STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poway Healthcare Center	15632 Pomerado Road Poway, CA 92064

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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38175 Based on interview and record review, the facility failed to ensure one resident (1) and their responsible party (RP) was informed of charges for Medicare and non-Medicare-covered services, per policy, at admission and did not provide a breakdown of charges at RP request for continued physical and occupational therapy services after benefit exhaustion. This deficient practice placed Resident 1 and the RP at risk of being uniformed of charges and obligations leading to undue hardship. Findings: Resident 1 was admitted to the facility on [DATE] with a diagnosis of a fracture to the right fibula (one of two bones, between the knee and the ankle, that support the body) and fracture of the right patella (a bone at the kneecap that protects the joint and aids in muscle movement) per the facility admission record. A review of the facility's document titled Eligibility Coverage Detail Report dated 3/14/24, indicated Resident 1 received Medicare benefits that were active through a Medicare Advantage plan. A review of the document dated 6/21/24 titled Notice of Denial of Medical Coverage, sent to the facility by Resident 1's insurance company, indicated Resident 1's skilled nursing facility (SNF) benefit coverage would end for Resident 1 on 6/23/24. A review of Resident 1 ' s order summary report, order date range: 03/01/2024 - 09/30/2024, indicated Resident 1 had physical therapy services ordered five to six times a week for the period of 3/15/24 - 8/26/24, and occupational therapy services ordered five times a week for the periods of 3/15/24 - 7/29/24, and 8/22/24 -9/19/24. (continued on next page)

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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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/24 at 1:27 PM, an interview and record review were conducted with the facility ' s business office manager (BOM). The BOM stated residents and/or their RP are provided with written financial information about Medicare-covered services on admission to the facility. The BOM stated if a resident has insurance managed by an HMO (Health Maintenance Organization, an insurance group that provides health services for a fixed annual fee) the resident will receive a breakdown of any copay obligations and non-covered services in writing as part of the written admission agreement which was reviewed and signed by with the resident and/or RP. The BOM stated a copy of the financial breakdown was given to the Admissions Director (AD) to include in the admissions packet to be reviewed and signed by the resident and/or RP. The BOM stated Resident 1 should have received a written breakdown of coverage and copay obligations with the admissions packet. On 9/18/24 at 1:47 P.M., an interview and concurrent record review of Resident 1's clinical record was conducted with the AD. The AD stated the admissions packet and accompanying financial breakdown of coverage from the business office was not provided to or signed by Resident 1 and/or RP. A review of Resident 1's clinical record indicated the facility had no evidence of a signed admissions packet for Resident 1. The AD stated he runs a monthly quality assurance performance improvement (QAPI) program report that indicates the names of residents who have not had an admissions packet reviewed and signed. The AD stated Resident 1 had been listed on the QAPI report for incomplete admissions packet review since March 2023 The AD stated the admission packet reviewed financial obligations, resident rights, and facility accommodations. The AD stated if the admissions packet was not signed and uploaded to the electronic health record, it was not completed. The AD acknowledged Resident 1, and the RP were not informed of resident rights and financial obligations at the time of admission, and they should have been. On 9/18/24 at 2:24 P.M., a subsequent interview and record review was conducted with the BOM at the facility. The BOM stated a few days before resident's skilled nursing facility (SNF) benefit became exhausted, the facility would inform the resident and/or RP that Medicare-covered services would be ending, and the resident would be charged as private pay if they did not have secondary insurance coverage. The BOM stated if the resident/RP requested to continue non-covered treatment services, they would receive a written financial statement estimating the cost of those charges on a weekly basis. The BOM stated charges for non-Medicare covered physical and occupational therapies were collected one week in advance from the resident/RP before the services were provided. The BOM stated Resident 1's RP requested physical therapy and occupational therapy services to continue following benefit exhaustion on 6/23/24. The BOM stated the facility started to charge Resident 1 for physical and occupational therapy services on 7/1/24. A review of the facility document titled Transaction Report Effective Date May 1, 2024- [DATE] printed 9/18/24, indicated one check for $2,400 on 6/28/24 and a second check for $1,100, on 8/11/24, was provided to the facility by Resident 1's RP for physical and occupational services. A review of the letter provided to the RP from the BOM, regarding physical and occupational therapy charges, dated 8/12/24, was conducted with the BOM. The BOM stated the resident and RP had not been provided with written information regarding payment and charges for skilled physical and occupational therapy services prior to this letter. (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 11:54 A.M., an interview with the director of nursing (DON) was conducted. The DON stated it was the expectation that residents are given written financial information upon admission regarding covered services and share of cost by the business office. The DON stated the expectation was that the admission packet, which included the financial information provided by the BOM, was reviewed and signed by the resident or the RP. On 9/27/24 at 12:05 P.M. a concurrent interview was conducted with the DON and the administrator (ADMIN). The ADMIN stated it was facility practice to provide a pricing sheet to the resident or RP for services requested not covered by insurance before those services were provided. The ADMIN stated a written estimate for those services should be provided prior to the services starting. The ADMIN stated he could see how it would create a financially unfair situation to the resident and RP if a cost estimate of uncovered services was not provided before receiving those services. The ADMIN acknowledged Resident 1 and RP was not provided written financial information regarding the cost of covered and non-covered services at admission or before non-covered physical and occupational therapy services were requested to continue. A review of the facility policy, revised March 2019, titled Admission Criteria indicated, . Policy Interpretation and Implementation 1. The objectives of our admission criteria policy are to . d. review with the resident, and/or his/her representative, the facility's policies and procedures relating to resident rights, resident care, financial obligations .