 354, 356, 364, 367, 375, 376, 380, 401, 411, 420, 427, 436, 457, 484, 529, 538, 540, 554, 592, 596, 598, 600

Level 4 eating is *“totally fed by hand: patient does not manually participate.”*

In 7 instances, documentation did not support that the resident was totally fed by hand. 23, 109, 168, 247, 271, 310, 556

Level 5 eating is *"tube or parenteral feeding for primary intake of food."*

In 2 instances, documentation did not support tube or parenteral feeding is primary intake for food. 222, 557

Transfer

The PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 21

Level 3 transfer continuous assistance; *"requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer."*

In 5 instances, documentation did not support constant guidance or physical assistance in transfer. 11, 41, 74, 394, 433

Level 4 transfer *"requires two people to provide constant supervision and/or physically lift. May need lifting equipment. Documentation must support a logical medical reason why the patient required two people to transfer."*

In 17 instances, documentation did not support the resident; required two people or the use of lifting equipment to transfer. 5, 25, 29, 42, 106, 109, 216, 225, 285, 328, 354, 403, 406, 421, 512, 528, 540

In 2 instances, documentation did not support a logical medical reason why the patient required two people to transfer. 109, 285

Toileting

The PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 22

Level 3 toileting resident is *"continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (i.e. colostomy, ileostomy, urinary catheter)."*

In 7 instances, documentation did not support constant supervision and/or physical assistance with toileting. 73, 292, 372, 414, 454, 503, 524

Level 4 toileting resident is *“incontinent 60% or more of the time; does not use a bathroom. The patient may be bed bound or mentally confused to the extent that a scheduled toileting program is not beneficial.”*

In 11 instances, documentation did not support incontinence 60% of the time.

25, 109, 143, 263, 285, 380, 444, 506, 521, 540, 555

Level 5 toileting resident is *“incontinent of bowel and/or bladder but is taken to a bathroom every two to four hours during the day and as needed at night.”* Additionally, PRI clarifications state that *“the resident’s care plan must establish a toileting assistance program that is based on an assessment of the resident’s needs. The assessment should establish the needs of the resident which lead to the development of the program.”* To meet Toileting Level 5 there must be a *“care plan established for the resident based on an assessment.”* The toileting schedule must include *“the name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance is provided.”*

In 174 instances, documentation did not support an individualized toileting schedule, the specific time the resident was toileted, the toileting schedule contained blanks, and/or or the toileting schedule contained intervals greater than four hours.

1, 4, 5, 8, 11, 22, 23, 27, 29, 31, 34, 35, 40, 41, 43, 45, 48, 49, 50, 52, 54, 68, 74, 76, 82, 84, 88, 89, 92, 94, 102, 103, 104, 106, 108, 110, 111, 112, 113, 117, 123, 193, 198, 201, 204, 218, 225, 227, 228, 229, 231, 233, 235, 238, 250, 251, 252, 257, 258, 270, 274, 276, 280, 283, 287, 289, 290, 293, 295, 297, 300, 301, 303, 311, 312, 314, 315, 317, 318, 322, 328, 329, 332, 335, 336, 339, 340, 342, 343, 344, 346, 347, 349, 353, 355, 356, 357, 359, 361, 362, 363, 367, 368, 369, 370, 373, 374, 375, 376, 378, 379, 381, 382, 383, 385, 386, 387, 389, 393, 394, 397, 400, 401, 403, 404, 407, 408, 409, 410, 411, 412, 416, 418, 420, 421, 423, 424, 426, 427, 428, 431, 432, 433, 434, 436, 437, 438, 441, 443, 445, 447, 448, 449, 472, 474, 480, 481, 484, 487, 502, 519, 522, 532, 534, 541, 547, 549, 581, 589, 595, 596, 597, 598, 599

Verbal Disruption

PRI instructions/clarifications define verbal disruption as “yelling, baiting, threatening, etc.”

10 NYCRR Section 86-2.30 (IV) 23

Level 4 verbal disruption is an “unpredictable reoccurring verbal disruption at least once per week for no foretold reason.” Also, to qualify a patient as level 4 an “active treatment plan for the behavioral problem must be in current use” and a “psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem.”

In 2 instances, documentation did not support verbal disruption at least once per week. 275, 277

Physical Aggression

The PRI instructions/clarifications define physical aggression as “assaultive or combative to self or others with the intent for injury.”

10 NYCRR Section 86-2.30 (IV) 24

Level 4 physical aggression is “unpredictable, recurring aggression at least once per week during the last four weeks for no apparent or foretold reason.”

Also, to qualify a patient as level 4 disruption “an active treatment plan for the behavioral problem must be in current use” and a “psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem.”

In 1 instance, documentation did not support the “intent for injury” qualifier. 344

In 2 instances, documentation did not support physical aggression at least once per week. 277, 596

In 1 instance, documentation did not support a psychiatric assessment existed to address the patient’s problem. 596

Disruptive, Infantile or Socially Inappropriate Behavior

The PRI instructions/clarifications define this behavior as *“childish, repetitive or antisocial physical behavior which creates disruption with others.”*

10 NYCRR Section 86-2.30 (IV) 25

Level 4 behavior is *“disruptive behavior at least once per week during the last four weeks.”*

Also, to qualify a patient as level 4 disruptive behavior an *“active treatment plan for the behavioral problem must be in current use”* and a *“psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem.”*

In 7 instances, documentation did not support disruptive, infantile or socially inappropriate behavior at least once per week. 275, 277, 278, 340, 341, 344, 346

