



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

THOMAS R. MEYER
Acting Medicaid Inspector General

January 28, 2015

[REDACTED]
Workmen's Circle Multicare Center
3155 Grace Avenue
Bronx, New York 10469

Re: Medicaid PRI Audit #09-3808
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 Workmen's Circle Multicare 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 revised draft audit report.

In your response to the revised draft audit report dated February 18, 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 \$3,212,368 to the total Medicaid overpayment shown in the revised draft audit report.

The findings applicable to the October 1, 2006 through March 31, 2009 Medicaid rates resulted in a Medicaid overpayment of \$938,794 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:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Coming Tower, Room 2739
File #09-3808
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.

[REDACTED]
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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 October 25, 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

Workmen's Circle Multicare Center
3155 Grace Avenue
Bronx, New York 10469

PROVIDER ID # [REDACTED]

AUDIT #09-3808

AMOUNT DUE: \$938,794

AUDIT	<input type="checkbox"/> PROVIDER
	<input checked="" type="checkbox"/> RATE
TYPE	<input type="checkbox"/> PART B
	<input type="checkbox"/> 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:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #09-3808
Albany, New York 12237-0048

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

CORRECT PROVIDER NUMBER

**WORKMEN'S CIRCLE MULTICARE CENTER
AUDIT #09-3808**

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 PRIMARY MEDICAL PROBLEM FINDINGS:

Sample #22 – 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 #37 – 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 #65– 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 #79 – 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 #95 – 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 #106– 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 #114 – 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 #115 – Finding: **Disallow Primary Medical Problem** –

Facility Comment: As per section 86-2.30 – Residential health care facilities patient assessment for certified rates/PRI guidelines. The primary medical problem should be selected based on the condition that has created the most need for nursing during the past four weeks. Condition listed was definitely supported by documentation. Patient was transferred to hospital July 25, 2006 for surgery; August 1, 2006 returned diagnosis right malleolus irritation; August 15, 2006 – treatment order bacitracin to right ankle x 5 days. Additional documentation submitted for review: CNA accountability records for September/October 2006; monthly nurses and physician notes; PRI instructions.

OMIG Response: PRI - ATP September 13, 2006 – October 10, 2006, additional documentation submitted by facility reviewed. There is no documentation in the medical record to indicate that the resident had cellulitis. There is no documentation to support that the resident received wound care during the ATP.

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

Sample #120 – 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 #141 – Finding: Disallow Primary Medical Problem –

Facility Comment: As per section 86-2.30 – Residential health care facilities patient assessment for certified rates PRI guidelines. The primary medical problem should be selected based on the condition that has created the most need for nursing during the past four weeks. Condition listed was definitely supported by documentation. Code 342.90 right hemiparesis is indicated in the monthly physician orders dated September 16, 2006 and October 11, 2006. Patient required supervision and constant minor physical assistance from staff in all areas of ADL's. Additional documentation submitted for review: CNA accountability records for September/ October 2006; monthly nurses and physician notes; PRI instructions.

OMIG Response: PRI - ATP September 18, 2006 – October 15, 2006, additional documentation submitted by facility reviewed. Nurses' notes dated September 18, 2006, September 21, 2006, September 23, 2006, October 2, 2006, October 4, 2006, October 7, 2006, October 8, 2006, October/September 2006 and October 11, 2006 document extended periods of time, up to three hours, that the resident independently leaves the facility to walk around the block. No other nursing statements on those days. Notes on September 30, 2006 and October 15, 2006 state PRI ADL note documents resident requires supervision with transfer and toileting due to right hemiparesis. CNA accountability sheets indicated independent with limited assist for ADL's, ambulation and locomotion independent. The physician progress notes say "s/p CVA with right hemiparesis." Admission diagnosis code is 438.20, late effects CVA with hemiparesis. Resident had documented finger sticks for blood glucose monitoring before each meal and medications for diabetic care. The documentation has discrepancies in that PRI note claims care for right hemiparesis yet resident is independent as evidenced by ability to be away from facility independently daily for long periods of time. Diabetes is the most documented nursing care.

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

Sample #155 – 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 #198 – 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 #209 – 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 #218 – 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 #234 – 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 #257 – Finding: Disallow Primary Medical Problem –

Facility Comment: As per section 86-2.30 – Residential health care facilities patient assessment for certified rates/ PRI guidelines. The primary medical problem should be selected based on the condition that has created the most need for nursing during the past four weeks. Condition listed was definitely supported by documentation. Patient required intermittent supervision and minor physical assistance from staff in all

areas of ADL's. Additional documentation submitted for review: CNA accountability records for September/October 2006, monthly nurses and physician notes, PRI instructions.

OMIG Response: PRI - ATP September 16, 2006 – October 13, 2006, additional documentation submitted by facility reviewed. Nurses' notes dated September 30, 2006 and October 16, 2006 document resident at level 2 for all ADL's - intermittent supervision. PT assessment indicates resident within normal limits of ROM and independently ambulates about unit. Resident has diagnosis of arteriosclerotic heart disease, angina, and coronary artery disease. CNA accountability sheets indicated independent with limited assist for ADL's, ambulation and locomotion independent. S/P CVA with hemi does not take most nursing time.

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

Sample #259 – 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 #261 – 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 #264 – 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 #267 – 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 #270 – Finding: Disallow Primary Medical Problem –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The primary medical problem should be selected based on the condition that has created the most need for nursing during the past four weeks. The care plan dated October 12, 2005 was for mood behaviors related to depression. Resident was depressed and needed assistance for all ADL's: feeding, grooming, bathing, and incontinent care. Nurses' notes, physician notes, and PRI instructions submitted to support finding.

OMIG Response: PRI - ATP September 24, 2006 – October 21, 2006, additional documentation submitted by facility reviewed. Nurses' notes document resident at level 2 for all ADL's - intermittent supervision. Resident has diagnosis of arteriosclerotic heart disease, CHF, and coronary artery disease. Medical record indicates monitoring of weight gain due to edema, close monitoring of lab values for PT/INR with Coumadin dosage change. There is no documentation to suggest care given as result of depression.

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

Sample #271 – 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 #273 – 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 #283 – Finding: Disallow Primary Medical Problem –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The primary medical problem should be selected based on the condition that has created the most need for nursing during the past four weeks. The care plan dated 6/26/06 was for verbally abusive behavior related

to dementia. October 19, 2006. Psychiatric consult stated dementia. Nurses' notes; resident plan of care, and PRI instructions submitted.

OMIG Response: PRI - ATP September 22, 2006 – October 19, 2006, additional documentation submitted by facility reviewed. Nurses' notes dated October 13, 2006 and October 15, 2006 document nonspecific episodes of verbally abusive behavior. October 25, 2006, October 27, 2006, October 28, 2006, and October 31, 2006 are outside the ATP. Physician order sheets do not list dementia as a diagnosis. Medical record supports 2959 as needing most time.

