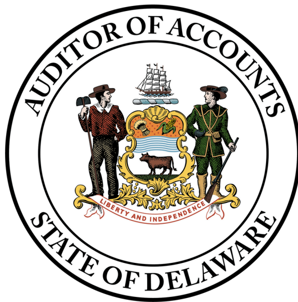

PARKVIEW NURSING AND REHABILITATION

EXAMINATION
FISCAL YEAR ENDED JUNE 30, 2020

PARKVIEW NURSING AND REHAB

REPORT SUMMARY FOR FISCAL YEAR ENDED JUNE 30, 2020

BACKGROUND

An examination of Parkview Nursing and Rehab Long-Term Care Facility fiscal records of the Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance, Medicaid Long-Term Care Facilities' Statement of Reimbursement Costs for Skilled and Intermediate Care Nursing Facilities – Title XIX and Nursing Wage Survey (cost report and nursing wage survey, respectively) for fiscal year ended June 30, 2020.

The State Auditor is authorized under 29 Del. C., §2906 to conduct post-audits of all financial transactions of all state agencies.

This engagement was conducted in accordance with federal requirements (42 CFR 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D) (criteria), as applicable to the Parkview Nursing and Rehab Long-Term Care Facility fiscal records. The criteria were used to prepare the Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey for fiscal year ended June 30, 2020, found in the report.

KEY INFORMATION AND FINDINGS

The State of Delaware is required to ensure that the fiscal records at the nursing care facilities are retained and properly support the cost report, or the financial report showing the cost and charges related to Medicaid activities. These costs must be compliant with federal and state regulations. Under the Delaware Medicaid State Plan, the state is required to examine a sample of facilities to ensure the facilities' cost reports, patient days, and nursing wage surveys are compliant.

A **qualified opinion*** was issued for this examination with eight (8) findings, one of which resulted in both a material weakness in internal control and a compliance finding. Specifically, Management was unable to provide a general ledger and supporting documentation for the period under examination. The total amount of untested costs was $7.7 million (60.4% of total costs). The facility changed ownership on April 1, 2020, during the Medicaid Cost Report period. The remaining seven (7) findings include five adjustments to the Trial Balance, Patient Days, or Nursing Survey Report and two comments as stated below:

1. The Provider did not provide supporting documentation for sampled expense on one account.
2. The Provider included non-allowable personal patient use cable television expense with reimbursable cost.
3. The Provider did not submit accurate costs of ownership of the facility.
4. The Provider submitted allocated costs pertaining to general liability insurance using unsupported total bed count statistics.
5. The Provider did not disallow related party management fees and did not submit a home office cost statement for fees.
6. The Provider did not properly calculate total patient days available on the cost report.
7. The Provider did not provide supporting documentation for three sampled patient funds disbursements.

*Qualified Opinion - The auditor believes, on the basis of his or her audit, that the financial statements contain a departure from generally accepted accounting principles, the effect of which is material, and he or she has concluded not to express an adverse opinion.

STATE OF DELAWARE
OFFICE OF AUDITOR OF ACCOUNTS

INDEPENDENT ACCOUNTANT'S REPORT

Examination of
Parkview Nursing and Rehab
For Fiscal Year Ended June 30, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Independent Accountant's Report

State of Delaware
Office of Auditor of Accounts
401 Federal Street
Dover, DE 19901

Department of Health and Social Services
Division of Medicaid and Medical Assistance
Medicaid's Long Term Care Facilities
1901 N. Dupont Highway, Lewis Building
New Castle, DE 19720

Provider: Parkview Nursing and Rehab
Period: Fiscal Year Ended June 30, 2020

We have examined management's assertions that Parkview Nursing and Rehab (Provider) has complied with federal requirements (42 Code of Federal Regulations [CFR] 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D) (criteria), as applicable, relative to the Provider's fiscal records of the Department of Health and Social Services (DHSS), Division of Social Services, Medicaid Long-Term Care Facilities' Statement of Reimbursement Costs for Skilled and Intermediate Care Nursing Facilities – Title XIX and Nursing Wage Survey (cost report and survey, respectively) for the fiscal year ended June 30, 2020. The Provider's management is responsible for the assertions and the information contained in the cost report and survey, which were reported to DHSS for purposes of the criteria described above. The criteria was used to prepare the Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey. Our responsibility is to express an opinion on the assertions based on our examination.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to our engagement.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Governmental Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether management's assertions are in accordance with the criteria in all material respects. An examination includes performing procedures to obtain evidence about management's assertions. The nature, timing, and extent of the procedures selected depend on our professional judgment, including an assessment of the risks of material misstatement of management's assertions, whether due to fraud or error. We believe the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our qualified opinion.

