STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on record review and interview, the facility failed to have a system in place to ensure residents who have diagnostic testing scheduled attend the scheduled appointment as ordered, and, if a scheduled appointment is missed/cancelled, the physician who requested the testing is updated and alternate scheduling occurs to ensure residents receive the care and treatment required in accordance with professional standards of practice. This affected 2 of 5 sampled residents (R2 and R4). R2 had a CT (computed tomography) scan scheduled for [DATE] following months of abdominal pain and to rule out the potential of kidney stones which the nurse practioner felt could be the contributing cause of R2's pain. R2 did not attend this appointment. The facility did not reschedule the appointment or inform the ordering physician that the resident had missed the appointment. This delayed diagnosis and treatment and allowed the underlying condition to continue. On [DATE], R2 had a severe change in condition where she ended up going to the ER (emergency room) and then directly to the OR (Operating Room) to have a ureteral stent due to finding a large kidney stone. R2 was diagnosed with urosepsis. R2 spent 7 days in the ICU (Intensive Care Unit) and expired as a result. The facility's failure to have a system in place to ensure residents attend scheduled appointments for diagnostic testing or a system to reschedule a missed appointment to ensure resident receives the necessary care and treatment required created a finding of immediate jeopardy which began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on [DATE] at 2:15 PM. The immediate jeopardy was removed on [DATE]; however, the deficient practice continues at a severity/scope of D (Isolated/Potential for No More than Minimal Harm) as the facility continues to implement its action plan. This is evidenced by: The Facility's Policy and Procedure entitled Transportation Scheduling for Resident Appointments dated [DATE], documents, in part: a.will facilitate the arrangement of transportation to and from medical appointments, as necessary, to meet the needs of the residents . Example 1 R2 was a [AGE] year-old resident that had been a resident of this facility since 2015. R2 had the following diagnoses: Type 2 Diabetes Mellitus, Hemiplegia and Aphasia following cerebral vascular infarction, calculus of kidney, and retention of urine. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per R2's medical record, she had been having abdominal pain on/off since July. The Facility was working with NP G (Nurse Practitioner) to attempt different interventions to diagnose the root cause of the pain and attempt to alleviate this pain. Per NP G's visit note dated [DATE] for visit on [DATE]; R2 was complaining of continued abdominal pain. NP G documented in part: .Abdominal pain, chronic .Unclear etiology, R2 does have multiple chronic conditions that may be contributing to abdominal pain including hx. (history) of nephrolithiasis, bilateral adnexal masses (known), chronic constipation with recent diarrhea . NP G also documented that she was going to speak to R2's Guardian regarding CT scan of abdomen and pelvis. The CT scan would show the provider if R2 has kidney stones that could be the source of her pain or contributing to her pain. Per typed fax from NP G in R2's medical record dated [DATE] an order for CT scan of abdomen and pelvis with and without contrast due to abdominal pain. --please call .radiology .to schedule CT scan .--please ensure that .Radiology department is aware that R2 is a Hoyer transfer . Also documented on this fax in handwriting is the following: [DATE] Fri 730 A (AM), Cr (creatinine) 30 days- [DATE] (date R2 had this lab completed), NPO (nothing by mouth) 4 hours prior, short sleeve There is no nurse initials or signature. In the facility's appointment planner on [DATE] it documents: R2's name .radiology, phone number. This information is crossed off with X, handwritten above is 5 20 53 canceled. To right of [DATE] in the Notes section, says R2's name, GI clinic GI, phone number for tube replacement. This has arrow to the [DATE] square. The arrow is then scribbled out. Surveyor nor Facility were sure if this appointment at the GI clinic played a role in R2 missing her appointment for scheduled CT scan on [DATE]. According to Kidney Stones: Overview, The usual symptoms of kidney stones can provide a basis for a diagnosis, but they aren't always enough to tell what the exact cause is. Ultrasound scans can be used to detect most kidney stones. If doctors still aren't sure, they may also use a computed tomography (CT) scan. https://www.ncbi.nlm.nih.gov/books/NBK348937/. Failing to ensure this resident made her appointment prevented the physician and nurse practitioner from diagnosing what was causing her pain and prevented early intervention. Per R2's Nurses Notes: On [DATE] at 06:15 (6:15 AM) R2 had large yellow emesis at around 0400 (4:00 AM), reported having nausea, left lower abdominal pain of ,d+[DATE], distention, tenderness, hypoactive (less than normal) BS (bowel sounds). VS (vital signs): 97.5 (temperature), 20 (respirations), ,d+[DATE] (blood pressure), 82 (pulse), 97% (RA- room air) (oxygen level). Resident is NPO, G-Tube fed, 0cc (cubic centimeter) residual on PEG tube aspiration. Called on-call Provider .who gave order to send to ER for further eval (evaluation), called .gave report to Nurse, transported by .ambulance .DON B (Director of Nursing) and . (son) were updated. Left voicemail for NP G. On [DATE] at 16:11 (4:11 PM) ED (Emergency Department) RN (Registered Nurse) called this AM to inquire about when last had tube feeding and or meds (medications) as res (resident) was on way to OR to have stent placed due to finding large kidney stone. Res is definitely being admitted to hospital. Admitting d/x (diagnoses) is urosepsis (severe infection of the urinary tract). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 14:42 (2:42 PM) Update on res, per . ICU RN that res is still in ICU but VS were stabilized, still receiving IV (intravenous) ATB (antibiotics) for urosepsis. RN states res kidney function levels remain very poor and no improvement seen in levels each day. Under discussions by MD's (Medical Doctors) whether or not to start res on a temp (temporary) dialysis until kidney function levels improve. RN states to expect res to be in hospital this week yet. On [DATE] at 1:56 PM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F what the process was when a resident received an order for an appointment, LPN F said she would call to set up the appointment, then she would write the resident's name, place, and time in the appointment planner. LPN F went on to explain and made it clear that the following is her system when she receives these type of orders, not the Facility's; LPN F said she puts a red dot next to the information on the planner when she has filled out the transportation slip that goes to DMR C (Director of Medical Records), then she writes noted, her name, and date. Surveyor asked LPN F why she gives the transportation slip to DMR C, LPN F said because she sets up the transportation for the appointments. On [DATE] at 2:25 PM, Surveyor interviewed LPN F. Surveyor asked LPN F if there were transportation issues with R2's [DATE] appointment. LPN F stated she had transportation set up, I don't know what happened. Surveyor asked LPN F if R2's appointment was canceled from the Clinic site would that be written somewhere in the planner, LPN F said no, possibly in a Nurse's Note. It is important to note that there are no Nurse's Notes in R2's medical record about receiving an order for the CT scan, setting CT scan up, or any issues regarding the CT scan. On [DATE] at 2:53 PM, Surveyor interviewed NP G. Surveyor asked NP G to explain what transpired from her visit with R2 on [DATE] to her passing away; NP G stated she spoke to R2's Guardian on [DATE] and R2's Guardian stated if R2 was willing to complete the scan then she would agree; if R2 did not want to complete the scan then they would need to discuss a different course of action. NP G said she then faxed the Facility the order for the CT scan on [DATE]; NP G said she was told the appointment had been scheduled when she was in the facility to see her patients. NP G explained between her visit with R2 in September and the day R2 went to ER, the Facility had contacted on call Providers twice due to R2's pain, one of which was abdominal and the other that was not. NP G stated she and R2 had been trying one intervention at a time in an attempt to pin-point the cause of the pain. Surveyor asked NP G if it were possible that the Radiology Clinic canceled R2's appointment, NP G verified in computer system that R2's GI appointment was actually scheduled for [DATE] and R2 was documented as no show; and R2's CT scan appointment was scheduled for [DATE] and R2 was documented as no show. NP G also then read a note from Radiology dated [DATE] saying Radiology attempted to call the Facility with a time change of CT scan for R2 but no one answered the phone. Surveyor asked NP G if she thought that R2 would have agreed to place the stent if the CT scan had shown the stone sooner, NP G said yes, R2 would have been agreeable to stent placement as she has had them in the past and they had helped. Surveyor asked NP G from the time R2 was sent to the OR for the stent placement, what happened; NP G explained R2 was intubated (breathing tube placed) during stent placement surgery and was never extubated (breathing tube removal), her blood pressure dropped putting her in septic shock and requiring norepinephrine and vasopressin (medications to attempt to stabilize blood pressure); she spent 7 days in the ICU and then passed away. Hospital documentation supports NP G's interview regarding R2's hospital course. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:49 PM, Surveyor interviewed NP G. Surveyor asked NP G if R2 would have had the CT scan when she was supposed to ([DATE]) would this have changed the outcome for R2. NP G stated yes, she would have had the option of placing the stent much sooner and avoiding urosepsis. Surveyor asked NP G if R2 didn't want the stent at the time the CT scan was supposed to be done ([DATE]), if that would still change the outcome for R2; NP G stated yes, we could have discussed hospice and remaining in the facility versus dying alone in the ICU. On [DATE] at 4:10 PM, Surveyor interviewed NM E (Nurse Manager) and DON B (Director of Nursing). Surveyor asked NM E and DON B what happened with R2 having her CT scan on [DATE]. NM E stated she was aware R2 did not have CT scan completed but wasn't sure what had gotten canceled whether it was the appointment or the transportation; DON B concurred. Surveyor asked NM E and DON B if anyone from the Facility contacted NP G to alert her that the CT scan had not been done. NM E said no; DON B concurred. When Surveyor asked NM E and DON B if anyone had attempted to re-schedule the CT scan, DON B said no; NM E concurred. According to Kidney Stones: Overview, Left untreated, kidney stones can block the ureters or make them narrower. This increases the risk of infection, or urine may build up and put added strain on the kidneys. Another article notes that, Apart from causing symptoms such as pain, vomiting and blood in the urine, kidney stones can cause serious medical complications. These include: Severe infections including septicemia (blood poisoning) which can be life-threatening. Renal scarring and damage to the kidneys, resulting in permanent renal failure. Loss of function of a kidney resulting in the need for removal of the kidney (nephrectomy). Bladder blockage can result when a large kidney stone has managed to pass into the bladder but gets stuck in the urethra resulting in painful urinary retention. https://kidneystonemelbourne.com.au/diagnosis/complications-kidney-stones Sepsis occurs when bacteria enter the bloodstream and spread throughout the body. It's a rapidly progressing, life-threatening condition that can cause organ failure. Sepsis is the leading cause of death in hospitals in the United States, severe sepsis is associated with an estimated in-hospital mortality risk between 25 and 30 percent. In the U.S. alone, more than 500,000 adult patients are admitted to hospitals every year with evidence of sepsis and organ dysfunction. Each year in the U.S. there are approximately 750, 000 cases of severe sepsis, which result in 215,000 deaths. https://www.theatlantic.com/health/archive/, d+[DATE]/sepsis-to-shock-what-happens-when-bacteria-invade-the-body/252852/ The failure to have a system in place to ensure that residents who have diagnostic testing scheduled are able to attend these appointments to obtain the results required for them to receive the treatment and care required and if a scheduled appointment is canceled/missed/delayed that the Provider who requested the testing is updated, created a reasonable likelihood for serious harm occurring and a finding of immediate jeopardy, which began on [DATE]. The facility removed the jeopardy on [DATE], when it had completed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Licensed Nursing staff to be educated on the Radiology & Other Diagnostic Policy and Procedure - Date 4. 1.2008 Revised 11.2016, [DATE] * Staff to be educated on the Resident Appointment and Transportation Scheduling Policy and Procedure - Dated 9.3.2021 Revised 11.23.2021 * Staff to be educated on the community centralized process of appointments, transportation requests and cancellation tools utilized in the process. * Discussed IJ (immediate jeopardy) and education at team huddle/cross shift report on 11.23.2021. Even though CNAs (Certified Nursing Assistants) do not answer telephones in general, want them to be aware of the process. Communication will continue through huddles/cross-shift reports. * On 11.23.2021, community reviewed the Radiology & Other Diagnostic Policy and Procedure - Date 4.1. 2008 Revised 11.2016, [DATE] to ensure it include the accountability to the timeliness of diagnostic procedures being completed. * On 11.23.2021, community reviewed the Policy and Procedure Resident Appointment and Transportation Scheduling - dated, 09.03.2021 to ensure it included process is in place regarding canceled/missed appointments. Policy updated to include the process of canceled/missed appointments: 10.1 - Nursing staff will be responsible to ensure resident, responsible party and/or family are notified of the cancellation. 10.2 - Nursing staff will be responsible to ensure Primary provider is notified of cancellation and will obtain orders as needed. 