RHODE ISLAND

Personal Needs Allowance Audit Findings

Overview of EOHHS' Audits of 25 Nursing Facilities, Findings, and Lessons Learned.

PNA Audit Findings Overview

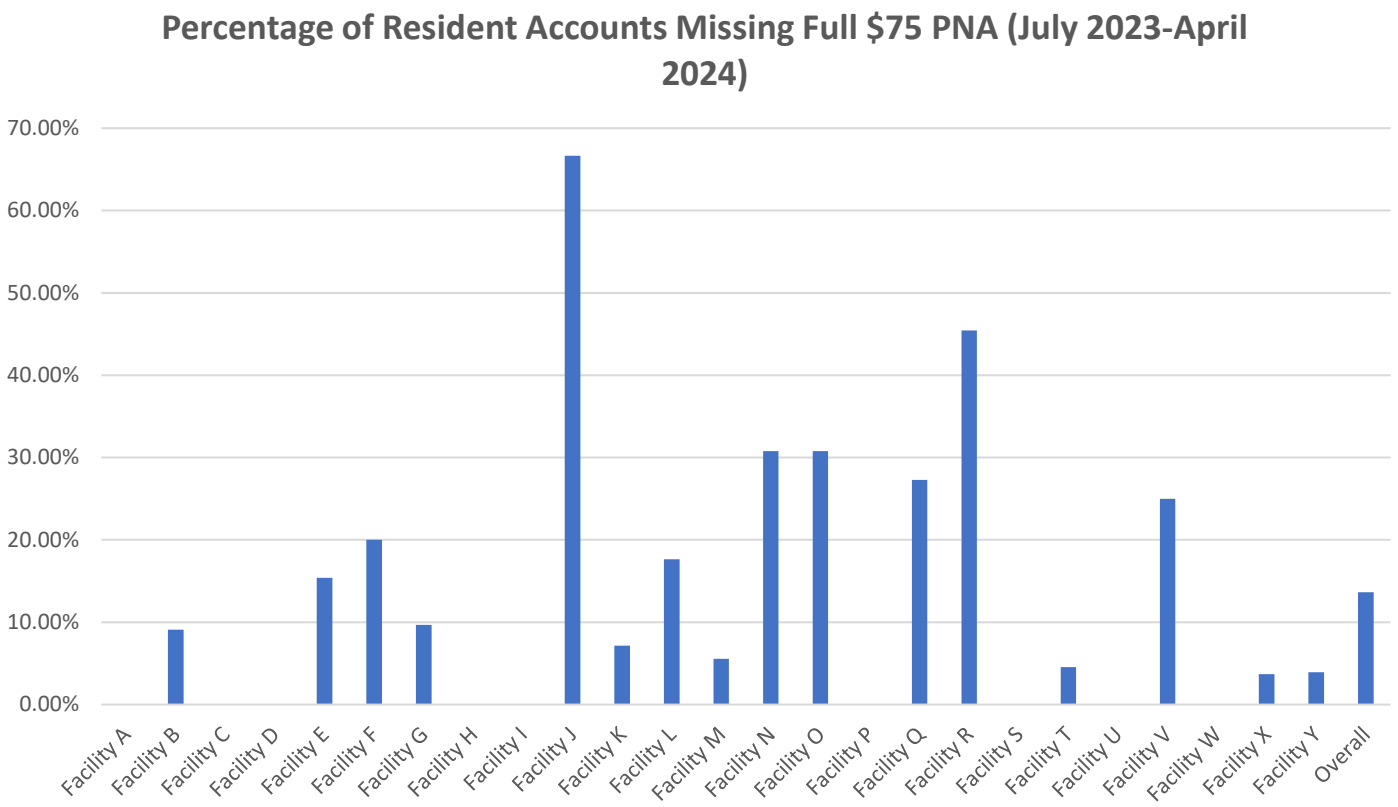
- Many of the nursing facilities did not increase the PNA from $50 to $75 immediately in July 2023. However, most subsequently increased the PNA amount and correctly credited the accounts at a later date. Prior to the audit, some residents were not credited.

