STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(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 250 SS=D	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.40(d) (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on hospital and facility record reviews, and staff and Nurse Practitioner interviews, the facility failed to arrange an endocrinology consultation (a specialty branch of medicine that deals with the diagnosis and treatment of diseases that involve hormones) as ordered by the physician (Resident #1) and a cardiology follow-up as recommended in the hospital's discharge summary (Resident #3) for 2 of 3 residents reviewed for the provision of medically-related Social Services. The findings included: 1. Resident #1 was admitted to the facility on 4/20/15, with re-entry from the hospital on 6/3/15. A review of Resident #1 ' s quarterly Minimum Data Set (MDS) assessment dated 11/21/16 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance from staff for all of her Activities of Daily Living. Resident #1 was sent out to the hospital on 1/3/17 and returned to the facility on 1/10/17. The resident ' s hospital Physician Discharge Summary dated 1/10/17 noted her principle problem as sepsis (the presence of pathogenic or disease-causing organisms or their toxins in the	F 250	The facility will schedule an appointment for resident #1 to have an endocrinology consultation. Resident #3 no longer resides in the facility. Administrative nursing staff will conduct a full audit of discharge summaries for admissions in the last 30 days to ensure any recommendations for follow-up appointments have been scheduled to be completed by 3/10/17. Administrative nursing staff will conduct 100% audit of resident telephone orders for the last 60 days to ensure orders for outside appointments have been scheduled. Audit will be completed by 3/15/17. All discharge summaries for new admissions and new physician orders will be reviewed five times weekly in the morning IDT team meeting ongoing. Outside appointments will be scheduled as they are identified by administrative nursing staff or designee. This will be completed by 3/16/17. Administrative nursing staff will audit orders for outside appointments randomly weekly for three months to ensure	3/16/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/09/2017

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F 250	Continued From page 1 blood or tissues). The Discharge Diagnoses also indicated Resident #1 had active problems of hyperthyroidism (overactive thyroid) and thyrotoxicosis with toxic single thyroid nodule (a condition which occurs when a lump grows on the thyroid gland, causing it to become enlarged and produce excess thyroid hormones) and thyrotoxic crisis or storm (a severe complication of hyperthyroidism characterized by a high fever, fast and often irregular heartbeat, vomiting, diarrhea, and agitation). However, the Discharge Summary also reviewed her hospital course and indicated the diagnosis of thyroid storm was uncertain. Resident #1 ' s medical record included a lab report dated 1/13/17. The report indicated a laboratory test for Thyroid Stimulating Hormone (TSH) was completed on that date with a result of 0.01 (the normal range noted on the lab report for TSH was 0.35-5.60). The resident ' s TSH level was designated as low on the laboratory report. Further review of Resident #1 ' s medical record included a Physician ' s Telephone Order dated 1/24/17 and written by the Nurse Practitioner (NP) which read, "Needs f/u (follow-up) with Endocrinology." An interview was conducted on 2/14/17 at 11:10 AM with the Nursing Secretary. The Nursing Secretary reported she was the person responsible to set up outside appointments and consultations for residents. The secretary reported when an outside consultation was ordered for a resident, the hall nurse would complete and give her a form entitled, "Appointment Needed." Alternatively, the secretary stated a nurse may pass along a copy	F 250	appointments have been scheduled as ordered. A QI audit tool will be utilized. Results of the audits will be reviewed by the facility quality committee monthly for three months.	

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F 250	Continued From page 2	F 250		

of physician ' s order to inform her of the consultation needed. Upon review of the Physician ' s Telephone Order dated 1/24/17 requesting an endocrinology appointment for Resident #1, the Nursing Secretary stated she was not aware of the order and knew for certain that she herself had not made an appointment. The secretary stated that sometimes a family member made appointments for the resident, but she did not know whether or not this had been done.

Upon her request, a follow-up interview was conducted on 2/14/17 at 11:50 AM with the Nursing Secretary. The secretary stated she had contacted the resident ' s family member and found out that no appointment had been made for an endocrinology consult to date.

