



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

July 1, 2014

[REDACTED]
Jewish Home and Hospital for the Aged
120 West 106th Street
New York, New York 10025

Re: Medicaid PRI Audit #09-4653
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 Jewish Home and Hospital for the Aged ("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 December 2, 2013, 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 \$473,946 to the total Medicaid overpayment shown in the revised draft audit report.

The findings applicable to the August 1, 2006 through March 31, 2009 Medicaid rates resulted in a Medicaid overpayment of \$1,652,926 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 Corning Tower, Room 2739
File #09-4653
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

[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]

[REDACTED]
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July 1, 2014

If you wish to request a hearing, the request must be submitted in writing to:

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

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

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

Should you have any questions regarding the above, please contact [REDACTED]
[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 August 21, 2006 and
November 7, 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

Jewish Home and Hospital for the Aged
120 West 106th Street
New York, New York 10025

AMOUNT DUE: \$1,652,926

PROVIDER ID [REDACTED]

AUDIT #09-4653

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 #09-4653
Albany, New York 12237-0048

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

[REDACTED]

CORRECT PROVIDER NUMBER

JEWISH HOME AND HOSPITAL FOR THE AGED

AUDIT # 09-4653

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 revised draft audit report response comments.

Sample #38 – Disallow Transfer – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #44 – Disallow Transfer – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #186 – Disallow Primary Medical Problem –

Facility Comment –

On 08/07/06 the resident was seen and examined by the MD for chronic pain. The MD plan to address her pain included management with a Fentanyl patch.

On 08/09/06 the resident was seen and examined by the MD to assess and address the effectiveness of her pain medication due to her continued pain.

OMIG Response –

08/07/06 MD Visit: Documentation reviewed is a physician's note which documents reason for visit as "Follow-up HTN (hypertension), chronic pain, senile dementia." Subjective component ("S") documented as "None." Objective component ("O") documentation is a physical exam - no acute findings documented. Assessment component ("Ass") documented as "clinically stable, no acute changes." Plan component ("P") documented as "Continue with current management." There is no documentation of a Fentanyl patch and no mention of pain except in diagnoses listing. Documentation reviewed does not support PRI qualifiers of *"the patient has a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)."* Finding stands.

08/09/06 MD Visit: Documentation reviewed is a physician's note with identical verbiage as previous visit of 08/07/06 (see above). MD again writes "Clinically stable; no acute change." Plan documented as "Continue current management." There is no documentation of a Fentanyl patch and no mention of pain except in diagnoses listing. No new orders documented. Documentation reviewed does not support PRI qualifiers of *"the patient has a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)."* Finding stands.

Disposition

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

Sample #189 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #215 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #233 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and will not be included in the final report.

Sample #243 – Disallow MD Visits –

Facility Comment

07/19/06 MD Visit: Facility states "the resident was seen by the specialist MD (Rehab Medicine) to be provided with a right knee contracture orthotic. In addition, wheelchair positioning and appropriate accessories were checked."

OMIG Response

07/19/06 MD Visit: Documentation reviewed is Rehabilitation Medicine physician note. Physician reviewed treatment for chronic condition of knee contracture and also checked the patient's orthopedic shoes. Documentation does not support PRI qualifier of *"medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)."*

Disposition

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

Sample #249 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #256 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #257 – Disallow MD Visits –

Facility Comment

08/06/06 Visit: Facility states "a skin tear was noted to the resident's left lower leg by nursing and the on-call MD was called to see the resident. After the on-call MD examined the resident, treatment was ordered and the resident was monitored for signs and symptoms of infection."

08/11/06 Visit: Facility states "the attending MD examined the resident who presented with dementia and documented evidence of confusion as to her condition. The resident did not have any focal deficits at that time but was to be monitored closely for any neurological changes."

OMIG Response

08/06/06 MD Visit: Documentation is physician note which documents. "Called to bedside to evaluate left tibia area small abrasion. No known history of trauma." Physical exam documented. Debility with dementia documented. "Assessment/Plan: Left tibia abrasion small Bacitracin BID till fully healed." There is a documented nurse's note on 08/06/06 prior to the MD visit "During AM care, CNA (certified nursing assistant) noted skin tear L (left) lower leg. Upon assessment, noted

skin tear with dried blood." Documentation reviewed and reason for visit does not support PRI qualifiers of *"a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)."* *"Do not include visits which could have been accomplished over the phone."*

08/11/06 MD Visit: Documentation is physician note. "Chief Complaint: Seen for follow-up of left lower leg skin tear." "No complaints of pain." "No acute deformity or tenderness at this time." The MD notes that resident has impaired cognition. "Plan: No change in treatment plan for now. Monitor closely." There are documented nurses' notes dated 8/7, 8/8, 8/9 which address the skin tear, stating no complaints of pain and no signs of infection. Documentation and reason for visit does not support PRI qualifiers of *"a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)"* *"Do not include visits which could have been accomplished over the phone."*

Disposition

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

Sample #260 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #263 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #267 – Disallow MD Visits –

Facility Comment

08/07/14 MD Visit: Facility states "the resident was seen by the MD for a skin tear on her right hand. Treatment was ordered by the MD."

OMIG Response

08/07/14 MD Visit: Documentation is a physician note with scant documentation addressing a skin tear due to fragile skin. Nurse's note dated 8/7/06 preceding the MD note documents a skin tear on right hand, with normal saline cleanse and Bacitracin application. The MD note reads "Follow-up skin tear right hand due to fragile skin. NSS (Normal Saline) wash and Bacitracin Ointment." No evidence that physician personally examined patient. Documentation reviewed does not support PRI qualifiers of *"a medical condition that is unstable and changing, or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result."* *"Do not include visits which could be accomplished over the phone."* *"A visit qualifies only if there is physician documentation that she/he has personally examined the patient to address the pertinent medical problem."*

Disposition

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

Sample #268 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #273 – Disallow Daily Oxygen – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #274 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #277 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #278 – Disallow MD Visits –

Facility Comment

08/16/06 MD Visit: Facility states "the attending MD examined the resident and noted that she was grossly stable with no acute change except for behavioral disorder." She was noted to have edema of her lower legs, a sign of potential CHF exacerbation; however, she had no other new symptoms of CHF exacerbation..."

08/17/06 MD Visit: Facility states "the attending MD saw and examined the resident for behavioral disorder/depression. Psychiatric re-evaluation as needed was planned.

OMIG Response

08/16/06 MD Visit: Documentation is a monthly progress note entitled "Interim note." "Chief Complaint: Patient's clinical medical condition grossly stable." Documentation entails evaluation of multiple chronic medical problems, including dementia/behavioral disorder. Assessment/Plan component lists all medical conditions and documents them as "stable". There is no nursing note documentation to support resident was unstable. Documentation and visit do not support PRI qualifiers of *"a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)."*

08/17/06 MD Visit: Documentation is a brief physician note which states "Follow-up Behavioral Disorder/Depression." The subjective component ("S") documents "None". The objective component ("O") documents a physical exam - no acute findings are noted. MD documents "trace of ankle edema." The Assessment component of the visit ("Ass") documents the diagnosis of "Behavioral Disorder/Depression." The Plan component ("P") documents "Reality orientation. Psychiatric re-evaluation as needed". No nursing documentation to support resident was unstable. Documentation and visit do not support PRI qualifiers of *"a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)."*

Disposition

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

Sample #282 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #288 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #301 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #303 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #304 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #307 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

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

Sample #309 – Disallow MD Visits –

Facility Comment

07/14/06 MD Visit: Facility states "the MD visit noted the resident was to continue on the medication Seroquel at night due to her anxiety. The MD also reduced her medication Namenda (for Alzheimer's dementia). Orders were written to decrease her warfarin dosage and check her coagulation time with bold tests (PT/INR)."

