

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Ormond Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Clyde Morris Blvd Ormond Beach, FL 32174	
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 interview and record review, the facility failed to ensure a refund was issued to the resident or resident representative within 30 days from the resident's date of discharge from the facility for 1 resident sampled for refunds, Resident #2. The findings include: Review of Resident #2's records revealed the resident was admitted to the facility on [DATE] and discharged from the facility on [DATE]. On [DATE] at 9:45 am, a phone interview was conducted with Resident #2's brother who stated he had not received a refund after Resident #2 expired on [DATE]. He explained that he had called the facility several times but never got a return call. During an interview on [DATE] at 1:22 pm, the Business Office Manager (BOM) was asked to explain the refund process following a discharge. She stated that refunds are issued within 30 days of discharge. When asked how she determines refund amounts, she stated she has a packet that she uses for everyone. She fills out the needed information to determine the amount to be refunded, then she sends this to the regional office for review. The regional office will complete the request and issue a check for the refund amount, and it is sent to the resident/family. When asked if there were any pending refunds, she stated there were no current refunds pending, the last two had their checks issued and are now complete. When the BOM was asked about the refund for Resident #2 who expired on [DATE]. She stated she was working on it. She stated that she sent her paperwork to the regional office which showed an amount of over \$1,100.00 due the brother. The regional office reviewed the request, and it was determined that the resident responsibility was greater than was being paid, after reconciling the money in the account there would have been around \$6.00 for a refund. (Photographic evidence obtained) When asked if she had been in contact with the brother of Resident #2 who paid the resident's responsibility every month, she did not answer. When asked if it was their policy to speak with family, she stated it was. When asked if she had any written communication sent to the brother, she could not produce any emails or letters. She also stated she had not spoken to him on the phone. Review of the facility's policy and procedure titled, Resident Refund Policy dated February 2011 read, Any funds on deposit with the Facility shall be refunded and the resident trust savings account must be closed and refunded when a resident leaves the Facility or expires. This must be done within 30 days of the discharge date (or sooner, according to State requirements). This process is to be handled by the Business Office Manager (BOM).		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE