

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Bethesda Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 3532 Dunn Road Eastover, NC 28301	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21483</p> <p>Based on record review and staff interviews, the facility failed to provide the required Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC) (form 10123) for 1 of 3 sampled residents reviewed for beneficiary protection notification review (Resident #49).</p> <p>The findings included:</p> <p>Resident #49 was admitted to the facility on [DATE] with Medicare Part A skilled services.</p> <p>Resident #49's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired.</p> <p>Resident #49's Medicare Part A skilled services ended on 4/08/2024 and her Medicare Part A Skilled Nursing Facility benefit was not exhausted. She remained in the facility.</p> <p>Record review revealed no evidence that Resident #49 or the resident's Responsible Party (RP) was provided with the NOMNC.</p> <p>During an interview with the Secretary Assistant on 11/31/2024 at 10:51AM, she stated she provided the RP with the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) on 03/25/2024 but she failed to provide NOMNC notice. The Secretary Assistant stated she was not aware she should have provided the RP with the NOMNC notice due to the resident remaining in the facility and still having Medicare Part A days remaining. The Secretary Assistant indicated moving forward she would provide the NOMNC notice to the residents or RP as required by the federal guidelines.</p> <p>During an interview with the Administrator on 11/31/2024 at 11:05 AM, she stated Resident #49 remained in the facility after being discharged from rehab services and the RP should have received the NOMNC as required by the federal guidelines.</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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