07/31/14 MD Visit: Facility states "the NP examined the resident for her complaint of difficulty in swallowing. In addition, she was noted to have a decrease in appetite. The MD ordered a nutritional supplement to improve her oral intake and made a referral to Speech-Language Pathology for a swallowing evaluation."

OMIG Response

07/14/06 Visit: Documentation is a brief physician notes which "f/u (follow-up) anxiety". As per niece, remains anxious. Tapered Namenda this week." Assessment / Plan component discusses planned medication regimen. No documentation of a physical exam. Documentation does not support PRI qualifiers of "A visit qualifies only if there is physician documentation that she/he has personally examined the patient to address the pertinent medical problem" "Do not include visits which could have been accomplished over the phone."

07/31/14 Visit: Documentation is a physician note stating "pt seen for c/o (complaints of) difficulty swallowing." Brief summary of issues includes "Companion reported patient didn't eat pureed food since Saturday. She said food stuck in her mouth and didn't go down, but patient tolerated Ensure pudding well." Assessment/Plan ("A/P") component of visit documents "decreased eating, difficulty swallowing? Referral made for swallowing eval and Ensure pudding three times a day." No documentation of a physical exam. Documentation reviewed does not support PRI qualifiers of "a visit qualifies only if there is physician documentation that she/he has personally examined the patient to address the pertinent medical problem." Do not include visits which could have been accomplished over the phone."

Disposition

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

Sample #318 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #320 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #322 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #323 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #332 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #336 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #337 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #341 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #346 – Disallow MD Visits –

Facility Comment

08/18/06 MD Visit: Facility states "the resident complained of not feeling well. On examination the MD noted dyspnea on exertion (DOE) and absent foot pulses. Medical findings included malaise, fatigue, and cognitive loss and no new hypertensive episodes noted. The MD reviewed the resident's lab values, noting renal insufficiency, probably due to diabetes and hypertension."

OMIG Response

8/18/06 Visit: Documentation is a physician note addressing resident's non-specific complaints of general malaise. Physician documents resident's statement "I feel a little tired today and not so well". (Review of record by this reviewer indicates resident's blood pressure had been monitored by staff the last three days - no abnormal blood pressure readings documented.) Physical exam documented, no unstable or acute findings documented. Impression/Plan component documents "fatigue, malaise, mild, no new physical findings. To monitor course, VS (vital signs), and sugars. DM (Diabetes Mellitus) stable. Renal insufficiency probably due to diabetes and HTN (hypertension) --monitor. S/p hyperthyroid no present evidence -- monitor, personality disorder and mild cognitive loss." No new orders are documented. Reason for visit and documentation reviewed does not support PRI qualifiers of "a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)/.

Disposition

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

Sample #347 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #349 – Disallow MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #482 – Disallow Dementia Add-on –

Facility Comment

Facility notes an 83-year-old resident with several diagnoses, including dementia with agitation. Resident exhibits bouts of aggression towards staff. Facility lists several documents whereby a dementia diagnosis is documented, as well as risk assessments, care plans, and daily care assignment sheets, which address the effects of the resident's cognitive impairment. Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Safety Plan of care not dated. Social Work/Psychosocial Assessment dated 01/24/06. Psychiatrist evaluation dated 01/26/06. Nursing Quarterly Progress Note dated 05/04/06. Are non-applicable because the dates are not within the PRI 28-day applicable time period.

All documentation submitted by facility and reviewed does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) which states "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, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #483 – Disallow Dementia Add-on –

Facility Comment

Facility notes a 96-year-old resident with diagnoses including dementia. Facility lists MD Interim note whereby a dementia diagnosis is documented, as well as risk assessments and care plans, which address the effects of the resident's cognitive impairment.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. MD Interim note dated 07/10/06 is non-applicable because the date is not within the PRI 28-day applicable time period.

All documentation submitted by facility and reviewed, including psychiatrist evaluation, risk assessments, and care plans, does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) which states "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, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #484 – 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 #485 – Disallow Dementia Add- on –

Facility Comment

Facility notes a 91-year-old resident with several diagnoses, including dementia. Facility lists documents whereby a dementia diagnosis is documented, as well risk assessments and care plans, which address effects of the resident's cognitive impairment.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. MD Interim note dated 07/12/06. Resident to Resident Abuse Evaluation dated 11/09/06 is non-applicable because the date is not within the PRI 28-day applicable time period. Sections of the care plan are not dated.

All documentation submitted by facility and reviewed, including MD notes, risk assessments, care plans, does not support dementia-add on qualifiers of 10 NYCRR Section 86-2.10 (o) (3) which states "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, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #487 – 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 #489 – Disallow Dementia Add-on –Facility Comment

Facility notes an 83-year old resident with diagnoses including dementia. Facility lists documents whereby a dementia diagnosis is documented, as well risk assessments, care plans, and daily care assignment sheets, which address effects of the resident's cognitive impairment.

Facility states "The dementia add-on occurs whenever a resident has a Dementia Diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Psychiatrist note dated 01/26/06 is non-applicable because the date is not within the PRI 28-day applicable time period. The Social Interaction Plan of Care (page 2) has a note which documents positive outcomes. This note is non-applicable because it is not dated. Other documentation submitted by facility and reviewed does not support dementia add-on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #492 – 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 #493 – Disallow Dementia Add-on –Facility Comment

Facility notes an 83-year-old resident with diagnoses, including dementia. Facility lists risk assessments and care plans, which address the effects of the resident's cognitive impairment. Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Several sections of Care Plan are not dated. All documentation submitted by facility and reviewed does not support dementia add-on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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 PRI applicable time period, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #494 – Disallow Toileting – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Sample #495 – 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 #497 – Disallow MD Visits, Disallow Dementia Add-on –

MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Dementia Add-on

Facility Comment

Facility notes an 80-year-old resident with multiple medical diagnoses, including dementia. Facility lists a physician note documenting dementia diagnosis and the resident's care plans which reflect the effects of the resident's cognitive impairment. Facility documents that resident exhibits aggressive behavior.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Physician note dated 07/25/06 documents "Dementia - supportive care as needed." All documentation submitted by facility and reviewed, including physician note, risk assessments, care plans, and interdisciplinary behavior record does not support dementia-add on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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 PRI applicable time period, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #498 – Disallow MD Visits, Disallow Dementia Add-on

MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Dementia Add-on

Facility Comment

Facility notes an 80-year-old resident with multiple medical diagnoses, including dementia. Facility states resident had "documented behavioral problems related to his dementia and was at risk for his abuse of other residents and staff." Facility lists a Psychiatrist note dated 12/23/04 and cares plans which document the diagnosis of dementia and reflect the effects of the resident's cognitive impairment. Facility documents that resident exhibits aggressive behavior.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Psychiatrist note dated 12/23/04 and Therapeutic Recreation progress note dated 08/28/06 are non-applicable because the dates are not within the PRI 28-day applicable time period. Sections of care plan contain documentation that is not dated. All documentation submitted by facility and reviewed, including progress notes, MD interim notes, and care plans, does not support dementia-add on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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 PRI applicable time period, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #499 – Disallow MD Visits, Disallow Dementia Add-on

MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Dementia Add-on

Facility Comment

Facility notes a 104-year-old resident with several medical problems including dementia. Facility lists a Psychiatrist note dated 08/25/06, a Fall Risk Assessment, and Resident Care Plan, which document the diagnosis of dementia and reflect the effects of the resident's cognitive impairment. Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Psychiatrist note dated 08/25/06, Fall Risk Assessment dated 10/07/06, and Resident Care Plan dated 01/25/06, 10/11/06 are non-applicable because the dates are not within the PRI 28-day applicable time period. Safety Plan of Care dated 08/12/06 documents resident was found on the floor. Sections of Care Plan contain documentation that is not dated. All documentation submitted by facility and reviewed does not support dementia add-on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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 PRI applicable time period, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #500 – Disallow Dementia Add-on –Facility Comment

Facility notes a 90-year-old resident with multiple medical conditions including Dementia/Alzheimer's. Facility states "She was known to have problem behaviors and would be frequently verbally aggressive with peers due to her cognitive status." Facility lists an MD visit dated 09/20/06, Risk Assessments, and Comprehensive Care Plans which document the diagnosis of Dementia and reflect the effects of the resident's cognitive impairment.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Physician visit note dated 09/20/06 and Comprehensive Care Plans, which are dated 2005, or not dated, are non-applicable because the dates are not within the PRI 28-day applicable time period. All documentation submitted by facility and reviewed does not support dementia-add on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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 PRI applicable time period, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #502 – Disallow MD Visits –Facility Comment

08/18/06 MD Visit: Facility states "The NP found the resident had abdominal cramps and diarrhea up to four times from 06:00 to 10:00 a.m. that day. The resident was noted to be aware of the need to be well hydrated and medication for the diarrhea was ordered."

OMIG Response

8/18/06 Visit: Documentation is physician note stating "patient seen for diarrhea." Physician documents "long history of chronic diarrhea." The assessment/plan component ("A/P") documents "diarrhea- lmodium 2mg pm after each loose stool (*ordered previously*)." No documentation of a physical exam. Documentation reviewed does not support PRI Physician Visit Qualifiers of "a medical condition that is unstable and changing or is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative)." "A visit qualifies only if there is physician documentation that she/he personally examined the patient to address the pertinent medical problem." "Do not include visits which could have been accomplished over the phone."

Disposition

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

Sample #503 – Disallow MD Visits, Disallow Dementia Add-on

MD Visits – Based on information and documentation provided by the Facility, this finding was reversed and is not included in the final report.

Dementia Add-on

Facility Comment

Facility notes an 86-year-old resident with multiple diagnoses, including dementia. Facility does not list any documentation to support the dementia add-on.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Nursing and physician progress notes submitted by facility and reviewed do not support dementia-add on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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 PRI applicable time period, *no positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

Sample #506 – 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 #507 – Disallow Dementia Add-on –

Facility Comment

Facility notes a 77-year-old resident with diagnosis of Senile Dementia who is "at high risk for falls, dehydration and elopement due to his dementia diagnosis and associated poor safety awareness. His clinical team developed comprehensive care plans to monitor, support and provide preventative measures to care for this resident."

Facility lists MD interim note dated 07/31/06, Psychiatry notes dated 08/19/05 and 10/20/06, Risk Assessments for Falls, Elopement, and Dehydration, and individualized Care Plans which document the diagnosis of dementia and reflect the effects of the resident's cognitive impairment.

Facility states "The dementia add-on occurs whenever a resident has a dementia diagnosis and a particular RUG score as per regulation. It is not an item dependent on a Nurse Assessor's consideration of the resident's chart documentation."

OMIG Response

Facility submissions reviewed. Psychiatry notes dated 08/19/05 and 10/20/06, and Dementia / Cognitive Loss Care Plan dated 11/05 are non-applicable because the dates are not within the PRI 28-day applicable time period. MD Interim note dated 07/31/06 documents diagnosis of dementia.

Other documentation submitted by facility and reviewed, including risk assessments, care plans, and progress notes, do not support dementia-add on qualifiers of *10 NYCRR Section 86-2.10 (o) (3)* which states "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.*" No *positive outcomes* related to dementia-care for this resident are documented.

Disposition

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

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 JEWISH HOME AND HOSPITAL FOR THE AGED
 AUDIT #09-4653
 CALCULATION OF MEDICAID OVERPAYMENT

<u>Service</u>	<u>Effective Period</u>	<u>Part B Non-Elig.</u>		<u>Part B-Elig</u>		<u>Difference</u>	<u>Medicaid Days</u>	<u>Medicaid Impact</u>
		<u>From</u>	<u>To</u>	<u>From</u>	<u>To</u>			
NF	08/01/06 - 10/31/06	290.58	285.10	284.58	279.10	5.48	30085	\$ 164,866
NF	11/01/06 - 12/31/06	290.97	285.84	284.97	279.84	5.13	19972	102,456
NF	01/01/07 - 03/31/07	310.61	305.35	304.46	299.20	5.26	28791	151,441
NF	04/01/07 - 06/30/07	309.03	303.81	302.92	297.70	5.22	29181	152,325
NF	07/01/07 - 08/31/07	296.49	291.27	290.38	285.16	5.22	20306	105,997
NF	09/01/07 - 12/31/07	296.49	291.27	290.38	285.16	5.22	38621	201,602
NF	01/01/08 - 03/31/08	318.14	312.81	311.89	306.56	5.33	28898	154,026
NF	04/01/08 - 06/30/08	310.01	304.72	303.81	298.52	5.29	28043	148,347
NF	07/01/08 - 12/31/08	320.24	314.95	314.04	308.75	5.29	59261	313,491
NF	01/01/09 - 03/31/09	293.19	287.75	286.86	281.42	5.44	29113	158,375

TOTAL MEDICAID OVERPAYMENT \$ 1,652,926

NOTE: Impact of the Dementia Per Diem Calculation handled as per diem disallowance on Schedule VII

OFFICE OF THE MEDICAID INSPECTOR GENERAL
JEWISH HOME AND HOSPITAL FOR THE AGED
CHANGE IN RUG CATEGORIES
AUGUST 21, 2006

RUG CATEGORY	CHANGE IN RUG CATEGORY			
	REPORTED INCREASE	DECREASE	ADJUSTED	
BA	0			0
BB	2			2
BC	0			0
CA	7		1	6
CB	66	17		83
CC	73		24	49
CD	13		5	8
PA	4	3		7
PB	15	8		23
PC	92	33		125
PD	35		10	25
PE	10		8	2
RA	7	2		9
RB	149		15	134
SA	5			5
SB	29			29
TOTAL	507	63	63	507