Basis for Qualified Opinion

The facility was unable to provide detailed support for certain costs. As a result, we were unable to obtain sufficient appropriate evidence about the accuracy and allowability of these costs. We were unable to determine whether adjustments to these amounts were necessary, and whether management's assertions related to these costs are accurate. The total amount of untested costs was

approximately $7.7 million (60.4% of total costs). Please see page 4 for the potential impact to each cost center.

Qualified Opinion

In our opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph and the items listed as adjustments on the accompanying Schedule of Adjustments to the Trial Balance, Patient Days, and Nursing Wage Survey for the period cited, management's assertions referred to above are fairly stated, in all material respects, based on the federal requirements (42 Code of Federal Regulations [CFR] 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D). The examination was performed in accordance with Government Auditing Standards issued by the Comptroller General of the United States, except for the application of procedures to the insufficient evidence related to the matter described in the previous paragraph.

Other Matters

In accordance with *Government Auditing Standards*, we also issued our report dated January 5, 2024 on our consideration of the Provider's internal control over reporting for the cost report and survey and our tests of its compliance with certain provisions of laws, regulations, contracts and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting and compliance. That report is an integral part of an examination performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our examination.

This report is intended solely for the information and use of the State of Delaware Office of Auditor of Accounts, DHSS, Division of Medicaid and Medical Assistance, and Medicaid's Long Term Care Facilities and is not intended to be and should not be used by anyone other than the specified parties. However, under 29 Del. C. §10002, this report is public record and its distribution is not limited. This report, as required by statute, was provided to the Office of the Governor, the Office of the Controller General, the Office of the Attorney General, the General Assembly, and the Office of Management and Budget.

Myers and Stauffer LC
Owings Mills, Maryland
January 5, 2024

Parkview Nursing and Rehab Schedule of Adjustments to the Trial Balance for the Fiscal Year Ending June 30, 2020				
Type of Cost	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Expenses				
Primary Patient Care Costs per Trial Balance of Costs		$ 5,942,777		
	Adjustments to Primary Patient Care Costs			
	None		$ -	
Net Primary Patient Care Costs		**$ 5,942,777**	**$ -**	**$ 5,942,777**
Primary Patient Care Cost Per Day (*)		**$ 123.9**	**$ -**	**$ 120.3**
Secondary Patient Care Costs per Trial Balance of Costs		$ 548,800		
	Adjustments to Secondary Patient Care Costs			
	None		$ -	
Net Secondary Patient Care Costs		**$ 548,800**	**$ -**	**$ 548,800**
Secondary Patient Care Cost Per Day (*)		**$ 11.4**	**$ -**	**$ 11.1**
Support Service Costs per Trial Balance of Costs		$ 2,150,908		
	Adjustments to Support Service Costs			
	None		$ -	
Net Support Service Costs		**$ 2,150,908**	**$ -**	**$ 2,150,908**
Support Service Cost Per Day (*)		**$ 44.8**	**$ -**	**$ 43.5**
Administrative & Routine Costs per Trial Balance of Costs		$ 2,401,643		
	Adjustments to Administrative & Routine Costs			
1	To remove expense not adequately documented		$ (2,956)	
4	To adjust general liability insurance expense to the verified amount		$ 1,780	
5	To remove related party management fees due to lack of home office cost statement		$ (172,681)	
Net Administrative & Routine Costs		**$ 2,401,643**	**$ (173,857)**	**$ 2,227,786**
Administrative & Routine Cost Per Day (*)		**$ 50.1**	**$ (3.5)**	**$ 45.1**

(*) Adjusted Cost Per Day is calculated utilizing days at minimum occupancy.

Parkview Nursing and Rehab Schedule of Adjustments to the Trial Balance for the Fiscal Year Ending June 30, 2020				
Type of Cost	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Expenses				
Capital Costs per Trial Balance of Costs		$ 1,338,617		
	Adjustments to Capital Costs			
2	To remove cable TV expense related to personal use		$ (3,158)	
3	To remove related party rent expense		$ (109,277)	
Net Capital Costs		**$ 1,338,617**	**$ (112,435)**	**$ 1,226,182**
Net Capital Cost Per Day (*)		**$ 27.9**	**$ (2.3)**	**$ 24.8**
Ancillary Costs per Trial Balance of Costs		$ 962,296		
	Adjustments to Ancillary Costs			
	None		$ -	
Net Ancillary Costs		**$ 962,296**	**$ -**	**$ 962,296**
Ancillary Cost Per Day (*)		**$ 20.1**	**$ -**	**$ 19.5**
Other Costs per Trial Balance of Costs		$ -		
	Adjustments to Other Costs			
	None		$ -	
Net Other Costs		**$ -**	**$ -**	**$ -**
Other Cost Per Day (*)		**$ -**	**$ -**	**$ -**

(*) Adjusted Cost Per Day is calculated utilizing days at minimum occupancy.