- The majority of nursing facilities did not have complete and accurate PNA Authorization Form (Exhibit A) for all residents. There was significant confusion surrounding this form and how to correctly complete it.

- The largest PNA compliance issue we observed was how to accurately complete the Authorization Form (Exhibit A) depending on a resident's choice of who (facility, external party, resident) managed the PNA account.

Dispersal of $75 Per Month

Did Nursing Facilities Increase the PNA to $75?

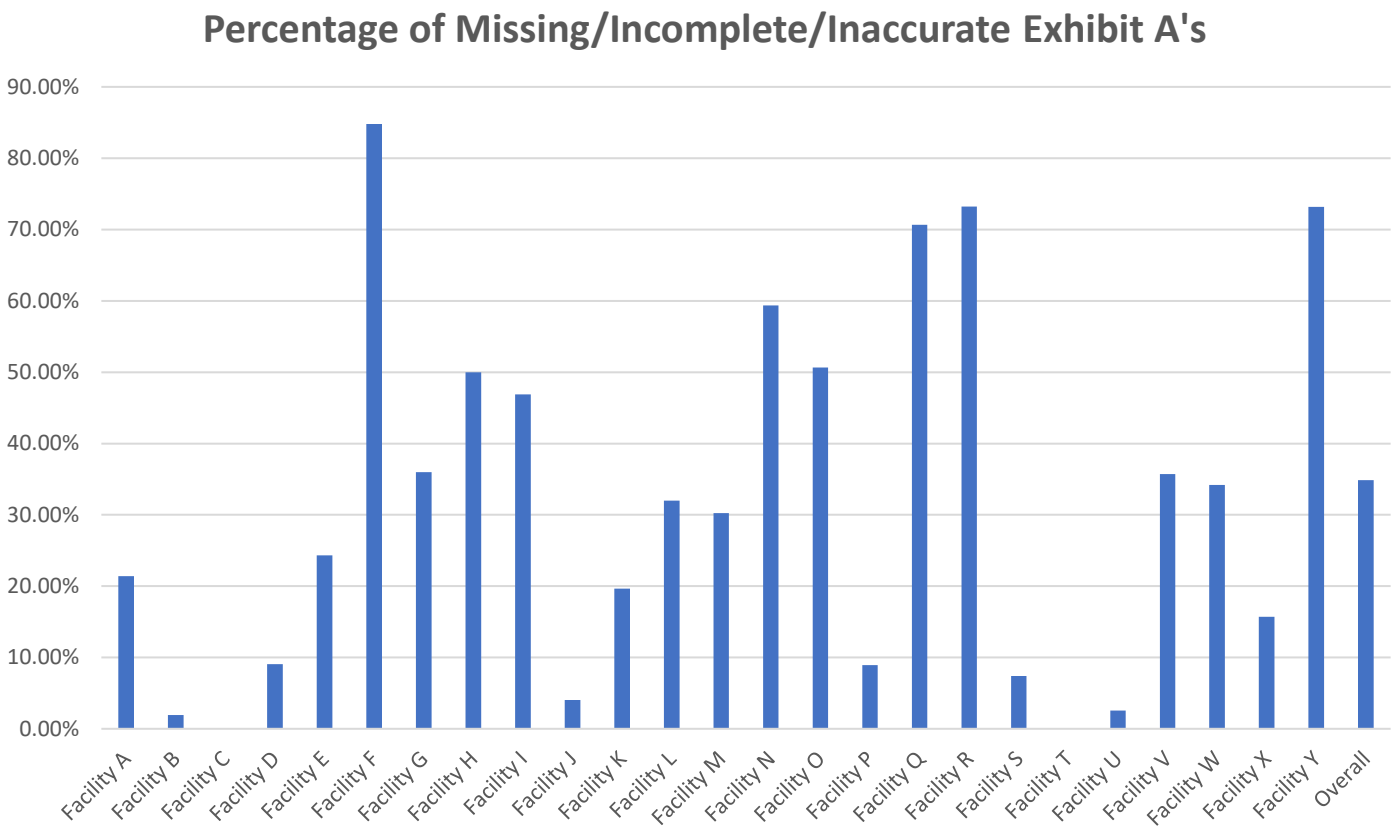


*Note: Data reflects review of PNA amounts dispersed from 7/1/23 through date of the facility's audit.

