STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106002	A. BUILDING _____ B. WING _____	**09/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEDGEWOOD HEALTHCARE CENTER	**1010 CARPENTERS WAY LAKELAND, FL 33809**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that it provided an accurate bill for room and board for 1 (#1) of 6 sampled residents. In addition, the facility failed to ensure that it provided to the residents and or their representatives in writing why specific services may not be covered and of the resident's/beneficiary's potential liability for payment for the non-covered services via a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) form CMS (Centers for Medicare and Medicaid Services)- for 4 (#1, #5, #6, #7) of 6 sampled residents. Findings include: 1. A review of Resident #1's clinical record, the Admission Record documented admission on 03/05/18 and readmission on 05/19/20. The Admission record documented a family member as a responsible party with address and phone number. A review of the facility discharge log documented that Resident #1 had discharged from the facility on 08/19/20. Resident #1 was not a current resident at the facility on 09/23/20. On 09/23/20 at 11:28 a.m., an interview was conducted with the Business Office Manager (BOM). She stated that Resident #1 was admitted to the facility for skilled care requiring Physical Therapy (PT). PT was discontinued for her; she was not making any progress. She was admitted under Medicare Part A and then had a payor source change to private pay. She said the balance was still owed on the resident's bill, that there were some hard feelings there and she was not pushing the bill. The BOM stated that she POA (Power of Attorney) for the resident felt like Resident #1 should have stayed on Medicare. I told that her that that would have been Medicare fraud. At 11:53 a.m., the BOM returned with a census list, documenting that Resident #1 had a payor source change on 07/31/20. The BOM stated, the resident went from Medicare to private pay on 07/31/20. Her last covered day was 07/30/20. She was asked if she spoke to the POA about applying for Medicaid and she said No, I did not. She went on to say that the payor source was changed and on 8/19/20 the resident discharged to the hospital. At 11:55 a.m., the BOM provided a billing statement, dated 09/01/20. She stated that this was the bill that was sent out in August. She stated that she normally prints and mails out the bill between the 1st and the 15th of the month. Review of the 09/01/20 bill, documented a balance due of $18,414.00. (07/31/20, 1 day; 08/01/20, 31 days; 09/01/20, 30 days. ($297. Per day.) At 12:05 p.m., BOM provided an admission packet for Resident #1 that was signed by the resident's family member on 05/20/20, which documented a rate of $284.00 per day for routine care, room and board. The BOM was asked if she had any paperwork that would justify why she was billing at $297.00 per day instead of the admission packet agreed upon rate of $284.00 per day. The BOM stated that she did not. The BOM then said, that the bill sent to the resident's POA provided around 09/15/20 (the one dated 10/01/20) had several charges that were backed out of the bill, with the resulting bill was for 18 days in August at $297.00 per day, which totaled $5, 643.00. It was noted that if the resident had been billed correctly for the private pay rate of $284.00 per day x 18 days (august) plus 1 day (July), the total of the bill would have been $5,396.00. 2. Payor source change for Resident #1, admitted on [DATE], was reported to have a payor source change on 07/31/20 from Medicare to Private Pay. Resident #1 remained in the facility until 08/19/20 when she was discharged to a hospital. The facility was not able to locate a Last Covered Day Notice that should have been provided 2 days prior to 07/30/20 for this resident. At approximately 1:30 p.m., Staff C, the MDS (Minimum Data Set) Coordinator provided an unsigned Notice of Medicare Non-Coverage, CMS form , that she said was a sample of what should have been presented to the resident for signing and then filed in the book. For Resident #5, the clinical record reflected that she admitted to the facility in 12/2017 with a readmission of 08/14/20. A review of the facility payor change log documented that on 08/29/20, Resident #5 had a payor change from Medicare A to Medicaid. Resident #5 was a current resident in the facility. A review of the Notice of Medicare Non-Coverage, CMS , signed by the resident on 08/25/20 documented the effective date coverage of your current skilled services will end on 08/28/20. The facility did not provide the resident a SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice), CMS- . For Resident #6, the clinical record reflected that she admitted to the facility on [DATE]. A review of the facility payor change log documented that on 09/04/20, Resident #6 had a payor change from Medicare A to Private pay. Resident #6 was a current resident in the facility. A review of the Notice of Medicare Non-Coverage (NOMNC), CMS , documented skilled services would end on 09/21/20. The form was not signed by the resident or the responsible party. The notice did have a handwritten comment: Spoke with Guardian and phone number to inform her that Medicare services end 09/21/2020. The note was dated 09/15/20. The facility did not provide the resident a SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice), CMS- . For Resident #6, when Staff C, the MDS Coordinator provided the Last Covered Day (LCD) Notice