

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Rose Linn Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2330 Debok Road West Linn, OR 97068	

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>41455</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were provided accurate information and informed in writing of advanced beneficiary information for 2 of 2 sampled residents (#s 114 and 115) reviewed for required beneficiary notification. This placed residents at risk for not being informed of financial liabilities and the right to an appeal. Findings include:</p> <p>Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) indicated notices are valid when all patient specific information required by the notice is included.</p> <p>1. Resident 114 was admitted to the facility in 9/2024 with diagnoses including diabetes and schizophrenia (mental health disorder).</p> <p>Resident 114's clinical record indicated the resident had Medicare Part A coverage.</p> <p>Resident 114's Profile indicated her/his financial and care POA (Power of Attorney) was Witness 3 (Family).</p> <p>A 9/25/24 facility email was sent to Witness 3 by Staff 9 (Former Social Services Director) that indicated Resident 114 was provided a Notice of Medicare Non-Coverage (NOMNC) form. The NOMNC form contained no information related to Resident 114's effective date of coverage, a date when coverage was to end or the contact information for the Quality Improvement Organization to request an appeal.</p> <p>A 9/28/24 Discharge Summary indicated Resident 114 was ready to discharge to her/his home with outpatient supervision.</p> <p>A 9/30/24 Social Services Note indicated Witness 3 did not sign and return Resident 114's NOMNC form.</p> <p>On 1/29/25 at 12:54 PM Staff 4 (Social Services Director) acknowledged Resident 114's NOMNC form was not valid due to incomplete information on the form.</p> <p>2. Resident 115 was admitted to the facility in 11/2024 with diagnoses including dementia and a thoracic vertebrae (spine) fracture.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Rose Linn Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2330 Debok Road West Linn, OR 97068	
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>Resident 115's clinical record indicated the resident had Medicare Part A coverage.</p> <p>A 12/17/24 Discharge Summary indicated Resident 115 completed her/his therapy services and was cleared to discharge.</p> <p>Review of Resident 115's clinical record revealed no Notice of Medicare Non-Coverage (NOMNC) form was provided to the resident.</p> <p>On 1/29/25 at 12:54 PM Staff 4 (Social Services Director) confirmed a NOMNC form was needed for Resident 115 and was not provided.</p>		