

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER Oak Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3650 Beavercrest Drive Lorain, OH 44053	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091</p> <p>Based on medical record review, review of census records, review of financial records, and staff interview, the facility failed to ensure a final accounting and disbursement of funds was completed timely following a resident death. This affected one (#1) of four residents reviewed for funds disbursement upon death or discharge. The facility census was 59.</p> <p>Findings Include:</p> <p>Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, dementia, and altered mental status.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was severely cognitively impaired and required extensive assistance for his activities of daily living.</p> <p>Further review of the medical record revealed Resident #1 expired at the facility on [DATE].</p> <p>Review of census records for Resident #1 revealed he was admitted under private pay with Medicare as secondary insurance.</p> <p>Review of financial records revealed Resident #1's responsible party wrote a check for \$8,005.44 (one month's private pay rate) on [DATE] for the upcoming month's care and services for Resident #1. Review of a detailed accounting statement for Resident #1 revealed Resident #1 had a credit of \$7,115.04 upon his death at the facility on [DATE]. Further review of business office records revealed a check in the amount of \$7,115.04 was sent to Resident #1's responsible party on [DATE].</p> <p>Interview with Regional Business Office Manager (RBOM) #100 on [DATE] revealed the facility was waiting on potential Medicare coverage for some of Resident #1's stay at the facility. RBOM #100 stated a formal denial of payment from Medicare was received on [DATE]. There was no evidence of communication between the facility's billing department and Resident #1's responsible party regarding the status of Resident #1's refund. RBOM #100 verified Resident #1's refund was sent out on [DATE] which was outside the requirement for final disbursement of funds upon death or discharge within 30 days.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154348.</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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