for Resident #6 at approximately 1:30 p.m., she stated that originally, Resident #6 was going to be cut on 09/03/20, but her skilled care was extended to 09/21/20. She provided a NOMNC, CMS only. For Resident #7, the clinical record reflected that she admitted to the facility on [DATE]. A review of the facility payor change log documented that on 09/17/20, resident #7 had a payor change from Medicare A to Medicaid. Resident #7 was a current resident in the facility. A review of the NOMNC, CMS , not signed by the resident or the responsible party was provided for review. The notice did have a handwritten comment: Spoke with (family member) and phone number to inform him that Medicare services end 09/16/20. The note was not dated. The facility did not provide the resident a SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice), CMS- . At 1:30 p.m., an interview with Staff C, MDS coordinator was conducted who stated, I am a case manager, that means that I send weekly updates to the insurance companies. I give weekly updates on the patients. The insurance company will e-mail me the NOMNC or they will let us know that they will send a Notice of non-coverage letter. I will forward those e-mails to social worker, (the whole team), administrator; (ITD team). The social worker, and or discharge planner. They work together under social services. I have looked through and cannot find the last covered day notice for Resident #1. At 1:42 p.m., the Nursing Home Administrator confirmed that they could not find the last covered day notice for Resident #1. At 2:58 p.m., Staff C, the MDS Coordinator stated that the residents that were reviewed were in house, the social worker takes the notice to them to sign and then the notice was filed in the chart. She stated that the notices were not mailed that she was aware of. Staff C was unaware of the CMS- notice.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure that the medical records of one (#1) out of six sampled residents included weekly skin evaluations and a Daily Skilled Note as ordered by the physician. Findings included: Resident #1 was admitted on [DATE]. The Admission Record identified [DIAGNOSES REDACTED]. A review of Resident #1's Order Review Report identified the following physician orders: - Weekly skin sweeps in the afternoon every Tuesday (Tue). The

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

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) order was to start on 5/26/20 with no end date. - Daily Skilled Note UDA, due every shift. Please complete the Daily Skilled Note UDA. The order was started on 5/19/20 and discontinued on 6/4/20. - Daily Skilled Note UDA, due every shift. Please complete the Daily Skilled Note UDA. The order was started on 6/5/20 and discontinued on 8/7/20. A policy titled, Skin Evaluation, effective 11/30/2014 and revised 4/1/2017, identified A License Nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation form. A review of the medical record identified three Weekly Skin Integrity Reviews for Resident #1 from 5/19/20 to 8/19/20 when she was discharged . The dates of the reviews was 6/2, 6/30, and 8/11/20. The review dated 6/2/20 identified redness to buttocks and no open areas. The review dated 6/30/20 indicated bottom has redness. The assessment dated [DATE] reported that the resident had fluid-filled blister to the left heel. A Braden Scale for Predicting Pressure Sore Risk, dated 5/19/20, identified a score of 10 which indicated Resident #1 was a high risk of developing a pressure sore. The care plan identified the resident had potential for pressure injury development related to (r/t) impaired mobility, initiated 5/29 and revised 6/4/20. The included interventions instructed staff to monitor/document/report as needed (prn) any changes in skin status. On 8/17/20, the Wound Care physician evaluated Resident #1's wounds, identifying two wounds, a non-pressure wound on the left heel and Moisture Associated Skin Damage (MASD) to the sacrum. During an interview, on 9/23/20 at 4:17 p.m., the Director of Nursing (DON) was asked how often staff were to document skin assessments. She stated skin assessments should be weekly, every seven days. When the DON reviewed Resident #1's medical record she stated the resident had received three skin assessments after her admission, on 5/19, until her discharge on 8/19/20. The DON stated that the wound care nurse should document in the assessment portion of the medical record. After reviewing the assessments completed by staff on Resident #1, the DON confirmed the wound care nurse had not documented on the resident. The policy titled, Daily Skilled Nursing Progress Note, effective 11/30/2014 and revised 9/29/2017, identified Residents receiving skilled care have progress documented daily in the medical record by the nurse. A review of the July and August 2020 Medication Administration Record [REDACTED]. A review of the electronic Daily Skilled Notes indicated there were no Daily Skilled Notes from June 27 until July 23, 2020. During an interview, on 9/23/20 at 4:17 p.m., the Director of Nursing (DON) was asked what her expectation in regards to documentation for a skilled resident. She stated a skilled resident was documented on every 24 hours. When asked to review the chart and identify the time frame that Resident #1 was a skilled resident, she stated the resident was skilled from 5/19/20 to 7/30/20. The DON stated she should see a Daily Skilled Note from 5/19 to 7/30/20. When asked if there were daily skilled notes, the DON confirmed there were not.