STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

(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 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §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. §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	F 582		5/22/18

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

Electronically Signed | 05/22/2018

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.

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F 582	Continued From page 1 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 record review and staff interviews the facility failed to provide the Notice of Medicare Non-Coverage letter indicating the resident was notified prior to Medicare coverage ending for 3 of 3 residents reviewed for beneficiary protection notification. (Residents #17, #32 and #83). The findings included: 1. Resident # 17 was admitted to the facility on 01/20/18 with diagnoses including Hypertension, Pneumonia, Urinary Tract Infection, Cerebrovascular Accident, Muscle Weakness and Unsteadiness on Feet. Resident #17 Medicare Part A skilled services ended on 04/17/18. Resident was discharged to home on 04/17/18 with home health. Record review revealed that Resident #17 was not given the Notice of Medicare Non-Coverage letter. During an interview with the Admission	F 582	There was not full understanding of the intent of the NOMNC at Pender Memorial Hospital SNF. Practice had been based on incorrect interpretation of the Standard that a NOMNC was not required if the patient was willfully discharging after collaborative discussion with the interdisciplinary team. It is now understood that the NOMNC is indicated in that situation and many others as listed in the Standard. Standard Work was completed for provision of NOMNC when indicated. The Admissions Coordinators will maintain a log of all residents in order to track entry data and changes in coverage as they occur. The delivery of written notices will also be tracked via this method with daily review Monday-Friday except on holidays. NOMNC will be delivered 2-7 days in advance of actual coverage changes. Full explanation will be provided regarding the	

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F 582	Continued From page 2 Coordinator on 05/10/18 at 9:00 AM, she stated that it was her understanding that the Notice of Medicare Non-Coverage or the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form would be given to the resident or resident representative after they have used of their 100 days. During an interview with the Administrator on 05/11/18 at 10:00 AM, she stated that is her expectation that the facility follows the CMS Federal guidelines and provide the Notice of Medicare Non-Coverage letter to resident and/or resident representative when required. 2. Resident # 32 was admitted to the facility on 03/29/18 with diagnoses including of Hypertension, Wound Infection, Muscle Weakness and Difficulty Walking. Resident #32 Medicare Part A skilled services ended on 04/19/18. Resident was discharged to home on 04/19/18 with home health. Record review revealed that Resident #32 was not given the Notice of Medicare Non-Coverage letter. During an interview with the Admission Coordinator on 05/10/18 at 9:00 AM, she stated that it was her understanding that the Notice of Medicare Non-Coverage or the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form would be given to the resident or resident representative after they have used of their 100 days. During an interview with the Administrator on 05/11/18 at 10:00 AM, she stated that is her	F 582	right to appeal. If a responsible party is not available in person to sign, the discussion will be held over the telephone if possible and a form sent via certified mail with a return receipt requested. The Admissions Coordinators will serve as the notifiers with back-up by other members of the Quality & Outcomes Dept. Advanced Beneficiary Notices (ABNs) will be provided with full explanation and signatures obtained at all indicated times prior to applicable services being delivered. Standard Work has been developed and will be utilized by all staff. Expected copays will be discussed prior to admission by the Admissions Coordinators. ABNs will be delivered and collected by the Patient Access Department who will serve as the notifier. The notifier will be informed by the Admissions Coordinator of all anticipated changes in coverage and applicable dates so that the notifier may meet with the patient &/or responsible party for ABN procurement prior to applicable dates. The process for delivery of each NOMNC and SNF ABN will be monitored for 90 days by the Chief Nurse Executive to ensure full compliance.	

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F 582	Continued From page 3 expectation that the facility follows the CMS Federal guidelines and provide the Notice of Medicare Non-Coverage letter to resident and/or resident representative when required. 3. Resident #83 was admitted to the on 09/25/17 with diagnoses including Atrial Fibrillation, Heart Failure, Hypertension, Hyperlipidemia and Muscle Weakness. Resident #83 Medicare Part A skilled services ended on 11/09/17. Resident was discharged to home on 11/09/17 with home health. Record review revealed that Resident #83 was not given the Notice of Medicare Non-Coverage letter. During an interview with the Admission Coordinator on 05/10/18 at 9:00 AM, she stated that it was her understanding that the Notice of Medicare Non-Coverage or the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form would be given to the resident or resident representative after they have used of their 100 days. During an interview with the Administrator on 05/11/18 at 10:00 AM, she stated that is her expectation that the facility follows the CMS Federal guidelines and provide the Notice of Medicare Non-Coverage letter to resident and/or resident representative when required.	F 582		
F 867 SS=B	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		5/22/18

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F 867	Continued From page 4 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee in June 2017 in order to achieve and sustain compliance. This was for one re-cited deficiency which was originally cited in June 2017 on a recertification survey and again on the current recertification survey of 05/11/18. The deficiency was in the area of Quality Assurance and Performance Improvement. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross reference to: §483.10(g)(17) Resident Rights (F582). Based on record review and staff interviews the facility failed to provide the Notice of Medicare Non-Coverage letter indicating the resident was notified prior to Medicare coverage ending for 3 of 3 residents reviewed for beneficiary protection notification. (Residents #17, #32 and #83). Medicaid / Medicare Coverage / Liability Notice (formerly 156) was originally cited during the recertification survey of 06/22/17 for failing to provide Medicare Non-Coverage letters indicating the residents were not notified prior to Medicare coverage ending.	F 867	Pender Memorial Hospital SNF had an incorrect understanding of the requirements for delivery of the NOMNC after our 2017 survey. Compliance was being measured against an incorrect interpretation. Corrective action for delivery of NOMNC and ABN have been implemented. The Chief Nurse Executive will monitor all short-term resident records for full compliance of delivery of NOMNC information at admission and delivery of a detailed NOMNC within 2-7 days of discharge. This data will be maintained on the master census spreadsheet by the Admission Coordinators. In addition, weekly care plan meetings will include discussion of potential discharges directly with the Admissions Coordinator to serve as notification that NOMNC is indicated in the coming week. A review of NOMC delivery percentages of completion will be a standing agenda item at all quarterly QAPI (Quality Assessment Performance Improvement) meetings.	

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F 867	Continued From page 5 During an interview with the Administrator on 05/11/18 at 10:00 a.m., the Administrator stated it was her expectation the facility staff resolve identified concerns and audit the plan of correction to ensure continued compliance.	F 867		