Accompanied by the Director of Nursing (DON), an interview was conducted with the NP on 2/14/17 at 12:50 PM.
The NP recalled she had telephoned in the order for Resident #1 ' s follow-up appointment with endocrinology based on recommendations made from her hospital discharge records. When the NP was asked if she would have expected the appointment to have been arranged by now (21 days after the order was written), she stated she would have. However, the NP reported she did not feel this was an emergent situation and did not feel failure to arrange the endocrinology appointment had resulted in harm for the resident at this point. When the DON was asked what her expectation would be for the arrangement of an outside consultation appointment, the DON stated she would expect an initial attempt to be made within a couple of weeks of receiving the order.

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A second follow-up interview was conducted on 2/14/17 at 1:30 PM with the Nursing Secretary. Upon inquiry, the secretary stated she would typically arrange an appointment ordered for an outside consultation, "on the day of or the next business day after the order was received."
2. Resident #3 was admitted to the facility on 12/3/16 with diagnoses which included: right tibia/fibula fracture, congestive heart failure, and NSTEMI (Non-ST-elevation myocardial infarction), adult failure to thrive, and severe protein-calorie malnutrition. The Admission MDS (minimum data set) dated 12/3/16 indicated the resident was cognitively intact and required extensive assistance with most activities of daily living.

Review of the Hospital Discharge Summary dated 12/3/16 revealed recommendations for Resident #3 to have outpatient follow-ups with her PCP (primary care physician) and a Cardiologist in two weeks of her discharge from the hospital.

Review of the facility's Monthly Physician Order Records for December 2016 and January 2017 included: Make sure patient has follow-up scheduled with PCP and Cardiology within two weeks of discharge.

A review of the facility's "Appointment Book" indicated Resident #3 had a Cardiologist appointment on 1/3/17 at 9:45am and a Gastroenterologist appointment on 1/13/17 at 9:00am. There was no available documentation indicating Resident #3 had a follow-up cardiology appointment scheduled during December 2016.

During an interview on 2/14/17 at 1:31pm, the Nursing Secretary indicated when a resident was

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F 250	Continued From page 4 admitted to the facility from the hospital, she (Nursing Secretary) would receive and review the resident's hospital discharge summary or the Admitting Nurse would complete an "Appointment Needed" form and submit it to the Nursing Secretary to follow through and schedule any hospital recommended appointments. She also revealed that she was responsible for completing the facility's "Transportation Schedule". The Nursing Secretary reported that she did not receive any follow-up appointments for Resident #3 from the hospital or from the facility's Admitting Nurse. She revealed Resident #3's family scheduled the resident's Cardiologist appointment for 1/3/17 and the Gastroenterologist appointment for 1/13/17; but she (Nursing Secretary) was not informed by the family until the day before each appointment. She indicated the facility provided transportation for the resident to both medical appointments. During an interview on 2/14/17 at 4:13pm, the Administrator acknowledged the cardiology follow-up recommended in Resident #3's hospital discharge summary was scheduled on 1/3/17 by the resident's family, not the facility.	F 250		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's	F 309		3/16/17

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F 309	Continued From page 5 comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on hospital and facility record reviews, and staff and Nurse Practitioner interviews, the facility failed to order laboratory tests to monitor a resident ' s thyroid function as requested by the physician for 1 of 3 residents (Resident #1) reviewed for the provision of care to maintain well-being. The findings included: Resident #1 was admitted to the facility on	F 309	Resident#1 refused to have labs drawn on 2/14/17. On 3/1/17 the nurse practitioner wrote an order for the resident to have no further lab draws per the resident's request. Administrative nursing staff conducted a 100% audit of all labs ordered for residents from 2/2/17 through 3/2/17 to ensure all labs have been correctly scheduled in the facility electronic medical	

