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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING ______ B. WING ______	C 05/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and family interviews the facility failed to follow up on results from a Computerized Tomography (CT) scan for 1 of 1 resident (Resident #2) who had a scheduled diagnostic CT. Findings included: Resident was admitted on 5/25/12 with a primary diagnosis of spinal stenosis. The residents other diagnosis include anxiety, glaucoma, diabetes, and high blood pressure. The most recent Minimum Data Set (MDS) quarterly review dated 2/18/13 indicated that the resident was severely cognitively impaired, hard of hearing and needed extensive assistance with activities of daily living (ADL's). The record review revealed a Doctor's order on 12/5/12 that stated to identify the source of the bleeding noted in the resident's diaper as urethral, vaginal, or rectal if it occurred again. The progress note by Physician's Assistant #1 dated 12/12/12 stated the resident was having	F 309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #2 is no longer a resident in the facility. 2. All current residents who have had any out of facility medical provider appointments since May 1, 2013 have had charts audited to ensure that there is a consult in place for each appointment. The licensed staff nurses have been re educated by the Director of Clinical Services or the Assistant Director of Clinical Services concerning the expectation that all residents that have appointments with an out of facility medical provider will be placed on the 24hour report on the day of the	6/20/13 6/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Holmes Holland — TITLE: Executive Director — (X6) DATE: 6/20/2013

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.

EH revision 6/26/2013

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F 309	Continued From page 1 vaginal bleeding with clots. Doctor ' s orders where written for a urine analysis and a Gynecologist consult to have been done. According to travel logs located with the appointment coordinator, the resident was sent to a hospital in Raleigh for testing and biopsy of uterus on 1/7/13. The record review of lab results indicated on 1/14/13 Resident #2 ' s biopsy of her uterus indicated cancer. On 1/16/13 there was a Doctor ' s order written by the PA to have arrangements made for transportation for Resident #2 to her Gynecologist appointment on 1/17/13 at 2:20 PM. According to the Gynecologist consult notes on 1/24/13 Resident #2 along with her family member discussed treatment options with the Gynecologist. During the doctors visit it was decided that the resident would not be a good candidate for surgery. It was decided that they would proceed with a CT of the abdomen and pelvis and start hormone therapy if the CT was clear. The CT was performed on 2/6/13. A record review indicated that Resident #2 was seen by a Nurse Practitioner on 2/19/13. The progress note stated CT report had not been received yet. On 3/27/13 a nurse ' s note stated Resident #2 ' s family called with concerns about the resident ' s CT results. The nurse ' s noted stated this concern was communicated to the Physicians Assistant (PA) and the PA would call the family back concerning the results of the CT scan. A doctor ' s order dated 3/27/13 stated to contact the gynecologist ' s office to obtain CT results from 2/6/13. According to the fax report located in the	F 309	appointment. The licensed nurse will document the return of the resident from the appointment and will document on the 24 hour report and in the resident's chart the receipt of the consult, or the actions taken if the report does not accompany the resident back to the facility. 3. The Director of Clinical Services or Unit Manager will bring the resident appointment scheduling calendar, the 24 hour report, and the resident chart into the morning meeting with the interdisciplinary team and verify that the consult report is in the chart, that any orders on the consult report have been properly transcribed, and that any follow up appointment on the consult is placed onto the scheduling calendar. The interdisciplinary team will be informed of the consult report contents and changes to the care plan and CNA Kardex will be made. The QI Monitoring Tool for Out of Facility Medical Provider	

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F 309	Continued From page 2 Resident ' s chart the CT results were faxed to the facility on 5/14/13 at 11:29 AM. The CT report stated Resident #2 had a 5.8 centimeter mass located in her uterus that was suspicious for resident ' s known history of uterine cancer. There was no further noted cancerous lesions noted at that time. The report was read on 2/6/13 at 11:53 AM by the radiologist. According to nurses notes dated 5/22/13, Resident #2 had a follow up appointment with an Oncology Radiologist to discuss treatment options. The Oncology Radiologist consult notes indicated Resident #2 and family had decided to start radiation treatments on the resident starting on 5/30/13 at 10:00 AM. During an interview with family on 5/28/13 at 11:30 AM the family stated they had been calling the Social Worker and leaving messages to have information obtained about what the CT report said and where to go from there with treatment. Per family, the Social Worker never returned any calls or emails. The Social Worker was unavailable for an interview. During an interview with NA #1 on 5/28/13 at 3:32 PM, it was revealed that the facility has an appointment board at each nurse ' s station and they are checked daily to arrange for consults at outside doctors offices. NA #1 indicated that the resident was scheduled to go to a hospital on 1//13 and then to the gynecologist office following that several weeks later. NA #1 stated that she did not handle the follow up of test results for residents after they have had testing done.	F 309	Consults will be completed to verify all of this has occurred and will be completed by the Director of Clinical Services or the Unit Manager at each morning meeting 5 days a week x 4 weeks, 3 days a week x 4 weeks, weekly x 4 weeks and then monthly x 9 months (See Exhibit A). 4. The Director of Clinical Services will report the results of the QI monitoring to the QA/PI committee monthly for review and any recommendations for amendment of the plan of correction. 5. The allegation of Compliance for this plan is June 25, 2013.	6/25/13

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F 309	Continued From page 3 During an interview with the facility ' s Medical Director on 5/29/13 at 9:52 AM the Medical Director stated they should receive reports from testing done on residents within 5-7 business days and that the facility needed to do a better job at obtaining those reports in a timely manner. During an interview on 5/28/13 at 9:45 AM the DON stated that there was no system in place to address the follow up of testing. The DON stated that she would bring all appointments to the facility meeting everyday so that she was aware of the follow ups that needed to be completed. She stated her expectations were they took it all appointments as a group with the Doctor and the PA ' s in the facility so follow up ' s on testing, if needed, would be done in a timely manner. During an interview on 5/29/13 at 10:00 AM with the DON and Administrator they both acknowledged that there was a communication breakdown that occurred with Resident #2 and stated that their expectations were that tests were followed up in a timely manner.	F 309		