Parkview Nursing and Rehab Scope Limitation Impact for the Fiscal Year Ending June 30, 2020			
Type of Cost	**Adjusted Amounts**	**Untested Amounts**	**% Untested by Cost Center**
Primary Patient Care Costs	**$ 5,942,777**	**$ 2,604,725**	**43.8%**
Secondary Patient Care Costs	**$ 548,800**	**$ 260,404**	**47.4%**
Support Service Costs	**$ 2,150,908**	**$ 1,366,318**	**63.5%**
Administrative & Routine Costs	**$ 2,227,786**	**$ 1,980,413**	**88.9%**
Capital Costs	**$ 1,226,182**	**$ 776,568**	**63.3%**
Ancillary Costs	**$ 962,296**	**$ 736,285**	**76.5%**
Other Costs	**$ -**	**$ 2,684**	**0.0%**
Total	**$ 13,058,749**	**$ 7,727,397**	**59.2%**

(1) - Untested amounts are reported costs related to the period July 1, 2019 through March 31, 2020. See Schedule of Findings.

Parkview Nursing and Rehab Schedule of Adjustments to Patient Days for the Fiscal Year Ending June 30, 2020				
Census Type	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Census				
Bed days available				54,900
Medicaid Non-Super Skilled Patient Days		41,121		
	Adjustments to Medicaid Patient Days		-	
Medicaid Super Skilled Patient Days		-		
	Adjustments to Medicaid Super Skilled Patient Days		-	
Medicare Patient Days		2,956		
	Adjustments to Medicare Patient Days		-	
Private Pay Patient Days		2,357		
	Adjustments to Private Pay Patient Days		-	
Medicare/Private Pay Hospice Patient Days		-		
	Adjustments to Medicare/Private Pay Hospice Patient Days		-	
Other Patient Days		1,530		
	Adjustments to Other Patient Days		-	
Total Patient Days		**47,964**	**-**	**47,964**
Minimum Occupancy				**49,410**

Parkview Nursing and Rehab Schedule of Adjustments to the Nursing Wage Survey for the Fiscal Year Ending June 30, 2020				
Nurse Type	**Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Nursing Wage Survey				
II-A Administrative Nurses				
	Director of Nursing - Total Payroll	$ 4,554	$ -	**$ 4,554**
	Director of Nursing - Total Hours	80.0	-	**80.0**
	Assistant Director of Nursing - Total Payroll	$ 3,689	$ -	**$ 3,689**
	Assistant Director of Nursing - Total Hours	80.0	-	**80.0**
	Registered Nurses - Total Payroll	$ 10,397	$ -	**$ 10,397**
	Registered Nurses - Total Hours	240.0	-	**240.0**
	Licensed Practical Nurses - Total Payroll	$ -	$ -	**$ -**
	Licensed Practical Nurses - Total Hours	-	-	**-**
	Nurse Aides - Total Payroll	$ -	$ -	**$ -**
	Nurse Aides - Total Hours	-	-	**-**
II-B All Remaining Nursing Staff				
	Registered Nurses - Total Payroll	$ 76,895	$ -	**$ 76,895**
	Registered Nurses - Total Hours	1,729.8	-	**1,729.8**
	Licensed Practical Nurses - Total Payroll	$ 35,049	$ -	**$ 35,049**
	Licensed Practical Nurses - Total Hours	985.5	-	**985.5**
	Nurse Aides - Total Payroll	$ 79,432	$ -	**$ 79,432**
	Nurse Aides - Total Hours	4,413.3	-	**4,413.3**

Parkview Nursing and Rehab
Resident Fund and General Commentary for the Fiscal Year Ending June 30, 2020

Commentary

1) The provider calculated bed days available based on 365 days instead of the leap year count of 366.