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F 309	Continued From page 6 4/20/15, with re-entry from the hospital on 6/3/15. A review of Resident #1 ' s quarterly Minimum Data Set (MDS) assessment dated 11/21/16 revealed the resident had intact cognitive skills for daily decision making. She required extensive assistance from staff for all of her Activities of Daily Living. Resident #1 was sent out to the hospital on 1/3/17 and returned to the facility on 1/10/17. The resident ' s hospital Physician Discharge Summary dated 1/10/17 noted her principle problem as sepsis (the presence of pathogenic or disease-causing organisms or their toxins in the blood or tissues). The Discharge Diagnoses also indicated Resident #1 had active problems of hyperthyroidism (overactive thyroid) and thyrotoxicosis with toxic single thyroid nodule (a condition which occurs when a lump grows on the thyroid gland, causing it to become enlarged and produce excess thyroid hormones) and thyrotoxic crisis or storm (a severe complication of hyperthyroidism characterized by a high fever, fast and often irregular heartbeat, vomiting, diarrhea, and agitation). However, the Discharge Summary also reviewed her hospital course and indicated the diagnosis of thyroid storm was uncertain. Resident #1 ' s hospital Physician Discharge Summary dated 1/10/17 included recommendations for outpatient follow-up and discharge instructions which requested a thyroid panel be obtained in 4 weeks. A thyroid panel typically includes laboratory tests for: thyroid-stimulating hormone (TSH), free thyroxine (free T4), and total or free triiodothyronine (total or free T3). The thyroid panel is used to evaluate thyroid function and/or help diagnose	F 309	record and have been obtained as ordered. Audit was completed 3/6/17. Licensed nurses will be reeducated by facility DNS or designee regarding scheduling new orders for labs in the electronic medical record. Education was completed 3/9/17. Administrative nursing staff will audit new orders for lab tests ordered beginning 3/6/17 randomly five times weekly for three months in the morning interdisciplinary team meeting to ensure they have been accurately scheduled to be obtained in the facility's electronic medical record and are obtained as ordered. A QI tool will be utilized. Results of QI audit tools will be reviewed in the monthly facility quality committee for three months.	

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hypothyroidism (underactive thyroid) and hyperthyroidism due to various thyroid disorders.

A review of the resident ' s medical record revealed Resident #1 was seen by the Nurse Practitioner (NP) on 1/11/17 at the facility. The NP ' s readmission note from this visit included an anticipatory plan of care. The note included, "Labs for 2/8/17: Thyroid Panel." Further review of Resident #1 ' s medical record revealed a Physician ' s Order written on 1/11/17 requested a thyroid panel be obtained on 2/8/17.

Resident #1 ' s medical record included a lab report dated 1/13/17. The report indicated a laboratory test for Thyroid Stimulating Hormone (TSH) was completed on that date with a result of 0.01 (the normal range noted on the lab report for TSH was 0.35-5.60). The resident ' s TSH level was designated as low on the laboratory report. No additional thyroid laboratory tests were included in the resident ' s medical record.

An interview was conducted on 2/14/17 at 1:20 PM with the facility ' s Director of Nursing (DON) and NP. Upon inquiry, the DON stated a review of the resident ' s medical record and laboratory records revealed the thyroid lab work ordered for 2/8/17 had been done on 1/13/17. She reported the order for the 2/8/17 lab work ordered "was missed" and the labs had not been done. When asked, the DON stated she would expect lab work ordered for 2/8/17 to be done on 2/8/17. The DON and NP reported the thyroid panel ordered for 2/8/17 had just been ordered, "STAT" (at once).

A telephone interview was conducted on 2/14/17 at 2:45 PM with the facility ' s Administrator. The

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F 309	Continued From page 8 Administrator reported that apparently when the lab orders were put into the system, the thyroid test was mistakenly done on the next lab day (1/13/17 instead of 2/8/17, as ordered). Upon request from the facility ' s Administrator, a follow-up telephone interview was conducted with the NP on 2/14/17 at 3:20 PM. During the interview, the NP reported the resident had a history of refusal for some tests and did refuse to have her blood drawn today for the lab work. In spite of this history, however, the NP stated she still would have ordered the thyroid panel for 2/8/17 to see if there were any changes in the resident ' s thyroid function.	F 309		