STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	**3609 BOND STREET RALEIGH, NC 27604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation, event ID # SP5Y11, Intake # NC00097335.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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,	F 156		9/5/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/16/2014

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 correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	**3609 BOND STREET RALEIGH, NC 27604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	**3609 BOND STREET RALEIGH, NC 27604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a resident/responsible party (RP) with a Medicare provider non-coverage notification letter in a timely manner, for 2 of 3 residents (Residents #39 and #70) whose notifications were reviewed. Findings included: 1. A Medicare provider non-coverage letter reviewed for Resident #39 documented the last day of Medicare skilled nursing coverage was 1/7/14. Resident #39 was no longer residing in the facility at the time of the survey, but was under guardianship of a Department of Social Services (DSS) worker while residing in the facility. A DSS guardian signed the notice on 6/4/14 after facility staff faxed the letter on 6/4/14 to be signed. 2. A Medicare provider non-coverage letter reviewed for Resident #70 documented the last day of Medicare skilled nursing coverage was 1/3/14. Resident #70 was still residing in the facility at the time of the survey. The letter was not signed, but was sent to the responsible party by certified mail on 6/4/14. In an interview with the facility's bookkeeper on 6/4/14 at 2:35 PM, she stated that resident #39's	F 156	Disclaimer Statement: Tower Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	**3609 BOND STREET RALEIGH, NC 27604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3 guardian was supposed to visit the facility on 1/7/14 and she was going to have her sign the letter at that time, but the guardian never made it to the facility and the letter got placed in a stack and forgotten until requested during the survey. She reported that when she noticed that it was not signed she faxed it to DSS to have it signed by the person who was reassigned to guardianship for resident #39 as the old guardian was no longer there. For Resident #70, she reported that she had spoken to the resident's responsible party on 1/3/14 and she was supposed to visit the facility to sign the notice on 1/11/14, but did not do so. The bookkeeper stated that she realized that she did not get the notice signed when she looked at the notice on 6/4/14 and sent it to the responsible party by certified mail at that time. She also reported that she was aware that she had not given Resident #70's responsible party the required notice of at least 48 hours prior to the expiration of Medicare coverage when she spoke with her on 1/3/14 for service coverage that expired on 1/3/14. In an interview with the facility's administrator on 6/5/14 at 11:50 AM, he stated that he was not aware that notices were not being administered in a timely manner, but that he understood the importance of notice of expiration of Medicare covered services being given at least 48 hours prior to coverage expiration and would expect that residents and/or responsible parties be provided notice as required.	F 156	F156 " AR Director faxed and obtained signature for resident□s (#39) letter on 6-4-14, resident□s (#70) letter was sent out certified mail on 6-4-14. " On 6-5-14 a 100% audit was completed by AR Director of all Medicare provider non-coverage letters dating back to March 2013 to ensure letters are signed and/or mailed out. Any areas identified were corrected. " The Administrator will complete an in-service on 6-10-14 with the A/R department regarding the importance of getting the notice of expiration for Medicare covered services letters signed at least 48 hours prior to coverage expiration, and to send letters certified mail-return receipt requested at least 48 hours prior to coverage expiration. " The A/R Director will keep a log of all Medicare non-coverage letters which the Administrator will review weekly for three months to ensure compliance. " Administrator will submit results of the logs to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	