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

FACILITY OBJECTIONS TO TOILETING FINDINGS:

Sample #16 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing - Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation in the medical record supports level 4.

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

Sample #22 – Finding: Disallow Toileting Level 4 – Based on information and documentation provided by the Facility, this finding was previously reversed and is not included in the final report

Sample #37 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing - Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #38 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident had diagnosis of urinary incontinence. She is a 57 year old woman. Toileting schedule had kept her dignity. Toileting schedule was individualized as indicated in her monthly care plan toileting sheets. Level 5 toileting was met as evidenced by toileting schedule signed by CNA, September 8, 2006 Resident Care Plan, and nurses' notes September 20, 2006 and October 20, 2006.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. The CNA accountability sheets are signed at times when the nurses' notes document the resident was out of the facility independently on a pass, such as on September 2, 2006, October 2, 2006, and October 8, 2006. Documentation in the medical record supports level 4.

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

Sample #45 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #58 – Finding: Disallow Toileting Level 5 –

Facility Comment: Level 5 toileting schedule met the criteria defined in the PRI instructions and clarifications (instructions and clarifications submitted by facility). The toileting schedule was validated by individualized toileting record signed by the CNAs'. The resident care plan signifies every 2-4 hours and as needed.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #65 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #89 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #124 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident has been on a toileting program for years. She has cognitive impairment and requires the constant guidance/assistance with toileting. She needs to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. CNA accountability sheets for September and October 2006; nurses' notes, and plan of care submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record; the care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have documented such a plan. Documentation supports level 4 toileting.

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

Sample #131 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident has been on a toileting program for years. She has visual impairment and required the constant guidance/assistance with toileting. She needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. CNA accountability sheets for September and October, 2006; nurses' notes, and plan of care submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have documented such a plan. Documentation supports level 4 toileting.

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

Sample #133 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have documented such a plan. Documentation supports level 4 toileting.

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

Sample #138 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have documented such a plan. Documentation supports level 4 toileting.

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

Sample #140 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #141 – Finding: Disallow Toileting Level 2– Based on information and documentation provided by the Facility, this finding was previously reversed and is not included in the final report

Sample #143 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #157 – Finding: Disallow Toileting Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #163 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #165 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #167 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #168 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #172 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #185 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #193 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #199 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident was incontinent and needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, and plan of care submitted as well as PRI instructions for scoring level 5 toileting.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #203 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident was on a toileting program for years. The resident had a diagnosis of diabetes mellitus and history of BPH. Resident required constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #205 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours and as needed to reduce episodes of incontinence. The September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at specific pre-scheduled intervals. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #218 – Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident required the constant guidance/assistance with toileting. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CNA accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at **specific pre-scheduled intervals**. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #229– Finding: Disallow Toileting Level 5 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident was incontinent, alert, and legally blind. The resident needed to be taken to the toilet every 2-4 hours to reduce episodes of incontinence. September, 2006 and October, 2006 CAN accountability sheets, nurses' notes, plan of care, and PRI instructions submitted.

OMIG Response: The documentation submitted by the facility was reviewed. The resident was incontinent as evidenced by the medical record. The care plan does not have a specific plan of care as to when the resident will be toileted. New York State Department of Health, Division of Health Care Financing – Clarification Sheet: Patient Review Instrument states for level 5 toileting the facility must have a mechanism in place to substantiate that the resident is taken to the bathroom at **specific pre-scheduled intervals**. The resident does not have such a plan documented. Documentation supports level 4 toileting.

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

Sample #253 – Finding: Disallow Toileting Level 2 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #258 – Finding: Disallow Toileting Level 2 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #261– Finding: Disallow Toileting Level 2 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

FACILITY OBJECTIONS TO TRANSFER FINDINGS:

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

Sample #22 – Finding: Disallow Transfer Level 4 - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #37 – Finding: **Disallow Transfer 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 Transfer Level 3-** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #58 – Finding: **Disallow Transfer Level 4-** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #89 – Finding: **Disallow Transfer Level 3-** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #140 – Finding: **Disallow Transfer Level 4 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #141 – Finding: **Disallow Transfer Level 3 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #144 – Finding: **Disallow Transfer Level 3 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #148 – Finding: **Disallow Transfer Level 3 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #193 – Finding: **Disallow Transfer Level 3 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #218 – Finding: **Disallow Transfer Level 3 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #253 – Finding: **Disallow Transfer Level 2 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #258 – Finding: **Disallow Transfer Level 2 -** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

FACILITY OBJECTIONS TO EATING LEVEL OF CARE FINDINGS:

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

Sample #13 – Finding: **Disallow Eating Level 4-** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #22 – Finding: **Disallow Eating Level 4-** Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #89 – Finding: **Disallow Eating 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 Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #133 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #172 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #193 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #198 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #209 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #218 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #225 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #233 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #234 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #241 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #242 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #243 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #253 – Finding: **Disallow Eating Level 3** - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #258 – Finding: **Disallow Eating Level 2** - 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 FINDINGS:

Sample #25 – Finding: **Disallow Physician Visits** –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident was seen September/23/06, September/24/06, September/25/06, and September/2September/06

for post fall evaluation. October 12, 2006 reviewed labs and EKG ordered. On October 16, 2006 resident was seen for scratches about face. With new order, residents with diabetes take longer to heal and open wounds can cause unstable blood sugar. Documentation supports four 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 during past four weeks." The ATP of September 27, 2006 – October 24, 2006, Physician visits on September 23, 2006, September 24, 2006, and September 25, 2006 were outside the ATP dates so they do not count for PRI. MD visits on September 29, 2006, post fall, October 12, 2006, evaluation of abnormal labs and EKG order; and October 16, 2006, evaluation of facial scratches, are counted for PRI. The facility submitted documentation of physician progress notes and orders, nurses' notes, and medication administration records. All were reviewed. The documentation does not support that the physician saw the resident for four visits during ATP. Documentation supports three physician visits.

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

Sample #37 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident was seen on October 6, 2006, October 11, 2006, October 16, 2006, October 18, 2006, October 12, 2006, and October 30, 2006. Documentation supports four 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 during past four weeks". The resident was out of facility to hospital October 18, 2006 – October 24, 2006. The ATP would be October 24, 2006 – October 25, 2006. Physician visits on October 6, 2006, October 11, 2006, October 16, 2006, October 18, 2006, October 12, 2006, and October 30, 2006 are all outside the look back period. The facility submitted documentation of MD progress notes and orders, nurses' notes, and medication administration records. All were reviewed. The documentation does not support that the physician saw the resident for four visits during ATP. Documentation does not support any physician visits.