Dementia Patient Per Diem Calculation

CA	5		5	0
BA	0		0	0
PA	3		2	1
PB	14		6	8
TOTAL	22	0	13	9

OFFICE OF THE MEDICAID INSPECTOR GENERAL
JEWISH HOME AND HOSPITAL FOR THE AGED
CHANGE IN RUG CATEGORIES
NOVEMBER 7, 2006

RUG CATEGORY	CHANGE IN RUG CATEGORY			
	REPORTED	INCREASE	DECREASE	ADJUSTED
BA	0			0
BB	3		1	2
BC	0			0
CA	7		1	6
CB	69	13		82
CC	72		23	49
CD	12		4	8
PA	4	2		6
PB	15	6		21
PC	90	39		129
PD	37		11	26
PE	8		7	1
RA	4	2		6
RB	161		15	146
SA	5	1		6
SB	25		1	24
TOTAL	512	63	63	512

Dementia Patient Per Diem Calculation

CA	5		5	0
BA	0		0	0
PA	3		2	1
PB	14		6	8
TOTAL	22	0	13	9

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 REVIEW OF PATIENT REVIEW INSTRUMENT
 JEWISH HOME AND HOSPITAL FOR AGED
 AUDIT # 09-4653

Sample#	DOB	Initials	PRIDate	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	Detailed Findings
26			8/8/2006	RB	RA	1.79	1.57	Dialow Tolerating
27			8/8/2006	RB	PC	1.79	1.03	Dialow Primary Medical Problem
28			8/8/2006	RB	RB	1.79	1.79	Dialow Physician Visits
29			8/8/2006	RB	RB	1.79	1.79	Dialow Eating
30			8/8/2006	RB	RB	1.79	1.79	Dialow PT Level
31			8/8/2006	RB	RB	1.79	1.79	Dialow Transfer
32			8/8/2006	RB	PC	1.79	1.03	Dialow OT Level
33			8/8/2006	RB	RA	1.79	1.57	Dialow Dementia Add-on
34			8/8/2006	RB	RB	1.79	1.79	Dialow Oxygen
35			8/8/2006	RB	RB	1.79	1.79	Dialow Physical Aggression
36			8/8/2006	RB	RB	1.79	1.79	Dialow Verbal Disruption
37			8/8/2006	RB	RB	1.79	1.79	Dialow Decubis Level
38			8/8/2006	RB	RB	1.79	1.79	Dialow Wound Care
39			8/8/2006	RB	RB	1.79	1.79	Dialow Disruptive Behavior
40			8/9/2006	RB	RB	1.79	1.79	Dialow Hallucinations
41			8/9/2006	RB	RB	1.79	1.79	Dialow Stasis/Ulcer
42			8/9/2006	RB	RB	1.79	1.79	Dialow Sucking
43			8/9/2006	RB	PD	1.79	1.17	Dialow Parental Feeding
44			8/9/2006	RB	RB	1.79	1.79	Dialow Chemo Therapy
45			8/9/2006	RB	RB	1.79	1.79	
46			8/9/2006	RB	RB	1.79	1.79	
47			8/10/2006	RB	RB	1.79	1.79	
48			8/10/2006	RB	RB	1.79	1.79	
49			8/10/2006	RB	RB	1.79	1.79	
50			8/11/2006	RB	RB	1.79	1.79	

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 REVIEW OF PATIENT REVIEW INSTRUMENT
 JEWISH HOME AND HOSPITAL FOR AGED
 AUDIT # 09-4653

Sample#	DOB	Initials	PRIDate	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	Detailed Findings
51			8/11/2006	RB	RB	1.79	1.79	Diallow Tolerating
52			8/11/2006	RB	RB	1.79	1.79	Diallow Primary Medical Problem
53			8/11/2006	RB	RB	1.79	1.79	Diallow Physician Visits
54			8/11/2006	RB	RB	1.79	1.79	Diallow Eating
55			8/11/2006	RB	RB	1.79	1.79	Diallow PT Level
56			8/11/2006	RB	RB	1.79	1.79	Diallow Transfer
57			8/11/2006	RB	RB	1.79	1.79	Diallow OT Level
58			8/12/2006	RB	RB	1.79	1.79	Diallow Dementia Add-on
59			8/12/2006	RB	RB	1.79	1.79	Diallow Oxygen
60			8/12/2006	RB	RB	1.79	1.79	Diallow Physical Aggression
61			8/12/2006	RB	RB	1.79	1.79	Diallow Verbal Disruption
62			8/14/2006	RB	RB	1.79	1.79	Diallow Deubitis Level
63			8/14/2006	RB	RB	1.79	1.79	Diallow Wound Care
64			8/14/2006	RB	RB	1.79	1.79	Diallow Hallucinations
65			8/14/2006	RB	RB	1.79	1.79	Diallow Disruptive Behavior
66			8/16/2006	RB	RB	1.79	1.79	Diallow Stasislicer
67			8/16/2006	RB	PC	1.79	1.03	Diallow Suctioning
68			8/16/2006	RB	SB	1.79	1.74	Diallow Parental Feeding
69			8/16/2006	RB	CD	1.79	1.64	Diallow Chemo Therapy
70			8/16/2006	RB	RB	1.79	1.79	Diallow Parental Feeding
71			8/17/2006	RB	RB	1.79	1.79	Diallow Parental Feeding
72			8/17/2006	RB	RB	1.79	1.79	Diallow Parental Feeding
73			8/18/2006	RB	RB	1.79	1.79	Diallow Parental Feeding
74			8/18/2006	RB	RB	1.79	1.79	Diallow Parental Feeding
75			8/18/2006	RB	RB	1.79	1.79	Diallow Parental Feeding

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 REVIEW OF PATIENT REVIEW INSTRUMENT
 JEWISH HOME AND HOSPITAL FOR AGED
 AUDIT # 08-4653

Sample#	DOB	Initials	PRIDate	Reported RUG		Derived RUG		Detailed Findings	
				Weight	Weight	Weight	Weight	1	1
76			8/18/2006	RB	1.79	RB	1.79	Disallow Tolerating	1
77			8/18/2006	RB	1.79	RB	1.79	Disallow Primary Medical Problem	1
78			8/18/2006	RB	1.79	RB	1.79	Disallow Physician Visits	1
79			8/18/2006	RB	1.79	RB	1.79	Disallow Eating	1
80			8/18/2006	RB	1.79	RB	1.79	Disallow PT Level	1
81			8/18/2006	RB	1.79	RB	1.79	Disallow Transfer	1
82			8/18/2006	RB	1.79	RB	1.79	Disallow OT Level	1
83			8/18/2006	RB	1.79	RB	1.79	Disallow Dementia Add-on	1
84			8/18/2006	RB	1.79	RB	1.79	Disallow Oxygen	1
85			8/18/2006	RB	1.79	RB	1.79	Disallow Physical Aggression	1
86			8/18/2006	RB	1.79	RB	1.79	Disallow Verbal Aggression	1
87			8/19/2006	RB	1.79	RB	1.79	Disallow Decubis Level	1
88			8/21/2006	RB	1.79	RB	1.79	Disallow Wound Care	1
89			8/21/2006	RB	1.79	RB	1.79	Disallow Hallucinations	1
90			8/21/2006	RB	1.79	RB	1.79	Disallow Disruptive Behavior	1
91			8/21/2006	RB	1.79	RB	1.79	Disallow Stasis/icer	1
92			8/21/2006	RB	1.79	RB	1.79	Disallow Suctioning	1
93			8/21/2006	RB	1.79	RB	1.79	Disallow Parental Feeding	1
94			8/21/2006	RB	1.79	RB	1.79	Disallow Chemo Therapy	1
95			8/21/2006	RB	1.79	RB	1.79		
96			8/21/2006	RB	1.79	RB	1.79		
97			8/21/2006	RB	1.79	RB	1.79		
98			8/21/2006	RB	1.79	RB	1.79		
99			8/21/2006	RB	1.79	RB	1.79		
100			8/21/2006	RB	1.79	RB	1.79		