- 13.64% of residents with facility-managed PNA accounts were not allotted the full PNA each month from July through April.
- Eight facilities accurately distributed the PNA each month.
- Seventeen facilities:
  - Missed increase to $75 in July and did not credit account; and/or
  - Incorrectly calculated patient liability
  - $0 PNA dispersal for one or more months, potentially due to timing of resident income receipt versus liability payment.

PNA Authorization Form (Exhibit A)

Were Nursing Facilities Compliant with Exhibit A?



- 34.89% of residents did not have a complete or accurate Exhibit A form.
- Only 2 facilities had 100% compliance on Exhibit A forms.
- Facilities provided corrected documentation after receipt of EOHHS audit findings which detailed next steps.
- Exhibit A Form had various levels of completion and facilities had different interpretations of how to complete, which is discussed on slide seven.

PNA Authorization Form (Exhibit A) Trends

- Some facilities only utilized the Exhibit A form for residents that opted to have their PNA account managed by the facility.
- Forms were not signed by either the resident/Power of Attorney and witnesses, or not properly signed by witnesses when marked as unable to sign.
- Facilities misunderstood optional PNA accounts versus facility handling PNA (lines 3 versus 3A on form). Often the resident (or POA/family member) would handle the PNA account, but Exhibit A showed the facility handled it. Line 3 would be filled out instead of Lines 1 or 2 in combination with 3A.
- Exhibit A's were not updated when residents' choice of PNA account management changed.
- Some Exhibit A's indicated that the resident or third-party (lines 1 or 2) managed the PNA account, but the facility actually managed the PNA account

- **All 25 audited nursing facilities were extremely cooperative and did an excellent job following up with the requested corrected forms!**

Clarification on PNA Authorization Form/Exhibit A

The facility must have a PNA Authorization Form/Exhibit A on file for each resident that accurately identifies the party responsible for the PNA account.

- Green = Indicates resident is responsible for their own PNA
  - Green + Magenta = Resident manages PNA + optional acct. w/ facility
- Blue = Indicates third party responsibility PNA
  - Blue + Magenta = Third Party manages PNA + optional acct. w/ facility
- Orange = Facility is responsible for their PNA
- Yellow = To be completed if resident is unable to sign the form. Two witnesses, POA, or legal guardian signature required.

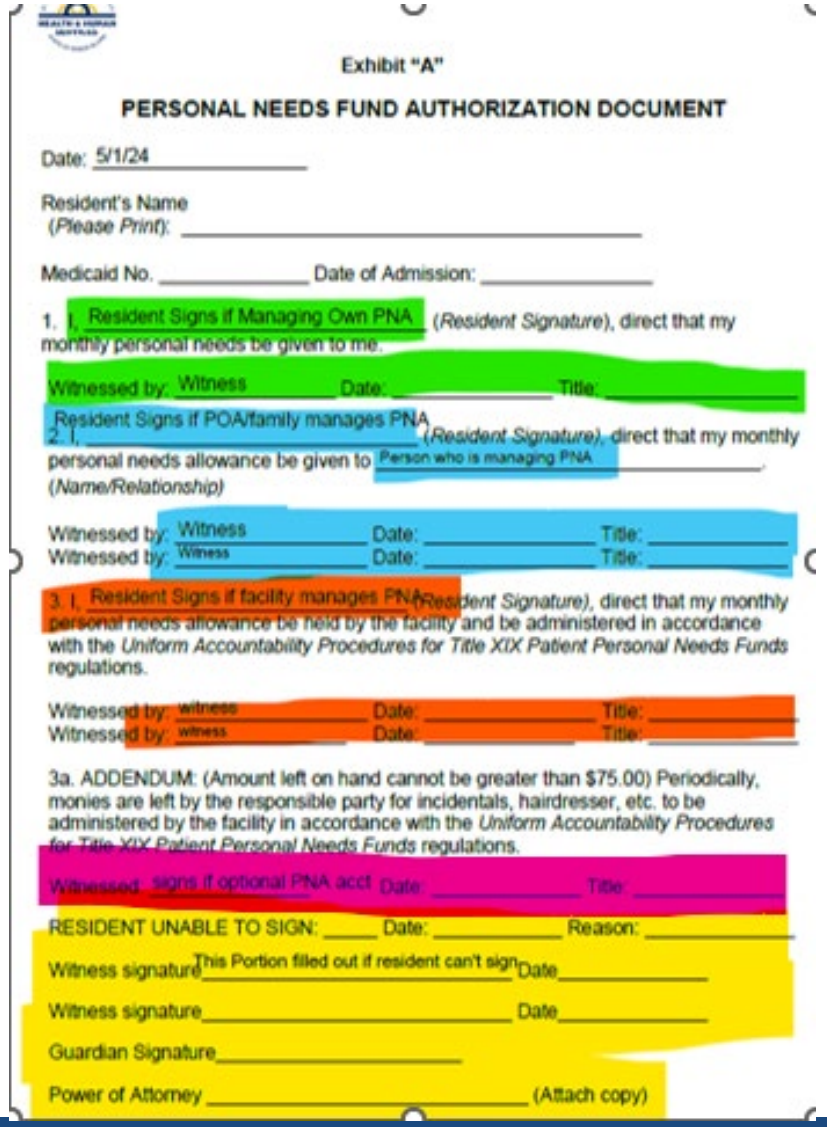


Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

Resident's Name
(*Please Print*): _____

Medicaid No. _____ Date of Admission: _____

1. I, Resident Signs if Managing Own PNA (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: Witness Date: _____ Title: _____

Resident Signs if POA/family manages PNA

2. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be given to Person who is managing PNA _____. (*Name/Relationship*)

Witnessed by: Witness Date: _____ Title: _____
Witnessed by: Witness Date: _____ Title: _____

3. I, Resident Signs if facility manages PNA (*Resident Signature*), direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: witness Date: _____ Title: _____
Witnessed by: witness Date: _____ Title: _____

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed signs if optional PNA acct Date: _____ Title: _____

RESIDENT UNABLE TO SIGN: _____ Date: _____ Reason: _____

Witness signature This Portion filled out if resident can't sign Date _____

Witness signature _____ Date _____

Guardian Signature _____

Power of Attorney _____ (Attach copy)

RHODE ISLAND

Exhibit A Examples

- Correct: This resident has opted to manage his PNA account and will not have an optional account with the facility.