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

Sample #79 – 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 #128 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Requirement met as evidenced by October 4, 2006 physician progress notes show evaluation of cough. October 6, 2006 had unstable labs. October 9, 2006 had unstable labs. October 12, 2006 follow-up for antibiotics and lab work ordered. October 18, 2006 resident monthly visit and labs ordered. October 20, 2006 had high labs with new diagnosis. Documentation supports six 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 during past four weeks". For the ATP of September 22, 2006 - October 19, 2006, the physician visit on October 20, 2006 was outside the ATP dates. It does not count for PRI. Physician visits on

October 4, 2006 to evaluate cough and rule out pneumonia, and October 12, 2006 to follow-up cough on antibiotics and to repeat abnormal labs order are counted for PRI. The facility submitted documentation of physician progress notes, orders, and nurses' notes and medication administration records. All were reviewed. The documentation does not support that the physician actually saw the resident on October 6, 2006. On October 6, 2006 and October 9, 2006 reviewed labs. Visit on October 18, 2006 was regular monthly visit and does not count for PRI. Documentation supports two physician visits during ATP.

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

Sample #143 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident was seen for unstable blood sugar/diabetes. September 15, 2006 x-ray to r/o plural effusion was negative. October 6, 2006 visit follow-up for diabetes. October 12, 2006 visit evaluation for diabetes and new orders. October 20, 2006 visit follow-up for diabetes and new orders. Due to resident's unstable blood sugar, requires frequent intervention by staff physician and coverage with insulin sliding scale. Documentation supports four 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 during past four weeks". The ATP of September 15, 2006 to October 12, 2006 excludes physician visits that are not in that time period. October 20, 2006 falls outside the ATP. The October 6, 2006 physician note was a review of lab work. There is no indication that the physician personally examined the resident. Physician visits on September 15, 2006 and October 12, 2006 meets PRI requirements. Medical record supports two visits.

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

Sample #144 – 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 #152 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. Resident was seen for unstable blood sugar/diabetes. October 4, 2006 visit follow-up for diabetes. October 11, 2006 visit for diabetes evaluation with new orders. October 1, 2006 visit resident seen for rash with new order. Residents with diabetes take longer to heal and open wounds can cause unstable blood sugar. October 25, 2006 visit evaluated and followed-up for diabetes. Due to residents unstable blood sugar requires frequent intervention by staff physician and coverage with insulin sliding scale. Documentation supports four 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 during past four weeks". The ATP of September 21, 2006 – October 18, 2006, the resident had three episodes of receiving coverage for finger stick/blood glucose. October 1, 2006, October 5, 2006, and October 14, 2006 all were given 5 units as per standing sliding scale order; none required a call to the physician. The facility submitted documentation of physician progress notes, orders, nurses' notes, and medication administration records. All were reviewed. The documentation does not support that the physician saw the resident on October, 4 2006; note states DM – ok. October 11, 2006 notes states review DM- NPH insulin decreased. On October 25, 2006 note says DM management. October 18, 2006 resident was seen

and evaluated for a new rash of unknown origin, orders written. Documentation supports one physician visits.

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

Sample #157 – Finding: Disallow Physician Visits –

Facility Comment: Requirement met as evidenced by September 1, 2006 physician progress notes that show evaluation of the patient. September 8, 2006 physician progress note “evaluates resident.” September 15, 2006 physician evaluated resident. September 20, 2006 resident was evaluated, follow-up for toe infection. September 27, 2006 refused medication. October 9, 2006 reviewed lab reports. October 25, 2006 was physician evaluation. Documentation supports five 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 during past four weeks”. The ATP of September 13, 2006 – October 10, 2006 excludes physician visits that are not in that time period. September 1, 2006, September 8, 2006, and October 25, 2006 all fall outside the ATP. The October 9, 2006 physician note was a review of lab work. There is no indication that the physician personally examined the resident. Physician visits on September 15, 2006, September 20, 2006, and October 9, 2006 meets PRI requirements. Medical record supports three physician visits.

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

Sample #165 – 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 #234 – 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 #242 – 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 #258 – 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 #259 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. PRI instruction/clarification state allowable physician visits “are those in which (1) the patient has a medical condition that is unstable or changing, or (2) is stable but has high risk of instability.” Resident was seen for conditions that were unstable or had the potential for serious complications if not evaluated. Resident was seen on September 8, 2006, September 13, 2006, September 23, 2006, October 4, 2006, October 11, 2006, and October 17, 2006. Documentation supports six 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, PRI instruction/clarification state allowable physician visits “are those in which (1) the patient has a medical condition that is unstable or changing, or (2) Is stable but has high risk of instability.” The ATP September 28, 2006 – October 25, 2006 places physician visits on September 8, 2006, September 13, 2006, and September 23, 2006 outside the 28

day look back period. Physician visits on October 4, 2006, October 11, 2006, and October 17, 2006 does meet PRI requirements. Medical record supports three medical visits.

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

Sample #262 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. PRI instruction/clarification state allowable physician visits “are those in which (1) the patient has a medical condition that is unstable or changing, or (2) is stable but has high risk of instability.” Resident was seen for conditions that were unstable or had the potential for serious complications if not evaluated. Resident was seen on September 14, 2006, September 18, 2006, and September 25, 2006 to evaluate labs. September 28, 2006 visit to evaluate ear cerumen. October 5, 2006 visit to evaluate resident lab values and Coumadin. On October 9, 2006 order written for oncology appointment. October 12, 2006 evaluation of lab work and diagnoses made by oncologist. October 17, 2006 seen for constipation and depression from diagnosis of cancer; and, October 23, 2006 referral for hospice care and psychiatric consult. Documentation supports five 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 during past four weeks”. The ATP of September 23, 2006 – October 20, 2006 excludes physician visits that are not in that time period. September 14, 2006 and September 18, 2006 fall outside the ATP. The September 25, 2006 and October 5, 2006 physician note was for a review of lab work. There is no indication that the physician personally examined the resident. September 28, 2006 was for an evaluation of ear cerumen. That is not an unstable condition. October 9, 2006 order for oncology consult was written, but no indication resident was seen. Physician visits on October 12, 2006 and October 17, 2006 meet PRI requirements. October 23, 2006 referral made for hospice and psychiatric consult, but no indication resident was seen. Medical record supports two visits, October 12, 2006 and October 17, 2006.

