

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345506	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/5/2021
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NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMU	STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC
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F 582	<p>Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services to one of three residents (Resident #16) reviewed for SNF Beneficiary Protection Notification Review.</p> <p>Findings included:</p> <p>Resident #16 was admitted to the facility on 5/24/16, discharged to the hospital on 1/4/21 and re-admitted to the facility on 1/7/21. Medicare part A services began on 1/7/21.</p> <p>The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by the Resident Representative on 1/30/21. The notice indicated that Medicare coverage for skilled services</p>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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F 582	<p>Continued From Page 1</p> <p>was to end 2/1/21. Resident #16 remained in the facility when Medicare coverage ended.</p> <p>The medical record further revealed a CMS-10055 SNF ABN was not provided to the resident or resident representative.</p> <p>An interview was completed with the Move In Coordinator on 3/4/21 at 3:38 PM. She reported she was responsible for the completion of the NOMNC and ABN forms. She explained that typically, the therapy department notified her of the date when a resident was being discharged from therapy. She then issued a NOMNC form to the resident or resident representative 3-5 days in advance of the therapy discharge date. A resident received the NOMNC form whether they discharged to the community or remained in the facility. The Move In Coordinator said that ABN forms were signed upon admission to the facility for each resident and the form was not updated when a resident came off therapy and remained in the facility.</p> <p>During an interview with the Executive Director on 3/5/21 at 10:55 AM, he shared that appropriate notices should be issued when a resident came of Medicare part A benefit.</p>		
F 640	<p>Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)</p> <p>§483.20(f) Automated data processing requirement-</p> <p>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. <p>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. 		

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F 640	<p>Continued From Page 2</p> <p>(iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.</p> <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a discharge tracking Minimum Data Set (MDS) assessment for 1 of 2 residents (Resident #1) reviewed for Resident Assessments.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 10/6/20 with diagnoses that included, in part, hyperlipidemia, osteoporosis and dementia.</p> <p>The medical record revealed a discharge tracking MDS assessment was opened on 11/19/20 but had not been completed.</p> <p>On 3/5/21 at 9:45 AM an interview was completed with MDS Coordinator #2. She stated the discharge MDS assessment should have been completed by the 14th day after discharge, which was 12/2/20. MDS Coordinator #2 stated she was responsible to have the assessment completed and it was an oversight that the discharge MDS assessment was missed.</p> <p>The Executive Director was interviewed on 3/5/21 at 11:02 AM. He said the facility typically had not checked behind and ensured MDS assessments were completed and added MDS Coordinator #2 should have completed the discharge MDS assessment with the 14 day required timeframe.</p>		