STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345194	A. BUILDING: _____ B. WING _____	3/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	**5701 FAYETTEVILLE ROAD LUMBERTON, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	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, 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 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.

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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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and documentation, the facility failed to provide evidence that a Medicare non-coverage letter was issued to a resident/responsible party prior to Medicare benefits ending (Resident #35) and the facility also failed to provide evidence a Medicare non-coverage letter was issued to a resident/responsible party (Resident #85) two days prior to Medicare services were ending for 2 of 4 sampled residents reviewed for Medicare liability notices.

The findings included:

1. Review of Resident #35's Minimum Data Set (MDS) dated 1/29/15 revealed that Resident #35 was readmitted to the facility on 10/6/14 on Medicare and Medicare coverage ended on 11/26/14.

During an interview on 3/18/15 at 11:05 AM, the Administrator revealed that Resident #35 transitioned to Medicaid in October, 2014. He stated that he could not find a Medicare non-coverage letter for Resident #35 and he revealed that the resident currently resided in the facility. He stated that he could not find where the Social Worker issued a Medicare non-coverage letter.

During an interview on 3/18/15 at 3:51 PM, the facility Social Worker stated that she was not able to find a Medicare non-coverage letter for Resident #35. The facility Social Worker explained that residents in Rehabilitation therapy choose their own dates in consultation with therapy about when they plan to finish therapy services. She revealed that a Medicare non-coverage letter was completed even though residents in Rehabilitation therapy end their own services. The Social Worker reported that she and the therapist communicate with each other. The Social Worker explained the process of how Medicare non-coverage letters were issued. She revealed that she would notify the Administrator when Medicare services ended, the Administrator would complete the Medicare non-coverage letter and when he completed the document then she would talk to the resident.

During an interview on 3/18/15 at 4:57 PM, the Administrator revealed that residents plan with therapy when they want to end therapy services and he revealed that over one hundred Medicare non-coverage letters had been issued in the past year to make sure residents were being notified. The Administrator explained that there was a problem of when to issue the Medicare non-coverage letters since short term residents set their own date for discharge and some residents transitioned from short term to long term care and remained in the facility.

2. Review of Resident #85's Medicare non-coverage letter revealed that Medicare coverage ended on 10/21/14 and Resident #85 signed the document on 10/21/14.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 2

Review of a Social Work note dated 10/20/14, read in part, "Elder signed the notice of Medicare provider non-coverage form on this date." (10/20/14).

During an interview on 3/18/15 at 3:51 PM, the facility Social Worker explained that residents in Rehabilitation therapy choose their own dates in consultation with therapy about when they plan to finish therapy services. She revealed that a Medicare non-coverage letter was completed even though residents in Rehabilitation therapy end their own services. The Social Worker reported that she and the therapist communicate with each other. The Social Worker explained the process of how Medicare non-coverage letters were issued. She revealed that she would notify the Administrator when Medicare services ended, the Administrator would complete the Medicare non-coverage letter and when he completed the document then she would talk to the resident.

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