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

Sample #263 – 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 #265 – 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 #269 – 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 #270 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. PRI instruction/clarification state allowable physician visits “are those in which (1) the patient has a medical condition that is unstable or changing, or (2) is stable but has high risk of instability.” Resident was seen for conditions that were unstable or had the potential for serious complications if not evaluated. Resident was seen on September 25, 2006 for rash on both hands and cortisone cream ordered. Resident was seen on October 4, 2006 for weight gain of 16 lbs. and edema. Visit on October 10, 2006 and October 19, 2006 for evaluation of lab work. October 21, 2006 resident complained of congestion and cough. Resident is unstable due to history of coronary bypass. Documentation supports five 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; PRI instruction/clarification state allowable physician visits "are those in which (1) the patient has a medical condition that is unstable or changing, or (2) is stable but has high risk of instability." Physician visit on September 25, 2006 resident was seen for rash on hands, cortisone cream ordered. This does not meet PRI requirements as resident was not unstable. October 4, 2006 weight gain of 16 lbs., edema, and history of heart failure visit meets PRI requirements. October 10, 2006 resident not seen, lab values evaluated, does not meet PRI requirements. October 19, 2006 resident seen and lab values evaluated with a new diagnosis of A- Fib does meet PRI requirements, October 21, 20/06 resident seen for chest congestion, cough with a history of coronary bypass does meet PRI requirements. Medical record supports three medical visits: October 4, 2006, October 19, 2006, and October 21, 2006.

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

Sample #272 – Finding: Disallow Physician Visits –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. PRI instruction/clarification state allowable physician visits "are those in which (1) the patient has a medical condition that is unstable or changing, or (2) is stable but has high risk of instability." Resident was seen for conditions that were unstable or had the potential for serious complications if not evaluated. Resident was seen on October 4, 2006 for rash on both feet with a diagnosis of Tinea Pedis. October 9, 2006 was for evaluation of lab work. October 10, 2006 was a podiatry consult. On October 11, 2006, follow-up with primary of podiatry. October 18, 2006- follow up for Tinea Pedis. Documentation supports 4+ 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. PRI instruction/clarification state allowable physician visits "are those in which (1) the patient has a medical condition that is unstable or changing, or (2) is stable but has high risk of instability." Physician visit on October 4, 2006 resident seen for rash on feet and treatment ordered. This meets PRI requirements. October 9, 2006 the resident was not seen. Lab values were evaluated. This does not meet PRI requirements. October 10, 2006, podiatry visit validated diagnosis and treatment of primary physician. Not an unstable condition. October 11, 2006 physician reviewed podiatry consultation and no new orders given. States resident is stable. October 14, 2006 primary physician visit states condition stable and resolving. Medical record supports three visits, neither the podiatric nor the primary classified condition as unstable.

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

Sample #273 – 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 #274 – 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 PHYSICAL THERAPY FINDINGS:

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 #25 – 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 #35 – 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 #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 #58 – Finding: Disallow PT Level 3 –

Facility Comment: Resident was a 86 year-old male with Glaucoma, advanced Prostate Cancer, Osteoarthritis, and Dementia. He was able to ambulate with cane. Was independent in transfers and remained high functioning from April 18, 2006 – May 23, 2006 when he fell. X-ray taken and was negative of fractures. This required increasing assistance for ADL's. August 31, 2006 was given PT evaluation and started on a program. The decline in residents' functional status was exacerbated by the development of a sacral ulcer. The therapy plan of care supported that the resident has the potential to improve within a short predictable period of time. Resident improved August 31, 2006 (he was unable to ambulate.) September 28, 2006 takes two to three steps in parallel bars with two assist. October 12, 2006 walks 8-10 feet in parallel bars with two assist. This was a big improvement for the resident.

OMIG Response: Resident ambulated with cane upon admission. May 23, 2006 takes a fall and continues to decline in functional status. Three months pass with no interventions. August 31, 2006 MDS assessment due. Resident is placed on physical therapy. Nurses' notes indicate September 25, 2006 resident requires extensive assistance of two staff with all ADL's. Monthly nurses' note for October, 2006 shows no improvement in functional status. Status continues to decline due to sacral ulcer and complaints of related pain. Medical record supports Level 2 Physical Therapy.

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

Sample #79 – 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 #115 – 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 #5 – 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 #13 – 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 #22 – 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 #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 #119 – 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 STASIS ULCER FINDINGS:

Sample #148 – Finding: Disallow Stasis Ulcer - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

FACILITY OBJECTIONS TO WOUND CARE FINDINGS:

Sample #115 – Finding: Disallow Wound Care –

Facility Comment: Patient was transferred to hospital July 25, 2006 for surgery. August 1, 2006 returned with diagnosis of right malleolus irritation. August 15, 2006 treatment order bacitracin to right ankle x 5 days. CNA accountability records for September and October, 2006, monthly nurses and physician notes, and PRI instructions supports wound care.

OMIG Response: PRI - ATP September 13, 2006 – October 10, 2006, additional documentation submitted by facility reviewed. There is no documentation in the medical record to indicate that the resident had cellulitis; there is no documentation to support that the resident received wound care during the ATP.

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

FACILITY OBJECTIONS TO VERBAL DISRUPTION FINDINGS:

Sample #209 – Finding: Disallow Verbal Disruption Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has diagnosis of poor vision, dementia, and depression. Resident has episodes of verbal disruption, screaming, threatening, and aggressive, inappropriate behaviors at least once weekly. Behavior

is unpredictable and requires staff to stop what they are doing to intervene. The resident is seen by a psychiatrist and has an active treatment plan. Documents have been submitted, psychiatrist notes, behavior plans; PRI directions and nurses notes describing behaviors on October 13, 2006; and October 19, 2006. This supports at least weekly requirement of PRI.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention and the results of the intervention..." The nursing note describing behaviors on October 19, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. The note of October 13, 2006 describes an actual occurrence. Documentation supports Level 1.

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

Sample #215 – Finding: Disallow Verbal Disruption Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has diagnosis of schizoaffective disorder, bipolar type. Resident exhibits verbal disruptions and socially inappropriate behaviors at least once weekly. Behavior is unpredictable and requires staff to stop what they are doing to intervene. The resident is seen by a psychiatrist and has an active treatment plan. Documents have been submitted: psychiatrist notes, behavior plans, PRI directions, and nurses' notes describing behaviors on September 29, 2006, October 6, 2006, October 13, 2006, and October 19, 2006 supporting at least weekly requirement of PRI.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention and the results of the intervention..." The nursing notes describing behaviors on September 29, 2006, October 6, 2006, October 13, 2006 and October 19, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Documentation supports Level 1.

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

Sample #259 – Finding: Disallow Verbal Disruption Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident had diagnosis of dementia, paranoid schizophrenia, and TIA's. Resident has verbally disruptive behavior, yelling for no apparent reason or provocation at least one or more times per week. Staff needed to intervene with resident's behavior. PRI instructions define verbal disruption as yelling, baiting, threatening, etc. Additional documentation submitted. Nursing notes of September 23, 2006, September 27, 2006, October 9, 2006, October 10, 2006, October 24, 2006, October 25, 2006, and; October 26, 2006 describe behavior and interventions. Behavior care plan dated November 28, 2006 also submitted.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention, and the results of the intervention..." The nursing notes describing behaviors on September, 23 2006, September 27, 2006, and October 26, 2006 do not count as they occurred outside ATP look back. Nursing behavioral notes on October 9, 2006, October 10, 2006, October 24, 2006, and October 25, 2006 describe the actual occurrence of the behavior. They occur in only two weeks of the four week look back period. There is no documentation to support behaviors occurred at

least once in each of the four week look back period. Documentation supports level 2 (one to three occurrences in past four weeks).