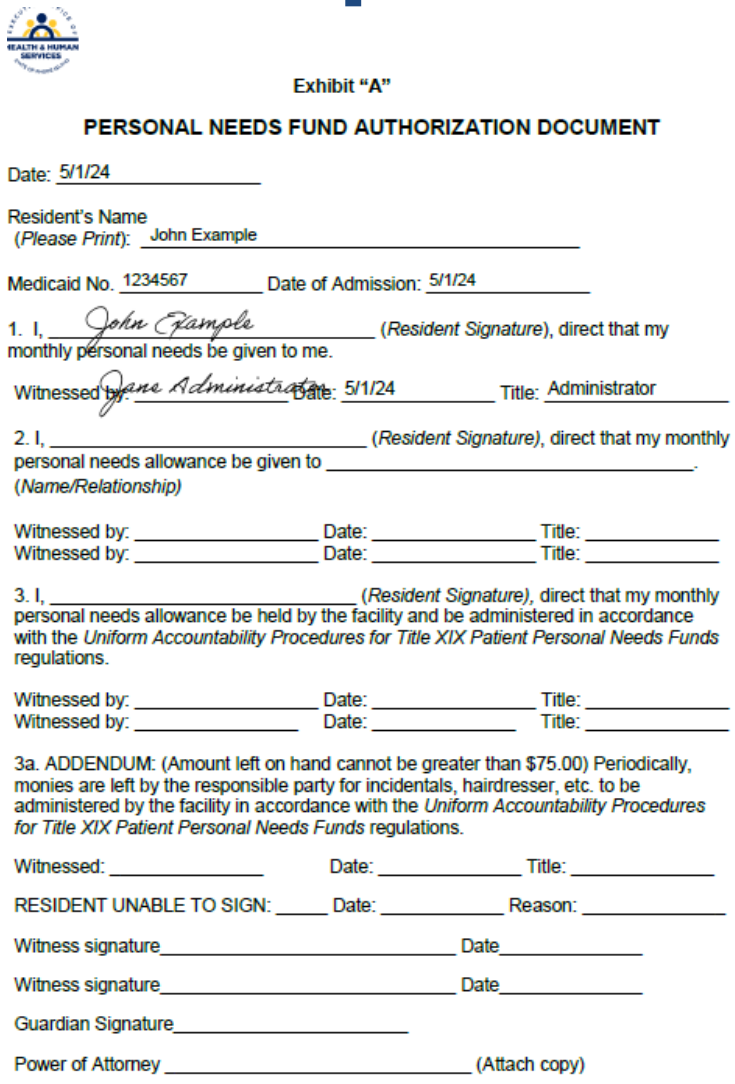


Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

Resident's Name (*Please Print*): John Example

Medicaid No. 1234567 Date of Admission: 5/1/24

1. I, John Example (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: Jane Administrator Date: 5/1/24 Title: Administrator

2. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be given to _____. (*Name/Relationship*)

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed: _____ Date: _____ Title: _____

RESIDENT UNABLE TO SIGN: _____ Date: _____ Reason: _____

Witness signature_____ Date_____

Witness signature_____ Date_____

Guardian Signature_____

Power of Attorney _____ (Attach copy)

- Incorrect: This resident has opted to manage his PNA, and wants to have an optional account, but it is signed in the wrong spot.

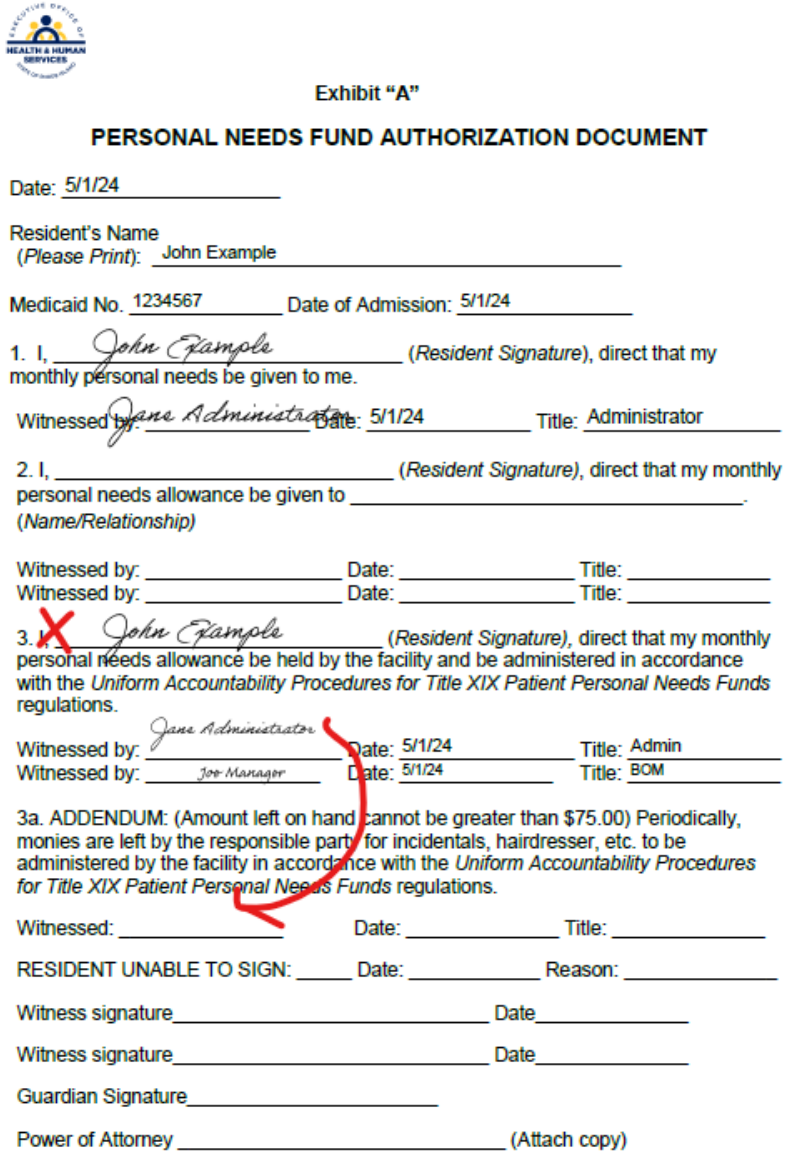


Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

Resident's Name (*Please Print*): John Example

Medicaid No. 1234567 Date of Admission: 5/1/24

1. I, John Example (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: Jane Administrator Date: 5/1/24 Title: Administrator

2. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be given to _____. (*Name/Relationship*)

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3. I, X John Example (*Resident Signature*), direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: Jane Administrator Date: 5/1/24 Title: Admin
Witnessed by: Joe Manager Date: 5/1/24 Title: BOM

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed: _____ Date: _____ Title: _____

RESIDENT UNABLE TO SIGN: _____ Date: _____ Reason: _____

Witness signature_____ Date_____

Witness signature_____ Date_____

Guardian Signature_____

Power of Attorney _____ (Attach copy)

Exhibit A Examples

- Correct: Facility will manage the resident's PNA account. Resident is unable to sign, so two witness signatures are required.

Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

Resident's Name (*Please Print*): John Example

Medicaid No. 1234567 Date of Admission: 5/1/24

1. I, _____ (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: _____ Date: _____ Title: _____

2. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be given to _____. (*Name/Relationship*)

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3. I, John Example (*Resident Signature*), direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: Jane Administrator Date: 5/1/24 Title: Administrator
Witnessed by: Joe Manager Date: 5/1/24 Title: BOM

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed: _____ Date: _____ Title: _____

RESIDENT UNABLE TO SIGN: x Date: 5/1/24 Reason: Mentally Incompetent

Witness signature Jane Administrator Date 5/1/24

Witness signature Joe Manager Date 5/1/24

Guardian Signature _____

Power of Attorney _____ (Attach copy)

- Incorrect: Resident intends to manage PNA account without an optional account, but the form is indicating that the facility is managing the PNA account. Additionally, this form is missing the witness signatures.

Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

Resident's Name (*Please Print*): John Example

Medicaid No. 1234567 Date of Admission: 5/1/24

1. I, _____ (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: _____ Date: _____ Title: _____

2. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be given to _____. (*Name/Relationship*)

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3. I, John Example (*Resident Signature*), direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed: _____ Date: _____ Title: _____

RESIDENT UNABLE TO SIGN: _____ Date: _____ Reason: _____

Witness signature _____ Date _____

Witness signature _____ Date _____

Guardian Signature _____

Power of Attorney _____ (Attach copy)

Exhibit A Examples

- Correct: Resident is opting for his daughter/POA to manage his PNA, and is opting to have an optional account with the facility.

