Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395796	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomeryville Skilled Nursing and Rehabilitati	640 Bethlehem Pike Montgomeryville, PA 18936

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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to provide timely notice of non-covered Medicare and other expenses for one of three sampled residents who had been discharged from the facility. (Resident 1) Findings include: Review of the facility policy entitled Accounts Receivable Policies and Procedures, last reviewed February 1, 2024, revealed that facility was to conduct a 72 hour financial meeting with all new admissions. The business office was to discuss financial responsibilities of the resident/representative and set financial expectations essential to securing payment for services provided. In addition, the business office was to review the resident's current payer coverage (primary, secondary and tertiary) that included any private liability for co-insurance, co-pays and deductibles. Further review revealed that the first 20 days of Medicare days were 100% covered while in the facility. The next 21-100 days required a monetary amount per day under a co-insurance. At the time of the 72 hour meeting, the business office manager was to indicate with the resident if a co-insurance was to be billed and the terms other alternatives of payment was to be discussed as this meeting. At this time, the resident or resident representative was to sign off on the financial meeting resident hand out to indicate that all terms of payment had been discussed as per facility policy. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE]. He was sent to the hospital on March 13 and was readmitted on [DATE]. The resident discharged from the facility on March 30, 2024. Resident 1 received a bill from the facility for payment of services for 44 days between February 15, 2024, through March 30, 2024, the day he was discharged from the facility. The bill reflected the balance of charges daily that were not covered under Medicare or his co-insurance. There was no documented evidence that Resident 1 had ever received notification from the facility through the 72 hour meeting that he was obligated to pay whatever services that Medicare of the secondary co-insurance did not cover. In an interview on September 30, 2024, at 12:30 p.m., the Administrator stated that there was no documented evidence that the facility had conducted the 72 hour meeting with the resident nor was his financial responsibilities discussed and documented during his stay at the facility as per facility policy and procedure. 28 Pa. Code 201.29(j) Resident rights.

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