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

Sample #263 – Finding: Disallow Verbal Disruption Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident had diagnosis of poly-substance abuse, seizure disorder, and depression. Resident has verbally disruptive behavior, yelling for no apparent reason or provocation at least one or more times per week. Staff needed to intervene with resident's behavior. PRI instructions define verbal disruption as yelling, baiting threatening etc. Additional documentation submitted. Nurses' notes of September 23, 2006, October 2, 2006, October 16, 2006, and October 23, 2006 describe behavior and interventions.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention, and the results of the intervention..." The nursing notes describing behaviors on September 23, 2006; October 2, 2006, October 16, 2006, and October 23, 2006 (October 23, 2006 does not count as well as it occurred after ATP date) describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Documentation supports Level 1.

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

Sample #280 – Finding: Disallow Verbal Disruption Level 4 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #283 – Finding: Disallow Verbal Disruption Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has a diagnosis of dementia, which is indicated in the physician's notes and in the resident's care plan. Resident had dementia with behavioral problems. She was verbally and physically disruptive to staff and other residents. The resident was seen by the psychiatrist on October 9, 2006 and October 23, 2006, and has an active treatment plan of June 26, 2006. Documents have been submitted, psychiatrist notes, behavior plans; PRI directions and nurses notes describing behaviors on October 13, 2006, October 15, 2006, October 27, 2006, October 28, 2006, October 29, 2006 and October 31, 2006 supporting Level 4 requirement of PRI.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: : Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention, and the results of the intervention..." The nursing notes describing behaviors on October 13, 2006 and October 15, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Nurses notes should describe behaviors when they occur. Behavior documentation on October 27, 2006, October 28, 2006, October 29, 2006, and October 31, 2006 are after the ARD and do not meet MDS criteria. Documentation supports Level 1.

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

FACILITY OBJECTIONS TO HALLUCINATIONS FINDINGS:**Sample #225 – Finding: Disallow Hallucinations Level 1 –**

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has a diagnosis of schizophrenia. There are nurses' notes September 28, 2006, October 11, 2006, October 12, 2006, and October 19, 2006 that support audio and visual hallucinations that staff needed to stop what they were doing and intervene to stop or redirect behavior. The resident saw psychiatric services for evaluation/consultations dated July 26, 2006, August 14, 2006, September 15, 2006, October 3, 2006, October 11, 2006, and October 19, 2006. Additional documentation submitted as well as PRI directions for hallucination behavior.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention and the results of the intervention... also, that the psychiatric assessment must address the specific behavior exhibited by the resident." The nursing notes describing behaviors on September 28, 2006, October 11, 2006, October 12, 2006, and October 19, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. The psychiatric notes/evaluation/consultations dated July 26, 2006, August 14, 2006, September 15, 2006, October 3, 2006, October 11, 2006, and October 19, 2006 documentation states no hallucinations.

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

Sample #280 – Finding: Disallow Hallucinations Level 1 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #281 – Finding: Disallow Hallucinations Level 1 – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

FACILITY OBJECTIONS TO INAPPROPRIATE BEHAVIOR FINDINGS:**Sample #198 – Finding: Disallow Inappropriate Behavior Level 4 -**

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has a diagnosis of schizophrenia. There are nurses' notes September 27, 2006, October 4, 2006, October 10, 2006, October 17, 2006, and October 20, 2006 that support disruptive behaviors that staff needed to stop what they were doing and intervene to stop or redirect behavior. Additional documentation submitted as well as PRI directions for scoring inappropriate behavior.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states "There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention and the results of the intervention..." The nursing notes describing behaviors on September 27, 2006, October 10, 2006, October 17, 2006, and October 20, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. There is only one note to describe an occurrence with date and time, and results of intervention, on October 4, 2006. Documentation supports Level 3.

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

Sample #215 – Finding: Disallow Inappropriate Behavior Level 4 -

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has a diagnosis of schizoaffective disorder, bipolar type; exhibits verbal disruptions and socially inappropriate behaviors at least once weekly. Behavior is unpredictable and requires staff to stop what they are doing to intervene. The resident is seen by psychiatrist and has an active treatment plan. Documents have been submitted, psychiatrist notes, behavior plans; PRI directions and nurses notes describing behaviors on September 29, 2006, October 6, 2006, October 13, 2006, and October 19, 2006 supporting at least weekly requirement of PRI.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states “There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention and the results of the intervention...” The nursing notes describing behaviors on September 29, 2006; October 6, 2006, October 13, 2006, and October 19, 2006; describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Documentation supports Level 1.

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

FACILITY OBJECTIONS TO PHYSICAL AGGRESSION FINDINGS:**Sample #140 – Finding: Disallow Physical Aggression Level 4 -**

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident is alert with periods of aggression toward staff; occurs even without provocation, combative during care, and with intent to harm staff. Documents have been submitted: psychiatrist notes, behavior plans, PRI directions, and nurses' notes describing behaviors on September 29, 2006, October 5, 2006, October 10, 2006, and October 16, 2006 supporting at least weekly requirement of PRI.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states “There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention, and the results of the intervention...” The nursing notes describing behaviors on September 29, 2006, October 5, 2006, October 10, 2006, and October 16, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Documentation supports Level 2.

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

Sample #278 – Finding: Disallow Physical Aggression Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has impaired decision making skills, dementia, diabetes mellitus, and periods of physical aggression toward staff and peers which occurs without provocation. Documents have been submitted: behavior plans, PRI directions, and nurses notes describing behaviors on September 5, 2006; September 18, 2006, September 25, 2006, October 2, 2006, October 9, 2006, and October 15, 2006 supporting at least weekly requirement of PRI. PRI instructions/clarifications define physical aggression as assaultive or combative to self or others with intent to injury. Documentation supports Physical Aggression Level 4.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states “There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention, and the results of the intervention...” The nursing notes describing behaviors on September 18, 2006, September 25, 2006, October 2 2006, October 9, 2006, and October 15, 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Documentation dated September 5, 2006 describes an actual occurrence; however, falls outside the ATP. The documentation supports Level 1. There is no indication in the medical record of an actual occurrence of the behavior.

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

Sample #282 – Finding: Disallow Physical Aggression Level 4 –

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The resident has impaired decision making skills, dementia, schizophrenia, psychosis, and cataracts with periods of physical aggression toward staff and peers which occurs without provocation. Documents have been submitted: behavior plans; PRI directions, and nurses’ notes describing behaviors on September 26, 2006, October 3, 2006, October 10, 2006, October 17, 2006 and October 19, 2006 supporting at least weekly requirement of PRI. PRI instructions/clarifications define physical aggression as assaultive or combative to self or others with intent to injury. Documentation supports Physical Aggression Level 4.