In 1 instance, documentation did not support an active treatment plan. 277

In 1 instance, documentation did not support a psychiatric assessment existed to address the patient’s behavior problem. 277

Hallucinations

The PRI instructions/clarifications define hallucinations as *“experienced at least once per week during the last four weeks, visual, auditory, or tactile perceptions that have no basis in external reality.”*

Additionally, to qualify a patient as Level 1 hallucinations an *“active treatment plan for the behavioral problem must be in current use”* and a *“psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem.”*

10 NYCRR Section 86-2.30 (IV) 26

In 5 instances, documentation did not support visual, auditory, or tactile hallucinations once per week for the last four weeks. 103, 272, 273, 342, 493

In 4 instances, documentation did not support a psychiatric evaluation was completed for hallucinations.	103, 272, 273, 493
In 3 instances, documentation did not support an active treatment plan.	103, 272, 273
Physical Therapy	
PRI instructions/clarifications state:	
<i>10 NYCRR Section 86-2.30 (V) 27A</i>	
PRI instructions/clarifications state <i>"there must be an order for restorative therapy."</i>	
In 6 instances, documentation did not support a physician, nurse practitioner, or an appropriately cosigned physician assistant's order for restorative therapy.	11, 32, 109, 491, 536, 554
In 3 instances, documentation did not support a licensed professional person with at least a four year specialized degree evaluated the program on a monthly basis.	109, 111, 491
In order for therapy to qualify as restorative <i>"there is positive potential for improved functional status within a short and predictable period of time"...</i> The qualifier for maintenance therapy is <i>"to maintain and/or retard deterioration of current functional/ADL status."</i>	
In 10 instances, documentation did not support the positive potential for improvement within a short and/or predictable period of time.	25, 32, 42, 88, 109, 111, 482, 488, 491, 544
PRI instructions/clarifications also state <i>"in order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week."</i>	
In 12 instances, documentation did not support treatment five days/ 2.5 hours per week.	25, 32, 73, 84, 88, 99, 108, 109, 111, 491, 536, 554
PRI instructions/clarifications state <i>"in order for therapy to qualify as restorative the resident must continue to show improvement during treatment."</i>	
In 14 instances, documentation did not support continued improvement in ADL/functional status through the past 28 days.	18, 25, 32, 73, 84, 88, 108, 109, 111, 482, 488, 491, 536, 554

Occupational Therapy

PRI instructions/clarifications state:

Title 10 NYCRR Section 86-2.30 (V) 27A

In order for therapy to qualify as restorative therapy *"there is positive potential for improved functional status within a short and predictable period of time"...* Qualifier for maintenance therapy is *"to maintain and/or retard deterioration of current functional/ADL status."*

In 6 instances, documentation did not support the positive potential for improvement within a short and/or predictable period of time.

8, 57, 103, 482, 483, 544

PRI instructions/clarifications further state *"in order for therapy to qualify as restorative the resident must continue to show improvement during treatment."*

In 4 instances, documentation did not support continued improvement in ADL/functional status through the past 28 days.

57, 62, 482, 483

Number of Physician Visits

The PRI instructions/clarifications state that allowable physician visits are those in which *"the patient has a medical condition that (1) is unstable and changing or (2) is stable, but there is high risk of instability."*

10 NYCRR Section 86-2.30 (V) 28

In 58 instances, documentation did not support the number of physician visits claimed were for unstable or potentially unstable conditions.

1, 4, 8, 18, 22, 27, 33, 42, 50, 55, 64, 81, 88, 99, 102, 127, 136, 142, 169, 173, 178, 191, 193, 202, 224, 225, 227, 238, 240, 244, 250, 252, 258, 260, 267, 271, 279, 281, 282, 284, 292, 294, 303, 307, 317, 318, 333, 346, 348, 390, 392, 404, 409, 415, 482, 512, 557, 570

Primary Medical Problem

The PRI instructions/clarifications state: *"The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past four weeks."*

10 NYCRR Section 86-2.30 (i) (VI) 30

In 49 instances, documentation did not support that the primary medical problem (ICD-9 code) was based on the condition that created the most need for nursing time.

11, 22, 37, 41, 62, 74, 84, 90, 93, 99, 103, 106, 109, 116, 120, 122, 128, 179, 182, 199, 218, 227, 244, 246, 248, 264, 267, 307, 365, 366, 372, 407, 443, 446, 483, 484, 491, 496, 497, 507, 515, 517, 529, 536, 539, 553, 554, 557, 578

Dementia Add-on

PRI instructions/clarifications state: *“Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from the implementation or continuation of programs to improve the care of eligible dementia patients.”*

10 NYCRR Section 86-2.10 (o)

In 4 instances, there was no documentation found in the record of activities that meet these criteria.

452, 453, 455, 603

RUGS-II Classifications Overturned

In 93 instances, the RUG-II classifications were overturned.

10 NYCRR Section 86-2.11

8, 11, 32, 41, 42, 57, 62, 73, 74, 84, 88, 99, 103, 108, 109, 111, 144, 157, 161, 163, 168, 174, 178, 179, 187, 191, 193, 198, 204, 216, 222, 225, 227, 228, 229, 233, 238, 239, 244, 246, 247, 248, 250, 252, 257, 258, 260, 270, 271, 272, 276, 279, 292, 294, 299, 303, 307, 310, 311, 312, 314, 315, 317, 318, 322, 328, 329, 332, 335, 336, 339, 340, 341, 342, 344, 346, 372, 380, 394, 414, 454, 457, 482, 483, 488, 491, 503, 536, 544, 554, 557, 595, 596