2) The provider was not able to provide resident disbursement records for three sampled disbursements.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Independent Accountant's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Examination of Financial Statements Performed in Accordance With *Government Auditing Standards*

State of Delaware
Office of Auditor of Accounts
401 Federal Street
Dover, DE 19901

Department of Health and Social Services
Division of Medicaid and Medical Assistance
Medicaid's Long Term Care Facilities
1901 N. Dupont Highway, Lewis Building
New Castle, DE 19720

We have examined management's assertions that Parkview Nursing and Rehab (Provider) has complied with federal requirements (42 Code of Federal Regulations [CFR] 447.253 and 483 Subpart B) and state requirements (Title XIX Delaware Medicaid State Plan, Attachment 4.19D), as applicable, relative to the Provider's fiscal records of the Department of Health and Social Services (DHSS), Division of Social Services, Medicaid Long-Term Care Facilities' Statement of Reimbursement Costs for Skilled and Intermediate Care Nursing Facilities – Title XIX and Nursing Wage Survey (cost report and survey, respectively) for the fiscal year ended June 30, 2020, and have issued our report thereon dated January 5, 2024. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to financial examinations contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America.

Internal Control Over Reporting

In planning and performing our examination, we considered the Provider's internal control over financial reporting in order to determine our examination procedures for the purpose of expressing our opinions on management's assertions, but not for the purposes of expressing an opinion on the effectiveness of the Provider's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency or combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of the cost report or survey will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies or material weaknesses. We

did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Provider's cost report and survey are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of reported amounts. However, providing an opinion on compliance with those provisions was not an objective of our examination, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Provider's internal control or on compliance. This report is an integral part of an examination performed in accordance with *Government Auditing Standards* in considering the Provider's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

This report is intended solely for the information and use of the State of Delaware Office of Auditor of Accounts, DHSS, Division of Medicaid and Medical Assistance, and Medicaid's Long Term Care Facilities and is not intended to be and should not be used by anyone other than the specified parties. However, under 29 Del. C. §10002, this report is public record and its distribution is not limited. This report, as required by statute, was provided to the Office of the Governor, the Office of the Controller General, Office of the Attorney General, the General Assembly, and the Office of Management and Budget.

Myers and Stauffer LC
Owings Mills, Maryland
January 5, 2024

Parkview Nursing and Rehab
Schedule of Findings for the Fiscal Year Ending June 30, 2020

Findings and Responses

Finding 20-01

Condition:	The Provider did not provide a general ledger and supporting documentation for the period July 1, 2019 through March 31, 2020.
Criteria:	The Medicaid Cost Report for Nursing Facilities should be supported by a trial balance and necessary schedules. The Facility should have internal controls in place to ensure that the trial balance and schedules be available for audit within the State of Delaware by the Medicaid Agency or its designated representative for a period of five years after the date of filing of the Medicaid Cost Report with the Medicaid Agency.
Cause:	The facility changed ownership on April 1, 2020 during the Medicaid Cost report period. New management was unable to access any records related to the period July 1, 2019 through March 31, 2020.
Effect:	Management was unable to provide the detail support for costs and patient census data recorded on the Cost Report and Nursing Wage Survey, resulting in both a material weakness in internal control and a compliance finding. Not being able to support the costs recorded could result in a disallowance of those costs, which would affect the Facility's calculated reimbursement rate.
Recommendation:	Management should ensure existing internal controls policies over record retention are followed to comply with the five year record retention requirement.
Management's Response:	Management made numerous attempts at the corporate level since the start of the examination to obtain the prior operators detailed information with no success.

Finding 20-02 **Adjustment Number(s) Impacted: 1**

Condition:	The Provider did not provide supporting documentation for sampled expense on one account.
Criteria:	The Medicaid Cost Report for Nursing Facilities should be supported by a trial balance and necessary schedules. The Facility should have internal controls in place to ensure that the trial balance and schedules be available for audit within the State of Delaware by the Medicaid Agency or its designated representative for a period of five years after the date of filing of the Medicaid Cost Report with the Medicaid Agency.
Cause:	A payroll vendor change occurred during the cost report period. Management was unable to access documentation from the prior payroll vendor.
Effect:	Management was unable to provide supporting documentation resulting in a compliance finding and the calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is overstated.
Recommendation:	Management should ensure existing internal controls policies over record retention are followed to comply with the five year record retention requirement.
Management's Response:	Management is taking steps to implement the above recommendation.