Sample#	DOB	Initials	PRDate	Reported RUG		Derived RUG		Reported RUG Weight		Derived RUG Weight		Detailed Findings
				Reported	Derived	Reported	Derived	Weight	Weight	Weight	Weight	
101			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
102			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
103			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
104			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
105			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
106			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
107			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
108			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
109			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
110			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
111			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
112			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
113			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
114			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
115			8/21/2006	RB	RB	CB	CB	1.79	1.18	1.79	1.18	Disallow Toking
116			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
117			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
118			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
119			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
120			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
121			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
122			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
123			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking
124			8/21/2006	RB	RB	PA	PA	1.79	0.55	1.79	0.55	Disallow Toking
125			8/21/2006	RB	RB	RB	RB	1.79	1.79	1.79	1.79	Disallow Toking

Sample#	DOB	Initials	PRIDate	Reported RUG		Derived RUG		Reported RUG Weight	Derived RUG Weight	Detailed Findings
				RUG	Weight	RUG	Weight			
201			8/8/2006	SA	1.51	CB	1.18	1	Disallow Taking Physician Visits	
202			8/9/2006	SA	1.51	SA	1.51	1	Disallow Eating	
203			8/17/2006	SA	1.51	SA	1.51	1	Disallow PT Level	
204			8/10/2006	PE	1.41	PD	1.17	1	Disallow Transfer	
205			8/11/2006	PE	1.41	PD	1.17	1	Disallow OT Level	
206			8/11/2006	PE	1.41	PE	1.41	1	Disallow Dementia Add-on	
207			8/15/2006	PE	1.41	PD	1.17	1	Disallow Physical Aggression	
208			8/15/2006	PE	1.41	PD	1.17	1	Disallow Verbal Aggression	
209			8/16/2006	PE	1.41	PD	1.17	1	Disallow Decubiti Level	
210			8/17/2006	PE	1.41	PD	1.17	1	Disallow Wound Care	
211			8/17/2006	PE	1.41	PD	1.17	1	Disallow Disruptive Behavior	
212			8/18/2006	PE	1.41	PD	1.17	1	Disallow Hallucinations	
213			8/21/2006	PE	1.41	PE	1.41	1	Disallow Stasis/Ulcer	
214			8/8/2006	CC	1.32	CB	1.18	1	Disallow Suctioning	
215			8/8/2006	CC	1.32	CC	1.32	1	Disallow Parental Feeding	
216			8/8/2006	CC	1.32	CB	1.18	1	Disallow Chemo Therapy	
217			8/8/2006	CC	1.32	CC	1.32	1	Disallow Oxygen	
218			8/8/2006	CC	1.32	CB	1.18	1	Disallow Verbal Aggression	
219			8/9/2006	CC	1.32	CC	1.32	1	Disallow Physical Aggression	
220			8/9/2006	CC	1.32	CC	1.32	1	Disallow Decubiti Level	
221			8/9/2006	CC	1.32	CC	1.32	1	Disallow Wound Care	
222			8/9/2006	CC	1.32	CC	1.32	1	Disallow Disruptive Behavior	
223			8/9/2006	CC	1.32	CC	1.32	1	Disallow Stasis/Ulcer	
224			8/9/2006	CC	1.32	CB	1.18	1	Disallow Suctioning	
225			8/10/2006	CC	1.32	CC	1.32	1	Disallow Chemo Therapy	

OFFICE OF THE MEDICAID INSPECTOR GENERAL
 REVIEW OF PATIENT REVIEW INSTRUMENT
 JEWISH HOME AND HOSPITAL FOR AGED
 AUDIT # 09-4653

Sample#	DOB	Initials	PRIDate	Reported RUG		Derived RUG		Derived RUG Weight	Detailed Findings
				Reported RUG	Derived RUG	Reported RUG	Derived RUG		
226			8/10/2006	CC	CB	1.32	1.18	1	Disallow Tolerating
227			8/10/2006	CC	CB	1.32	1.18		Disallow Physician Visits
228			8/10/2006	CC	CC	1.32	1.32	1	Disallow Primary Medical Problem
229			8/10/2006	CC	CC	1.32	1.32		Disallow Eating
230			8/10/2006	CC	CC	1.32	1.32		Disallow PT Level
231			8/10/2006	CC	CC	1.32	1.32		Disallow Transfer
232			8/10/2006	CC	CC	1.32	1.32		Disallow OT Level
233			8/10/2006	CC	CC	1.32	1.32		Disallow Dementia Add-on
234			8/11/2006	CC	CC	1.32	1.32	1	Disallow Oxygen
235			8/11/2006	CC	CC	1.32	1.32	1	Disallow Physical Aggression
236			8/11/2006	CC	CC	1.32	1.32	1	Disallow Decubitis Level
237			8/11/2006	CC	CC	1.32	1.32	1	Disallow Wound Care
238			8/11/2006	CC	CC	1.32	1.32	1	Disallow Disruptive Behavior
239			8/11/2006	CC	CC	1.32	1.32	1	Disallow Halucinations
240			8/14/2006	CC	CB	1.32	1.18	1	Disallow Stasis/Ulcer
241			8/14/2006	CC	CC	1.32	1.32		Disallow Suctioning
242			8/14/2006	CC	CC	1.32	1.32		Disallow Parental Feeding
243			8/14/2006	CC	PD	1.32	1.17	1	Disallow Chemo Therapy
244			8/14/2006	CC	CB	1.32	1.18	1	Disallow Parental Feeding
245			8/14/2006	CC	CB	1.32	1.18	1	Disallow Parental Feeding
246			8/14/2006	CC	CC	1.32	1.32	1	Disallow Parental Feeding
247			8/14/2006	CC	CC	1.32	1.32		Disallow Parental Feeding
248			8/15/2006	CC	CB	1.32	1.18	1	Disallow Parental Feeding
249			8/15/2006	CC	CC	1.32	1.32	1	Disallow Parental Feeding
250			8/15/2006	CC	CC	1.32	1.32		Disallow Parental Feeding