OMIG Response: The NYS DOH, Division of Health Care Financing, clarification sheet: Patient Review Instrument states “There must be appropriate notes on the chart describing each occurrence of the behavior, the date and time, the intervention and the results of the intervention...” The nursing notes describing behaviors on September 26, 2006, October 3, 2006, October 10, 2006, October 17, 2006 and October 19 2006 describe the type of behaviors the resident has had in the past. There is no documentation in the medical record to describe the actual occurrence of the behavior. Documentation supports resident resistive to care becomes physically aggressive. This would be predictable behavior. Documentation supports Level 3.

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

FACILITY OBJECTIONS TO DAILY OXYGEN USE FINDINGS:

Sample #267 – Finding: Disallow Daily Oxygen Use – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

FACILITY OBJECTIONS TO DAILY SUCTIONING USE FINDINGS:

Sample #106 – Finding: Disallow Daily Suctioning Use - Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #114 – Finding: Disallow Daily Suctioning Use:

Facility Comment: Our facility respectfully disagrees with the PRI item disallowed by OMIG auditors. The Resident had a feeding tube and as such was a high risk for aspirations. She had MD orders for daily suctioning September 14, 2006. Nurse’s notes October 3, 2006 and October 17, 2006 indicate resident

was suctioned. The treatment kardex is signed as given for suctioning on September 14, 2006 – September 24, 2006. Resident received suctioning as ordered daily during ATP period.

OMIG Response: A review of the medical record indicates that the documentation does not support daily documentation of suctioning during the ATP of September 28, 2006 – October 25, 2006. The resident was in the hospital from September 24, 2006 – September 30, 2006. There is no documentation for suctioning other than two days, October 3, 2006 and October 17, 2006.

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

FACILITY OBJECTIONS TO DEMENTIA ADD-ON FINDINGS:

Sample # 233 – Finding – Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan on Psychotropic Medication, Neurology Consult, Interim Physician Orders, CNA Accountability Records, PRI Functional Status Nursing Notes, and Universal Progress Notes. Facility requests review of these documents. Facility lists several documents in OMIG binder for review.

OMIG Response: Per PRI instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP.

All documents reviewed. Documentation does not support Dementia Add-on qualifiers of 10 NYCRR Section 86-2.10 (o) (3). “Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.”

During the PRI 28-day applicable time period September 23, 2006 – October 20, 2006, no positive outcomes related to dementia care or attendances at particular programs for dementia are documented.

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

Sample #243 – Finding: Disallow Dementia Add-On – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #245 – Finding: Disallow Dementia Add-On – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #246 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on hospital PRI dated October 13, 2006, Comprehensive Care Plan for Cognitive Loss/Dementia, and Psychiatrist Consults. Facility requests review of these documents. Facility lists several miscellaneous documents for review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP.

All documents reviewed. Documentation does not support Dementia Add-on qualifiers of 10 NYCRR Section 86-2.10 (o) (3). “Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.”

During the 28-day ATP September 23, 2006 – October 20, 2006, no positive outcomes related to dementia care or attendances at particular programs for dementia are documented.

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

Sample #249 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Senile Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Admission/Re-Admission Evaluation, Monthly Physician’s Order Form, and Psychiatry Consults. Facility requests review of these documents.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Facility’s submitted documents are dated before or after the ATP.

All documents reviewed. Documentation does not support Dementia Add-on qualifiers of 10 NYCRR Section 86-2.10 (o) (3). “Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.”

During the 28-day ATP September 23, 2006 – October 20, 2006, no positive outcomes related to dementia care or attendances at particular programs for dementia are documented.

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

Sample #251 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Comprehensive Care Plan on Activities, and Psychiatric Consult. Facility requests review of these documents. Facility lists several other miscellaneous documents for review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2 10 (o) (3). “Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of

policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 23, 2006 – October 20, 2006, no positive outcomes related to dementia care or attendances at particular programs for dementia are documented.

Documented diagnosis is "Alcoholic Dementia." Per 10 NYCRR Section 86-2.10 (o) (4) Alcoholic Dementia is not an eligible diagnosis for the Dementia Add-on per diem amount.

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

Sample #253 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan for Psychotropic Meds, Comprehensive Care Plan at Risk for Falls, PRI Functional Status – Monthly Nurses Notes, CNA Accountability Records, and Universal Progress Notes. Facility requests review of these documents. Facility lists several miscellaneous documents for review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 23, 2006 – October 20, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #254 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission/Readmission Evaluation, Comprehensive Care Plan for Cognitive Loss/Dementia, Monthly Physician's Evaluation, Monthly Physician's Order Form, and Psychiatry Consults. Facility requests review of these documents.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 19, 2006 – October 16, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #255 – Finding: Disallow Dementia Add-On – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #259 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan for Behavioral Problems, Universal Progress Notes, and Interim Physician's Orders. Facility lists several miscellaneous documents for review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP. The Comprehensive Care Plans are generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 28, 2006 – October 25, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #270 – Finding: Disallow Dementia Add-On – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #283 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Psychiatric Consults, Hospital PRI dated 2004, Comprehensive Care Plan on Activities. Facility requests review of these documents.

Facility lists several miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP, including The Comprehensive Care Plan for Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and

promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 22, 2006 – October 19, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #290 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan on Cognitive Loss/Dementia, Monthly Physician's Order Forms, and Psychiatric Consults. Facility requests review of these documents.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the PRI applicable time period, including The Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 16, 2006 – October 13, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #295 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan for Cognitive Loss/Dementia, Universal Nurses Notes, Interim Physician's Orders, Monthly Physician's Orders Forms, Neurology Consult, Psychiatry Consult, Ophthalmology Consult, Dental Consult, and Comprehensive Care Plan for Activities. Facility requests review of these documents.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the PRI ATP, including The Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 20, 2006 – October 17, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #299 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Monthly Physician's Order Form, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including The Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 18, 2006 – October 15, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #300 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Monthly Physician's Order Form, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP including the Activities Comprehensive Care Plan and The Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, the Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 25, 2006 – October 22, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #303 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Monthly Physician's Evaluation, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including The Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 18, 2006 – October 15, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

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

Sample #310 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan on Cognitive Loss/Dementia, Comprehensive Care Plan on Activities, Physician Monthly Evaluations, Monthly Physician's Order Form, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including The Comprehensive Care Plan for Cognitive Loss/Dementia and The Comprehensive Care Plan for Activities.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10r (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 19, 2006 – October 16, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample # 313 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnoses of Alzheimer’s disease and Dementia. Facility states Dementia Add-on qualifiers are supported in: Comprehensive Care Plan on Cognitive Loss/Dementia, Physician Orders, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including The Comprehensive Care Plan for Cognitive Loss/Dementia and The Comprehensive Care Plan for Activities.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day ATP September 20, 2006 – October 17 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #315 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia with Behavioral Disturbance. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Physician Monthly Evaluations, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including the Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2. 10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 22, 2006 – October 19, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample # 316 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive

Care Plan on Cognitive Loss/Dementia, Monthly Physician's Order Forms, and Monthly Physician's Evaluations. Facility requests review of these documents.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including the Comprehensive Care Plan on Cognitive Loss/Dementia.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the 28-day applicable time period September 20, 2006 – October 17, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample # 317 – Disallow Dementia Add-On – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #320 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Physician's Monthly Evaluations, Monthly Physician Order Forms, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including The Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 20, 2006 – October 17, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #321 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia with Psychosis. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List,

Psychiatry Consult, and Comprehensive Care Plan on Cognitive Loss/Dementia. Facility requests review of these documents.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 20, 2006 – October 17, 2006, no positive outcomes related to dementia care or attendances at particular programs for dementia are documented.

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

Sample #323 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan on Cognitive Loss/Dementia, Monthly Physician’s Order Form. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including the Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this care plan is generic and not individualized.

The Physician Order Forms list a diagnosis of Dementia with no other documentation regarding this diagnosis.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 20, 2006 – October 17, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #327 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission Face Sheet, Comprehensive Care Plan Diagnosis List, Comprehensive Care Plan on Cognitive Loss/Dementia, Comprehensive Care Plan on Activities, Physician’s Monthly Evaluations, Monthly Physician’s Order Forms, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including the Comprehensive Care Plans on Cognitive Loss/Dementia and Comprehensive Care Plan on Activities. The Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized. The Physician Monthly Evaluations and Physician Order Forms, list a diagnosis of Dementia with no other documentation regarding this diagnosis.

All documents submitted reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 20, 2006 – October 19, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #337 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility lists numerous documents to support Dementia Add-on qualifiers, including Comprehensive Care Plan for Cognitive Loss/Dementia, Comprehensive Care Plan Evaluation, Universal Progress Notes, Physician Progress Notes, and Physician Order Forms. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). Several documents requested for review are dated before or after the ATP. The Physician’s Monthly Evaluations and Physician’s Order Forms list diagnosis of Dementia with no other documentation regarding this diagnosis. The Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized. The Comprehensive Care Plan for Cognitive Loss/Dementia Evaluation dated 10/09/06 documents “Resident remains cooperative with staff”. Unable to determine if this is a positive outcome because there is no documentation regarding resident’s previous level of cooperation.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 20, 2006 – October 17, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #340 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia with Delusions. Facility states Dementia Add-on qualifiers are supported on Physician’s Admission/Re-Admission Evaluation, MDS with ARD

September 26, 2006, Comprehensive Care Plan on Cognitive Loss/Dementia dated September 26, 2006, Monthly Physician Evaluation, Monthly Physician Order Form, and Psychiatry Consults. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP. Additionally, The Care Plan on Cognitive Loss/Dementia is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 20, 2006 – October 17, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #355 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Alcohol Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia and Monthly Physician's Order Forms. Facility requests review of these documents. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP, including the Comprehensive Care Plan on Cognitive Loss/Dementia. Additionally, this Care Plan is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 22, 2006 – October 19, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #357 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Comprehensive Care Plan on Activities, Physician's Monthly Evaluations, and Monthly Physician's Order Forms. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP).

Several submitted documents are dated before or after the ATP, including the Comprehensive Care Plan on Cognitive Loss/Dementia and Comprehensive Care Plan on Activities. The Care Plans are generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) “Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.”

During the ATP September 22, 2006 – October 19, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #360 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Admission/Readmission Evaluation, Interim MD Orders, Monthly Physician’s Order Forms, Comprehensive Care Plan on Cognitive Loss/Dementia, and Psychiatry Consults. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). The submitted documents are dated before or after the ATP. The Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) “Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.”

During the ATP September 22, 2006 – October 19, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #365 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan on Cognitive Loss/Dementia, Comprehensive Care Plan on Activities, and Physician’s Monthly Evaluation. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, “the time period for questions is the past four weeks, unless stated otherwise.” This is referred to as the Applicable Time Period (ATP). All other submitted documents are dated before or after the ATP. Additionally, the Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 23 2006 – October 20, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #370 – Finding: Disallow Dementia Add-On

Facility Comment: Facility states diagnoses of Pre-Senile Dementia. Facility states Dementia Add-on qualifiers are supported on Admission/Readmission Evaluation, Comprehensive Care Plan on Cognitive Loss/Dementia, Monthly Physician's Order Forms, and Psychiatry Consult. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP. In addition, the Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 25, 2006 – October 22, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

Sample #371 – Disallow Dementia Add-On

Facility Comment: Facility states diagnosis of Dementia with Depression. Facility states Dementia Add-on qualifiers are supported on Comprehensive Care Plan for Cognitive Loss/Dementia, Physician's Monthly Evaluations, Monthly Physician's Order, and Psychiatric Consults. Facility lists other miscellaneous documents for OMIG review.

OMIG Response: Per PRI Instructions, "the time period for questions is the past four weeks, unless stated otherwise." This is referred to as the Applicable Time Period (ATP). Several submitted documents are dated before or after the ATP. Additionally, the Comprehensive Care Plan on Cognitive Loss/Dementia is generic and not individualized.

All documents reviewed. Documentation does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) "Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated."

During the ATP September 25, 2006 – October 22, 2006, no positive outcomes related to dementia-care or attendances at particular programs for dementia are documented.

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

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 WORKMEN'S CIRCLE MULTICARE CENTER
 AUDIT #09-3808
 CALCULATION OF MEDICAID OVER PAYMENT

<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	10/01/06 - 12/31/06	279.48	277.09	277.86	275.47	2.39	36437	\$ 87,084
NF	01/01/07 - 03/31/07	284.86	282.23	283.20	280.57	2.63	35208	92,597
NF	04/01/07 - 06/30/07	283.54	280.92	281.89	279.27	2.62	36431	95,449
NF	07/01/07 - 08/31/07	281.32	278.70	279.67	277.05	2.62	24578	64,394
NF	09/01/07 - 12/31/07	281.32	278.70	279.67	277.05	2.62	48548	127,196
NF	01/01/08 - 03/31/08	284.75	282.12	283.06	280.43	2.63	36167	95,119
NF	04/01/08 - 06/30/08	280.19	277.58	278.52	275.91	2.61	35987	93,926
NF	07/01/08 - 12/31/08	284.62	282.01	282.95	280.34	2.61	72077	188,121
NF	01/01/09 - 03/31/09	285.11	282.44	283.40	280.73	2.67	35546	94,908
TOTAL MEDICAID OVERPAYMENT								\$ 938,794

