

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Maple Ridge Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Wyoming Avenue Kingston, PA 18704	

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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records, guidance issued by the Centers for Medicare and Medicaid Services and facility documentation, and staff interview, it was determined that the facility failed to develop and implement policies and procedures designed to protect residents from unacceptable practices of disenrolling residents from their Medicare health plans by ensuring all risks of disenrolling are explained, both verbally and in writing, and the residents are found to be competent to make informed decisions for seven of 13 reviewed the facility disenrolled from Medicare health plans (Resident CR1, 13, 50, 59, 61, 75, and 81).</p> <p>Finding include:</p> <p>A review of a CMS guidance entitled Memo to Long Term Care (LTC) Facilities on Medicare Health Plan Enrollment dated [DATE] revealed that CMS continues to hear reports of the unacceptable practice of nursing facilities or skilled nursing facilities (collectively, long-term care or LTC facilities) disenrolling beneficiaries from Medicare health plans (Medicare Advantage plans with and without Part D, Medicare-Medicaid plans, or Programs of All-Inclusive Care for the Elderly {PACE}) without the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding.</p> <p>CMS guidance noted that Only a Medicare beneficiary, the beneficiary's authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan. Changes in a beneficiary's health care coverage generally must be initiated by the beneficiary or their representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's health care coverage, the LTC facility should take the following steps to help ensure changes to a beneficiary's health care coverage comply with regulations regarding enrollment/disenrollment and resident rights:</p> <p>1) Explain orally and in writing the impact to the beneficiary if they change coverage (e.g., to a stand-alone prescription drug plan (PDP) and Original Medicare, or to a different Medicare health plan).</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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage. At a minimum, information should include the circumstances under which the facility can assist a beneficiary with a plan change. The need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that that the beneficiary and/or the representative understand the information. The need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment, attesting that the beneficiary or representative requested the change and that the beneficiary or representative (as applicable) received and understood the minimum required information listed above. In cases where beneficiaries request disenrollment from PACE, LTC facilities that are contracted with PACE organizations should work directly with the PACE organization and the participant's interdisciplinary team to ensure the PACE participant receives the information required under the PACE regulations and to coordinate the transition of care, including as specified in their contract requirements.</p> <p>If a LTC facility cannot provide documentation of a beneficiary's request to change enrollment, this may suggest that the enrollment action was not initiated by the beneficiary or their legal representative and therefore was not legally valid.</p> <p>Lastly If the facility has the beneficiary sign documentation regarding their understanding of an enrollment change, CMS will expect to find that the beneficiary's assessed cognitive function also supports an ability to understand this type of information. If CMS becomes aware of enrollment actions that the beneficiary alleges were taken without their request, consent, knowledge, and/or complete understanding, CMS will expect the facility to provide the above noted documentation to support that it appropriately assisted the beneficiary with their choice to change coverage, including that the beneficiary's cognitive function supports such decision-making.</p> <p>A review of Resident CR1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes, peripheral vascular disease, and bilateral below the knee amputations.</p> <p>Upon admission the resident's primary insurance payer was noted to be Aetna Medicare Advantage Plan. On February 1, 2024, the resident's primary insurance payer was changed to traditional Medicare with Medicaid pending.</p> <p>Review of documentation dated [DATE], completed by the facility's Business Office Manager (BOM), revealed that on [DATE], the BOM spoke with Resident CR1 about transitioning to straight Medicare since he will be long term. Went over how the transition will benefit him here at the facility regarding his therapy and possibly getting more time. According to the documentation, the resident chose to disenroll in his Aetna MCA and give straight MCA [Medicare] a try.</p> <p>A review of a facility form entitled Medicare Advantage Disenrollment Form dated [DATE], revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare prescription plan (Part D) benefits.</p> <p>Resident CR1 no longer resides at the facility, he expired at the hospital on February 13, 2024.</p> <p>(continued on next page)</p>		

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