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Sample#	DOB	Initials	PRIDate	Reported RUG		Derived RUG		Reported RUG Weight		Derived RUG Weight		Detailed Findings
				Reported RUG	Derived RUG	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight			
276			8/17/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow Tolerating
277			8/17/2006	CC	CC	CB	CB	1.32	1.32	1.18	1.18	Disallow Primary Medical Problem
278			8/18/2006	CC	PC	PC	PC	1.03	1.03	1.03	1.03	Disallow Physician Visits
279			8/18/2006	CC	CB	CB	CB	1.32	1.32	1.18	1.18	Disallow Eating
280			8/18/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow PT Level
281			8/18/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow Transfer
282			8/18/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow OT Level
283			8/18/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow Dementia Add-on
284			8/21/2006	CC	CC	CB	CB	1.32	1.32	1.18	1.18	Disallow Verbal Aggression
285			8/21/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow Physical Aggression
286			8/21/2006	CC	CC	CC	CC	1.32	1.32	1.32	1.32	Disallow Decubiti Level
287			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Wound Care
288			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior
289			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Status/Lacer
290			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Suiciding
291			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Chemo Therapy
292			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Parental Feeding
293			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Stair/Licer
294			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Hakiucinations
295			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior
296			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior
297			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior
298			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior
299			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior
300			8/8/2006	CB	CB	CB	CB	1.18	1.18	1.18	1.18	Disallow Disruptive Behavior

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Sample#	DOB	Initials	PRIDate	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS
326			8/11/2006	CB	CB	1.18	1.18	
327			8/11/2006	CB	CB	1.18	1.18	
328			8/14/2006	CB	CB	1.18	1.18	
329			8/14/2006	CB	PC	1.18	1.03	
330			8/14/2006	CB	CB	1.18	1.18	
331			8/14/2006	CB	CB	1.18	1.18	
332			8/14/2006	CB	CB	1.18	1.18	
333			8/15/2006	CB	CB	1.18	1.18	
334			8/15/2006	CB	CB	1.18	1.18	
335			8/15/2006	CB	CB	1.18	1.18	
336			8/15/2006	CB	PC	1.18	1.03	
337			8/15/2006	CB	CB	1.18	1.18	
338			8/15/2006	CB	CB	1.18	1.18	
339			8/15/2006	CB	CB	1.18	1.18	
340			8/15/2006	CB	CB	1.18	1.18	
341			8/16/2006	CB	CB	1.18	1.18	
342			8/16/2006	CB	CB	1.18	1.18	
343			8/16/2006	CB	CB	1.18	1.18	
344			8/17/2006	CB	CB	1.18	1.18	
345			8/17/2006	CB	CB	1.18	1.18	
346			8/18/2006	CB	CB	1.18	1.18	
347			8/18/2006	CB	PB	1.18	0.83	
348			8/18/2006	CB	CB	1.18	1.18	
349			8/18/2006	CB	CB	1.18	1.18	
350			8/21/2006	CB	PB	1.18	0.83	

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376			8/15/2006	PD	PC	1.17	1.03	Disallow Toiletting
377			8/15/2006	PD	PC	1.17	1.03	Disallow Physician Visits
378			8/15/2006	PD	PC	1.17	1.03	Disallow Primary Medical Problems
379			8/15/2006	PD	PC	1.17	1.03	Disallow OT Level
380			8/16/2006	PD	PD	1.17	1.17	Disallow Transfer
381			8/17/2006	PD	PD	1.17	1.17	Disallow PT Level
382			8/17/2006	PD	PC	1.17	1.03	Disallow Dementia Add-on
383			8/17/2006	PD	PC	1.17	1.03	Disallow Oxygen
384			8/17/2006	PD	PC	1.17	1.03	Disallow Physical Aggression
385			8/17/2006	PD	PC	1.17	1.03	Disallow Verbal Aggression
386			8/18/2006	PD	PC	1.17	1.03	Disallow Decubile Level
387			8/18/2006	PD	PD	1.17	1.17	Disallow Wound Care
388			8/21/2006	PD	PD	1.17	1.17	Disallow Disruptive Behavior
389			8/21/2006	BB	BB	1.03	1.03	Disallow Malnutrition
390			8/21/2006	BB	BB	1.03	1.03	Disallow Statistics
391			8/8/2006	PC	PC	1.03	1.03	Disallow Suctioning
392			8/8/2006	PC	PC	1.03	1.03	Disallow Parental Feeding
393			8/8/2006	PC	PC	1.03	1.03	Disallow Chemo Therapy
394			8/8/2006	PC	PC	1.03	1.03	Disallow Feeding
395			8/8/2006	PC	PC	1.03	1.03	Disallow Aggression
396			8/8/2006	PC	PC	1.03	1.03	Disallow Aggression
397			8/8/2006	PC	PC	1.03	1.03	Disallow Aggression
398			8/8/2006	PC	PC	1.03	1.03	Disallow Aggression
399			8/9/2006	PC	PB	1.03	0.83	Disallow Aggression
400			8/9/2006	PC	PC	1.03	1.03	Disallow Aggression

Sample#	DOB	Initials	PRIDate	Reported RUG		Derived RUG		Weight	Detailed Findings
				Reported RUG	Derived RUG	Reported RUG	Derived RUG		
401			8/9/2006	PC	PC	PC	1.03	1	Disallow Toiletting
402			8/9/2006	PC	PC	PC	1.03	1	Disallow Physician Visits
403			8/9/2006	PC	PC	PB	0.83	1	Disallow Primary Medical Problem
404			8/9/2006	PC	PC	PC	1.03		Disallow Earing
405			8/9/2006	PC	PC	PC	1.03		Disallow PT Level
406			8/9/2006	PC	PC	PC	1.03		Disallow Transfer
407			8/9/2006	PC	PC	PC	1.03		Disallow OT Level
408			8/9/2006	PC	PC	PC	1.03		Disallow Dementia Add-on
409			8/9/2006	PC	PC	PC	1.03		Disallow Oxygen
410			8/10/2006	PC	PC	PC	1.03	1	Disallow Physical Aggression
411			8/10/2006	PC	PC	PC	1.03		Disallow Verbal Aggression
412			8/10/2006	PC	PC	PC	1.03		Disallow Decubitis Level
413			8/10/2006	PC	PC	PC	1.03		Disallow Wound Care
414			8/10/2006	PC	PC	PC	1.03		Disallow Disruptive Behavior
415			8/10/2006	PC	PC	PC	1.03		Disallow Hallucinations
416			8/10/2006	PC	PC	PC	1.03		Disallow Status/Licer
417			8/10/2006	PC	PC	PC	1.03		Disallow Suctioning
418			8/10/2006	PC	PC	PC	1.03		Disallow Chemo Therapy
419			8/11/2006	PC	PC	PC	1.03		Disallow Parental Feeding
420			8/11/2006	PC	PC	PC	1.03		Disallow Chemo Therapy
421			8/11/2006	PC	PC	PC	1.03		Disallow Parental Feeding
422			8/11/2006	PC	PC	PC	1.03		Disallow Parental Feeding
423			8/11/2006	PC	PC	PC	1.03	1	Disallow Parental Feeding
424			8/11/2006	PC	PC	PC	1.03		Disallow Parental Feeding
425			8/11/2006	PC	PC	PC	1.03		Disallow Parental Feeding