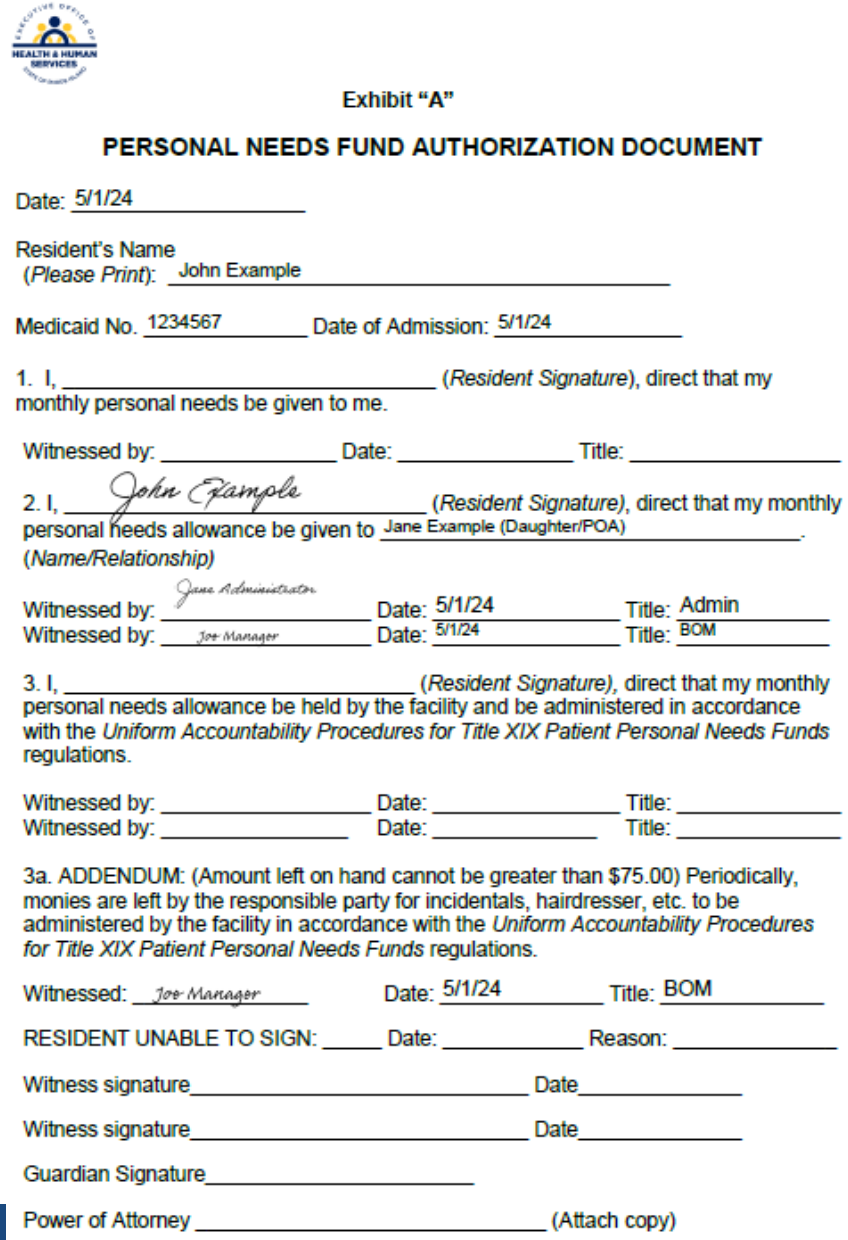


Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

Resident's Name
(*Please Print*): John Example

Medicaid No. 1234567 Date of Admission: 5/1/24

1. I, _____ (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: _____ Date: _____ Title: _____

2. I, John Example (*Resident Signature*), direct that my monthly personal needs allowance be given to Jane Example (Daughter/POA).
(*Name/Relationship*)

Witnessed by: Jane Administrator Date: 5/1/24 Title: Admin
Witnessed by: Joe Manager Date: 5/1/24 Title: BOM

3. I, _____ (*Resident Signature*), direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed: Joe Manager Date: 5/1/24 Title: BOM

RESIDENT UNABLE TO SIGN: _____ Date: _____ Reason: _____

Witness signature_____ Date_____

Witness signature_____ Date_____

Guardian Signature_____

Power of Attorney _____ (Attach copy)