

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Timberridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9848 SW 110th St Ocala, FL 34481	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15234</p> <p>Based on record review and interview the facility failed to ensure 1 resident, Resident #512, of 3 residents reviewed for insurance and payor source change was informed of co-pay obligations following a payor source change.</p> <p>Findings include:</p> <p>Review of Resident #512's admission record showed Resident #512 was initially admitted to the facility on [DATE] with diagnoses that included unspecified fracture of sacrum, subsequent encounter for fracture with routine healing.</p> <p>Review of Resident #512's pre-admission insurance/managed care verification form, dated 4/5/2024, [name of the managed care insurance company] was documented as Resident #512's primary payor source. A co-pay of \$125.00 a day for days 21-100 was indicated on the form.</p> <p>During an interview on 8/27/2024 and 10:15 AM, Resident #512 stated she was told by the Business Manager that her insurance wouldn't cover services after 20 days and the facility was going to switch her over to Medicare for coverage. Resident #512 reported she asked the Business Manager if there would be a co-pay, and the Business Manager had told her there would not be a co-pay. Resident #512 stated that when she went to settle up at discharge she was told there had been a co-pay of \$205.00 a day.</p> <p>Review of Resident #512's Managed Medicare Conversion Form and Medicare Part D Enrollment agreement showed Resident #512 had signed the coverage conversion form on 4/30/2024. The conversion form did not specify a daily co-pay cost.</p> <p>During interview on 8/27/2024 beginning at 12:50 PM, the Business Office Manager stated it was a team decision that Resident #512 be switched to Medicare due to Resident #512 needing more time under skilled care. The Business Office Manager reported she had spoken with Resident #512 and explained everything to her, however, she had not documented the conversation.</p> <p>(continued on next page)</p>

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
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the policy and procedure titled Medicare Conversions, last reviewed 8/22/2024, read Procedure 1. Explain verbally and in writing the impact of changing coverage and that the beneficiary will be choosing another type of plan and losing the current plan coverage. Explain medical coverage will be billed to original Medicare and/or Medicaid if the beneficiary is disenrolled from Medicare health plan and what this means regarding deductibles ad co-pays/insurance and or loss of lack of supplemental coverage for the beneficiary. The name of the new drug plan will be discussed along with all co-pays and co-insurance.</p>		