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Sample#	DOB	Initials	PRIDate	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	DETAILED FINDINGS
451			8/15/2006	PC	PC	1.03	1.03	Disallow Toileting
452			8/15/2006	PC	PC	1.03	1.03	Disallow Primary Medical Problem
453			8/15/2006	PC	PC	1.03	1.03	Disallow PT Level
454			8/15/2006	PC	PC	1.03	1.03	Disallow Transfer
455			8/15/2006	PC	PC	1.03	1.03	Disallow OT Level
456			8/15/2006	PC	PC	1.03	1.03	Disallow Dementia Add-on
457			8/15/2006	PC	PC	1.03	1.03	Disallow Oxygen
458			8/15/2006	PC	PC	1.03	1.03	Disallow Physical Aggression
459			8/15/2006	PC	PC	1.03	1.03	Disallow Verbal Aggression
460			8/15/2006	PC	PC	1.03	1.03	Disallow Decubiti Level
461			8/15/2006	PC	PC	1.03	1.03	Disallow Wound Care
462			8/15/2006	PC	PC	1.03	1.03	Disallow Disruptive Behavior
463			8/15/2006	PC	PC	1.03	1.03	Disallow Hallucinations
464			8/15/2006	PC	PC	1.03	1.03	Disallow Status/Eicer
465			8/15/2006	PC	PC	1.03	1.03	Disallow Suctioning
466			8/15/2006	PC	PC	1.03	1.03	Disallow Parental Feeding
467			8/15/2006	PC	PC	1.03	1.03	Disallow Chemo Therapy
468			8/16/2006	PC	PC	1.03	1.03	
469			8/16/2006	PC	PC	1.03	1.03	
470			8/16/2006	PC	PC	1.03	1.03	
471			8/16/2006	PC	PC	1.03	1.03	
472			8/17/2006	PC	PC	1.03	1.03	
473			8/17/2006	PC	PC	1.03	1.03	
474			8/17/2006	PC	PC	1.03	1.03	
475			8/18/2006	PC	PC	1.03	1.03	

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Sample#	DOB	PRIDate	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	Disalow Toiletting	Disalow Physician Visits	Disalow Primary Medical Problem	Disalow Eating	Disalow PT Level	Disalow Transfer	Disalow OT Level	Disalow Dementia Ad-on	Disalow Oxygen	Disalow Physical Aggression	Disalow Verbal Aggression	Disalow Decubiti Level	Disalow Wound Care	Disalow Disruptive Behavior	Disalow Hallucinations	Disalow Stasis/Ulcer	Disalow Suctioning	Disalow Parental Feeding	Disalow Chemo Therapy	
601		11/7/2006	RB	RB	1.79	1.79																				
602		11/7/2006	RB	RB	1.79	1.79																				
603		11/7/2006	RB	RB	1.79	1.79																				
604		11/7/2006	RB	RB	1.79	1.79																				
605		11/1/2006	SB	SB	1.74	1.74																				
606		11/7/2006	SB	SB	1.74	1.74																				
607		11/6/2006	CD	CD	1.64	1.64																				
608		11/3/2006	RA	RA	1.57	1.57																				
609		11/7/2006	RA	RA	1.57	1.57																				
610		11/7/2006	RA	RA	1.57	1.57																				
611		11/1/2006	SA	SA	1.51	1.51																				
612		11/1/2006	CC	CC	1.32	1.32																				
613		11/1/2006	CC	CC	1.32	1.32																				
614		11/1/2006	CC	CC	1.32	1.32																				
615		11/1/2006	CC	CC	1.32	1.32																				
616		11/6/2006	CC	CC	1.32	1.32																				
617		11/6/2006	CC	CC	1.32	1.32																				
618		11/1/2006	CB	CB	1.18	1.18																				
619		11/2/2006	CB	CB	1.18	1.18																				
620		11/2/2006	CB	CB	1.18	1.18																				
621		11/6/2006	CB	CB	1.18	1.18																				
622		11/7/2006	CB	CB	1.18	1.18																				
623		11/7/2006	PD	PD	1.17	1.17																				
624		11/7/2006	PD	PD	1.17	1.17																				
625		11/1/2006	PC	PC	1.03	1.03																				

DETAILED FINDINGS

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Sample#	DOB	Initials	PRIDate	Reported RUG	Derived RUG	Reported RUG Weight	Derived RUG Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
626			11/1/2006	PC	PC	1.03	1.03	1																													
627			11/2/2006	PC	PC	1.03	1.03																														
628			11/7/2006	PC	PC	1.03	1.03																														
629			11/7/2006	PC	PC	1.03	1.03																														
								206	164	105	19	17	17	14	13	9	8	4	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

DETAILED FINDINGS

- Disallow Telling
- Disallow Physician Visits
- Disallow Primary Medical Problem
- Disallow Eating
- Disallow PT Level
- Disallow Transfer
- Disallow OT Level
- Disallow Dementia Add-on
- Disallow Oxygen
- Disallow Physical Aggression
- Disallow Verbal Disruption
- Disallow Decubiti Level
- Disallow Wound Care
- Disallow Disruptive Behavior
- Disallow Hallucinations
- Disallow Stasis/Ulcer
- Disallow Suctioning
- Disallow Parental Feeding
- Disallow Chemo Therapy

JEWISH HOME AND HOSPITAL FOR THE AGED 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 2 instances, documentation did not support a description of the wound as decubitus level 2, 3, or 4. 37,249

In 1 instance, documentation did not support circumstance or medical condition which led to the decubitus. 76

In 1 instance, documentation did not support a necrosis qualifier. 593

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. 335

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 1 instance, documentation did not support the daily frequency requirement for suctioning. 520

Oxygen - (Daily)

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

10 NYCRR Section 86-2.30 (II) 18C

In 9 instances, documentation did not support the daily frequency requirement for oxygen. 37, 129, 152, 156, 295, 329, 350, 509, 559

Parenteral Feeding

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

10 NYCRR Section 86-2.30 (II) 18F

In 1 instance, the medical record did not support parenteral feeding during the past 28 days. 152

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 1 instance, documentation did not support wound care due to surgery, trauma, or cancerous lesion during the past 28 days. 325

In 1 instance, wound care for decubiti, stasis ulcers, skin tears and feeding tubes are excluded. 310

Chemotherapy

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

10 NYCRR Section 86-2.30 (II) 18H

In 1 instance, the medical record did not support the chemotherapy during the past 28 days. 45

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 12 instances, documentation did not support continual help with eating. 29, 53, 93, 114, 200, 227, 251, 382, 408, 449, 516, 582

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

In 5 instances, documentation did not support that the resident was totally fed by hand. 16, 83, 377, 429, 559

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

In 2 instances, documentation did not support tube or parenteral feeding is primary intake for food. 163, 515

Transfer

The PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 21

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

In 8 instances, documentation did not support constant guidance or physical assistance in transfer. 32, 124, 201, 339, 398, 456, 479, 619

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

In 9 instances, documentation did not support the resident; required two people or the use of lifting equipment to transfer.

28, 84, 94, 120, 182, 335, 465, 559, 563

Toileting

The PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (III) 22

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

In 5 instances, documentation did not support constant supervision and/or physical assistance with toileting.

32, 124, 297, 490, 508

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

8, 109, 120, 121

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."*

ATTACHMENT D

In 197 instances, documentation did not support an individualized toileting schedule, the specific time the resident was toileted, the toileting schedule contained blanks, and/or or the toileting schedule contained intervals greater than four hours.

1, 4, 6, 12, 14, 23, 24, 25, 26, 27, 28, 29, 31, 33, 34, 35, 40, 42, 47, 49, 50, 51, 53, 55, 56, 57, 58, 63, 86, 115, 142, 179, 181, 182, 184, 185, 186, 189, 199, 200, 201, 202, 204, 205, 207, 208, 209, 210, 211, 212, 214, 216, 218, 223, 224, 226, 233, 234, 236, 237, 239, 244, 245, 248, 252, 253, 254, 256, 257, 259, 260, 261, 262, 263, 265, 267, 270, 272, 274, 276, 277, 278, 279, 282, 284, 286, 292, 296, 298, 300, 301, 302, 303, 309, 311, 316, 319, 321, 323, 324, 329, 334, 336, 337, 340, 341, 343, 346, 349, 354, 357, 358, 359, 361, 362, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 376, 377, 378, 381, 382, 383, 384, 385, 388, 389, 393, 394, 395, 396, 399, 401, 402, 403, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 419, 420, 423, 425, 426, 429, 430, 431, 432, 434, 435, 436, 437, 438, 439, 441, 443, 445, 446, 447, 448, 450, 451, 453, 454, 457, 458, 459, 461, 463, 464, 465, 468, 470, 473, 474, 475, 477, 478, 481, 624, 626

Verbal Disruption

PRi instructions/clarifications define verbal disruption as "yelling, bating, 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 6 instances, documentation did not support verbal disruptions 1-3 times during the past 28 days.

145, 215, 346, 423, 432, 518,

Level 3 verbal disruption is "short-lived disruption at least once per week... or predictable disruption regardless of frequency."

In 2 instances, documentation did not support short-lived disruption at least once per week or predictable disruption regardless of frequency.

249, 372

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 2 physical aggression is *"unpredictable aggression during the past four weeks, but not at least once per week."*

In 4 instances, documentation did not support unpredictable aggression during the past four weeks, but not at least once per week.

215, 362, 429, 527

Level 3 physical aggression is *"predictable aggression during specific care routines or as a reaction to normal stimuli . . . regardless of frequency."*

In 5 instances, documentation did not support predictable aggression during specific care routines.

145, 157, 365, 372, 624

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

In 2 instances, documentation did not support the behavior occurred 1-3 times during the four weeks.

362, 429

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 2 instances, documentation did not support visual, auditory, or tactile hallucinations once per week for the last four weeks. 179, 624

Physical Therapy

PRI instructions/clarifications state:

10 NYCRR Section 86-2.30 (V) 27A

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

In 12 instances, documentation did not support the positive potential for improvement within a short and/or predictable period of time. 3, 15, 22, 27, 42, 65, 67, 68, 94, 528, 571, 594

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 4 instances, documentation did not support treatment five days/ 2.5 hours per week. 124, 512, 579, 597

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

In 6 instances, documentation did not support continued improvement in ADL/functional status through the past 28 days. 31, 42, 67, 512, 528, 594

Occupational Therapy

PRI instructions/clarifications state:

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

In order for therapy to qualify as restorative therapy *"there is positive potential for improved functional*

status within a short and predictable period of time"... Qualifier for maintenance therapy is "to maintain and/or retard deterioration of current functional/ADL status."

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

67, 115, 517, 528, 556, 594

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 4 instances, documentation did not support treatment five days/ 2.5 hours per week.

49, 61, 111, 124

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

In 9 instances, documentation did not support continued improvement in ADL/functional status through the past 28 days.

16, 59, 67, 95, 115, 517, 528, 561, 594

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

1, 2, 3, 13, 19, 21, 22, 23, 24, 28, 34, 36, 43, 49, 50, 51, 52, 54, 56, 58, 60, 66, 67, 68, 69, 71, 72, 74, 76, 79, 80, 82, 85, 89, 91, 92, 93, 97, 105, 108, 109, 112, 118, 119, 121, 122, 124, 125, 126, 127, 128, 129, 132, 135, 137, 138, 141, 142, 144, 145, 151, 154, 155, 156, 160, 161, 164, 169, 171, 174, 177, 178, 183, 186, 193, 194, 196, 197, 199, 200, 201, 202, 207, 216, 217, 220, 224, 243, 246, 253, 257, 258, 259, 267, 270, 272, 276, 278, 287, 291, 294, 295, 305, 309, 312, 313, 343, 346, 351, 358, 396, 423, 432, 437, 459, 496, 502, 510, 515, 517, 518, 520, 521, 522, 526, 527, 528, 530, 533, 534, 535,

ATTACHMENT D

536, 537, 543, 545, 547, 549, 550,
554, 555, 559, 565, 571, 572, 573,
574, 575, 579, 580, 581, 582, 588,
596, 598, 602, 603, 604, 606, 607,
613, 617, 620, 621, 622

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 105 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.

17, 19, 29, 30, 33, 36, 38, 43, 45, 47,
52, 56, 59, 61, 66, 67, 71, 72, 73, 74,
81, 83, 84, 85, 90, 92, 93, 94, 95, 98,
100, 112, 116, 118, 119, 120, 121,
123, 125, 127, 129, 130, 137, 138,
139, 148, 149, 176, 193, 194, 196,
197, 252, 260, 264, 271, 275, 284,
312, 345, 352, 438, 440, 466, 491,
508, 510, 512, 519, 524, 525, 526,
530, 533, 538, 545, 547, 549, 551,
553, 555, 556, 557, 566, 572, 573,
574, 576, 578, 580, 585, 588, 589,
590, 591, 595, 596, 597, 598, 599,
600, 606, 610, 621, 627

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

482, 483, 485, 486, 489, 493, 497,
498, 499, 500, 503, 505, 507

RUGS-II Classifications Overturned

In 109 instances, the RUG-II classifications were overturned.

10 NYCRR Section 86-2.11

3, 15, 16, 22, 26, 27, 31, 32, 42, 49,
65, 67, 68, 115, 124, 152, 179, 181,
182, 184, 185, 186, 189, 201, 204,
205, 207, 208, 209, 210, 211, 212,
214, 216, 218, 224, 226, 227, 239,
243, 244, 245, 248, 251, 252, 253,
254, 257, 258, 259, 260, 265, 267,
270, 271, 272, 274, 275, 277, 278,
279, 284, 309, 313, 325, 329, 335,
346, 350, 352, 354, 357, 358, 359,
361, 362, 364, 365, 366, 367, 368,
369, 370, 371, 372, 373, 376, 377,
378, 381, 382, 383, 384, 385, 398,
399, 403, 443, 448, 457, 490, 502,
508, 512, 517, 528, 594, 620, 624