STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045407	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MAPLES AT HAR-BER MEADOWS	**6456 LYNCHS PRAIRIE COVE SPRINGDALE, AR 72762**

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 -** Few	**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 provide a resident's representative written notice of changes in service that were not covered with the resident's Medicare plan and the resident's liability for payment for 1 (Resident #3) of 1 resident. This failed practice had the potential to affect 17 residents currently receiving skilled services with a Medicare policy per a Daily Census Report provided by the Administrator on 07/30/2020. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set with an Assessment Reference Date of 05/04/2020 documented the resident scored 6 (0-7 indicates severe cognitive impairment) per a Brief Interview for Mental Status and required extensive assistance with transfers and toileting needs. a. The resident was admitted to the facility on [DATE] and discharged on [DATE]. The resident's Medicare services started on 05/01/2020 and were discontinued on 06/05/2020. b. On 08/11/2020 at 9:37 a.m., the Complainant was asked if she was notified in writing of her father's therapy sessions ending on 06/05/2020. The Complainant stated, No, I never got anything in writing from the facility. They told me they were going to move my dad to a different room and that he had plateaued with this therapy sessions. I didn't really know what they meant at that time. They did not let me know they stopped therapy. I did not get a letter or phone call. If they would of let me know, I could of talked to my Dad and told him how important therapy was for him getting better and being able to get out of there. c. On 08/11/2020 at 2:49 p.m., the Business Office Manager (BOM) was asked if the facility informed the family or representative of Resident #3 by mail of the discontinuing of his therapy sessions and that the family or representative would be responsible for payment. The BOM stated, That was the previous Medicare Manager's responsibility. I was not able to verify that he sent that notification out. I'm not sure she ever received one. d. On 08/12/2020 at 11:27 a.m., the Administrator was asked if he had any evidence that the Skilled Nursing Facility Advanced Beneficiary Notice had been sent to Resident #3's family or representative. The Administrator stated, I looked all over for it and I could not find it. I tried to get a hold of the previous Medicare Manager, but he did not return my phone calls. He apparently wasn't the best about filing forms or scanning them in. We are supposed to keep a record of the notices we send out to families.

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.