NOTE: Impact of the Dementia Per Diem Calculation handled as per diem disallowances on Schedule VII, Line "B".
 on Schedule VII

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 WORKMEN'S CIRCLE MULTICARE CENTER
 CHANGE IN RUG CATEGORIES
 OCTOBER 25, 2006

RUG CATEGORY	CHANGE IN RUG CATEGORY			ADJUSTED
	REPORTED	INCREASE	DECREASE	
BA	6		5	1
BB	9		4	5
BC	3		3	0
CA	21		13	8
CB	23		6	17
CC	12		3	9
CD	0			0
PA	89	33		122
PB	42	11		53
PC	76	22		98
PD	15	4		19
PE	5	1		6
RA	7		2	5
RB	122		35	87
SA	2			2
SB	20			20
TOTAL	452	71	71	452

Dementia Patient Per Diem Calculation

CA	2		2	0
BA	2		1	1
PA	28		22	6
PB	23		12	11
TOTAL	55	0	37	18

WORKMEN'S CIRCLE MULTICARE 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."*

In addition, *"necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone"* must be documented.

10 NYCRR Section 86-2.30 (II) 16

In 1 instance, documentation did not support a description of the wound as decubitus level 2, 3, or 4. 109

In 1 instance, documentation did not support circumstance or medical condition which led to the decubitus. 78

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. 61

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 2 instances, documentation did not support the daily frequency requirement for suctioning. 114, 264

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 2 instances, documentation did not support wound care due to surgery, trauma, or cancerous lesion during the past 28 days. 57, 115

Transfusion

The PRI instructions/clarifications define transfusion as *"introduction of whole blood or blood components directly into the blood stream"* and there is a likelihood that the resident would *"still require"* additional transfusions.

10 NYCRR Section 86-2.30 (II) 18-I

In 1 instance, the medical record did not support transfusion during the past 28 days and/or that an additional transfusion would be required. 79

Eating

PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 19

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 13 instances, documentation did not support continual help with eating. 3, 8, 21, 32, 84, 171, 180, 188, 196, 201, 221, 222, 228

Transfer

The PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 21

Level 2 transfer intermittent assistance; a "staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis."

In 2 instances, documentation did not support intermittent assistance with transfers. 228, 371

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

In 1 instance, documentation did not support the resident required two people or the use of lifting equipment to transfer. 3

Level 5 transfer resident is "bedfast - cannot and is not gotten out of bed."

In 2 instances, documentation did not support the resident could not or was not transferred out of bed. 7, 177

Toileting

The PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 22

Level 2 toileting resident is "continent or incontinent of bowel and bladder" but a "staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis."

In 1 instance, documentation did not support intermittent assistance. 371

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 2 instances, documentation did not support constant supervision and/or physical assistance with toileting. 40, 228

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 2 instances, documentation did not support incontinence 60% of the time. 53, 136

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 100 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, 2, 4, 6, 8, 10, 11, 12, 15, 16, 17, 27, 29, 31, 32, 34, 37, 38, 41, 43, 45, 47, 52, 58, 59, 60, 61, 62, 63, 65, 66, 67, 69, 72, 74, 78, 82, 83, 84, 89, 93, 103, 105, 122, 124, 131, 133, 134, 137, 138, 139, 140, 143, 151, 156, 159, 163, 165, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 178, 179, 180, 181, 182, 185, 186, 188, 189, 191, 192, 193, 194, 196, 197, 199, 200, 203, 204, 205, 211, 213, 216, 217, 218, 220, 221, 222, 223, 224, 229, 230

Verbal Disruption

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

10 NYCRR Section 86-2.30 (IV) 23

Level 2 verbal disruption is *“verbal disruption one to three times during the last four weeks.”*

In 1 instance, documentation did not support verbal disruptions 1-3 times during the past 28 days. 371

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 4 instances, documentation did not support verbal disruption at least once per week. 8, 209, 215, 263

In 3 instances, documentation did not support unpredictable disruption. 259, 276, 283

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 2 instances, documentation did not support the “intent for injury” qualifier. 136, 139

In 2 instances, documentation did not support physical aggression at least once per week. 139, 278

In 2 instances, documentation did not support unpredictable physical aggression. 278, 282

In 1 instance, documentation did not support an active treatment plan. 140

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 2 behavior is *“physical actions by the patient may be irritating, but do not create a need for immediate action by the staff.”*

In 2 instances, documentation did not support the behavior was disruptive. 177, 371

Level 3 behavior is *“disruptive behavior during the past four weeks but not at least once per week.”*

In 1 instances, documentation did not support the behavior occurred 1-3 times during the four weeks. 34

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 2 instances, documentation did not support disruptive, infantile or socially inappropriate behavior at least once per week. 198, 215

In 1 instance, documentation did not support the disruptive component of the behavior. 169

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 1 instance, documentation did not support an active treatment plan. 225

Physical Therapy

PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (V) 27A

PRI instructions/clarifications also state *“in order for therapy to qualify as restorative, treatment is provided at least five days per week and 2.5 hours per week.”*

In 2 instances, documentation did not support treatment five days/ 2.5 hours per week. 18, 267

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

In 1 instance, documentation did not support continued improvement in ADL/functional status through the past 28 days. 58

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 2 instances, documentation did not support the positive potential for improvement within a short and/or predictable period of time. 50, 91

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

In 1 instance, documentation did not support continued improvement in ADL/functional status through the past 28 days.

21

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

3, 7, 11, 18, 20, 22, 25, 31, 34, 37, 69, 72, 73, 76, 77, 78, 86, 91, 98, 109, 112, 115, 121, 122, 126, 128, 143, 152, 154, 155, 156, 157, 220, 244, 251, 259, 260, 262, 266, 269, 270, 272, 286, 289, 295, 307, 332, 333, 335, 343

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 39 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.

3, 7, 11, 29, 31, 41, 55, 68, 72, 78, 81, 85, 86, 98, 109, 112, 115, 125, 141, 169, 177, 179, 219, 227, 241, 251, 257, 258, 270, 283, 299, 305, 323, 343, 353, 355, 357, 365, 371

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

233, 240, 241, 246, 249, 251, 253, 254, 256, 258, 259, 270, 283, 290, 295, 299, 300, 303, 305, 310, 313, 315, 316, 317, 320, 321, 323, 327, 337, 340, 355, 357, 360, 365, 370, 371

RUGS-II Classifications Overturned

In 40 instances, the RUG-II classifications were overturned.

10 NYCRR Section 86-2.11

16, 38, 50, 58, 114, 124, 128, 131, 133, 138, 139, 140, 141, 143, 152, 157, 163, 165, 167, 168, 169, 182, 185, 198, 199, 203, 205, 209, 215, 225, 228, 229, 257, 259, 262, 270, 272, 278, 282, 283