Finding 20-03 **Adjustment Number(s) Impacted: 2**

Condition:	The Provider included non-allowable personal patient use cable television expense with reimbursable cost.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 21, Section 2106.1 requires the removal from allowable costs any costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients.
Cause:	Non-allowable expenses were submitted with allowable costs on the State of Delaware Medicaid Cost Report.
Effect:	Management did not properly address non-allowable expense resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the capital cost center is overstated.
Recommendation:	Management should review submitted cost report expense to ensure they are appropriate when completing the State of Delaware Medicaid Cost Report.
Management's Response:	Management is taking steps to implement the above recommendation.

Finding 20-04	**Adjustment Number(s) Impacted: 3**
Condition:	The Provider did not submit accurate costs of ownership of the facilty.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 10, Section 1011.5 requires rent paid to the related party lessor by the provider be deemed not allowable cost. The provider, however, would include in its costs the costs of ownership of the facility.
Cause:	A cost report adjustment was proposed to properly disallow related party rent and replace disallowed cost with the actual costs of ownership of the facility. However, management did not calculate depreciation accurately.
Effect:	Management did not accurately submit costs related to the realty company on the cost report resulting in a compliance finding. The calculated reimbursement rate submitted on the cost report for the administrative cost center and the capital cost center are overstated.
Recommendation:	Management should ensure accuracy of the working trial balance used to complete the State of Delaware Medicaid Cost Report.
Management's Response:	Management is taking steps to implement the above recommendation.

Finding 20-05	**Adjustment Number(s) Impacted: 4**
Condition:	The Provider submitted allocated costs pertaining to general liability insurance using unsupported total bed count statistics.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 23, Section 2304 requires that statistical records should be maintained in a consistent manner from one period to another.
Cause:	General liability insurance premiums are allocated across three commonly owned facilities which are under the same insurance policy. Management utilized various different bed counts for the statistical allocation, however, only one set of bed counts was supported.
Effect:	Management was unable to provide support for all statistics used to allocate insurance premiums resulting in a compliance finding and the calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is overstated.
Recommendation:	Management should maintain support for all statistics used in allocating expense.
Management's Response:	Management is taking steps to implement the above recommendation.

Finding 20-06	**Adjustment Number(s) Impacted: 5**
Condition:	The Provider did not disallow related party management fees and did not submit a home office cost statement for fees.
Criteria:	Provider Reimbursement Manual 15-1, Chapter 21, Section 2153 requires a provider in a chain to furnish a detailed home office cost statement as a basis for reimbursing the provider for home office costs and equity capital. If a provider or the home office does not furnish a home office cost statement then home office costs need to be removed.
Cause:	During the cost report preparation stage management did not believe the management company equated to a home office under Provider Reimbursement Manual 15-1, Chapter 21, Section 2150. However, per the management agreement, control exists and multiple related facilities are also under the agreement.
Effect:	Management did not complete and submit a home office cost statement resulting in a compliance finding and the calculated reimbursement rate submitted on the cost report for the administrative and routine cost center is overstated.
Recommendation:	Management should complete a home office cost statement for the related party management company on an annual basis.
Management's Response:	Management is taking steps to implement the above recommendation.

Finding 20-07	**Comment Number(s) Impacted: 1**
Condition:	The Provider did not properly calculate total patient days available on the cost report.
Criteria:	Delaware Medicaid Nursing Facility Cost Report instructions Patient Days section requires line 4 of Page 6 Patient Days reflect total bed days available for the year. This is determined by multiplying the number of available beds by the number of days in the reporting period.
Cause:	Management calculated bed days available based on 365 days rather than 366 actual days in the reporting period.
Effect:	Management did not properly calculate total patient days available resulting in a compliance finding. The calculated reimbursement rates submitted on the cost report for all cost centers are overstated.
Recommendation:	Management should ensure that all calculated fields are accurate on the State of Delaware Medicaid Cost Report prior to submission.
Management's Response:	Management is taking steps to implement the above recommendation.

Finding 20-08	**Comment Number(s) Impacted: 2**
Condition:	The Provider did not provide supporting documentation for three sampled patient funds disbursements.
Criteria:	Under CFR 483.10 (f) (10) (iii) Patient Rights, the facility must establish and maintain a system that assures full, complete, and separate accounting, according to generally accepted accounting principles (GAAP), of each resident's personal funds entrusted to the facility on the resident's behalf.
Cause:	Management asserted that the supporting documentation for the three fund disbursements were misplaced.
Effect:	Management was not able to confirm the establishment and maintenance of full, complete, and separate accounting for patient personal funds.
Recommendation:	Management should ensure that the internal controls over patient funds are followed, including maintaining a full, complete, and separate accounting in accordance with GAAP.
Management's Response:	Management is taking steps to implement the above recommendation.