10.3 - Medical Records Director and/or Designee will be notified of the cancellation to assure appointment is rescheduled 10.4 - Medical Records Director and/or Designee will track the cancellation. * On 11.23.2021, the clinical leadership team at community reviewed the desktop calendars in each of the nurse stations that contain appointment calendars. Appointments were reviewed from 09.01.2021 to ensure compliance with orders and that any cancellations had been rescheduled. In addition, the team reviewed orders in EPIC to ensure those orders had been scheduled. * Numerous staff received education via the phone. Any individual receiving phone education will receive the written education upon their first shift back at the facility. They will then sign the training log next to their name where by phone has been written. * DON and/or Designee will conduct audits daily x2 weeks, weekly x 8 weeks, and monthly x3 months resident's appointments to ensure appointment was completed, if not completed Primary Provider was notified, upon notification new orders received, and if appointment was missed was it rescheduled. * Results will be brought to QAPI (Quality Assurance Performance Improvement) meeting for tracking and trending purposes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	42482 Example 2 R4 was admitted on [DATE] with diagnoses of diabetes, cellulitis of the right lower extremity and hypertension. R4 had been hospitalized prior to admission with acute heat stroke and core body temperature of 107 Fahrenheit. R4's admission MDS (Minimum Data Set, a standardized assessment tool) dated [DATE] indicates R4 had a BIMS (Brief Interview for Mental Status) score of 11 which suggests moderate cognitive impairment. Per The Mayo Clinic article entitled, 'Heat Stroke,' [DATE], heatstroke can cause your brain or other vital organs to swell, possibly resulting in permanent damage. X-rays and other imaging tests may be ordered to check for damage to your internal organs. Through record review, Surveyor was able to ascertain that R4 had an echocardiogram and vascular referral ordered on [DATE]. On [DATE] there is medical record evidence of hospital schedulers attempting to contact R4 directly and were unsuccessful. The record was also updated on [DATE] that R4 was living at the facility and to contact R4 or the nursing staff at the facility (telephone number documented) to schedule the appointment. On [DATE] at 10:45 AM, Surveyor asked DON B (Director of Nursing), did the facility had knowledge of the physician orders for an echocardiogram and vascular referral? DON B replied, R4 had the vascular referral. Surveyor asked for this report. DON B produced a Doppler study-which may have been a recommendation from the vascular referral but DON B never produced the actual vascular referral. The Doppler study report produced by DON B was completed on [DATE]. Surveyor asked DON B, why was scheduling of the vascular referral and subsequent Doppler study not completed until November? DON B responded, Because we didn't know about it, R4 takes his own phone calls and probably never told us. Surveyor showed DON B the communication notes in R4's medical record between schedulers attempting to contact R4 for appointments and then the schedulers realizing R4 was a resident of the facility. The record shows on [DATE] that a scheduler then left a message with a nurse at the facility to call to schedule the echocardiogram. DON B, stated That is not true, no message was left. Surveyor asked DON B, when was the echocardiogram completed? DON B stated, It is scheduled. Surveyor asked DON B, when was the appointment made? DON B responded, Today. Surveyor asked DON B, would you consider this a delay in service? DON B answered, No, because we didn't know about it. On [DATE] at 12:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding the facility knowledge of the physician ordered tests on [DATE]. NHA A responded, R4 has his own phone and probably took the call and didn't tell us. Surveyor showed NHA A, the communication between schedulers attempting to make appointments on [DATE]. NHA A stated, These communication notes were not printed until [DATE] so we didn't know about these orders until then. That is why the Doppler study wasn't completed until November. On [DATE] at 1:55 PM, Surveyor attempted to speak with MD J (Medical Doctor), R4's primary care provider, and left a message requesting a return call. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:11 PM, Surveyor spoke with RN D (Registered Nurse) at MD J's clinic. RN D was able to confirm via medical record documentation that R4 had physician orders for an echocardiogram and vascular referral ordered on [DATE]. RN D states The echocardiogram was ordered to check heart function secondary to peripheral edema and an elevated BNP (brain natriuretic peptide-a blood test that measures levels of a protein called BNP that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure). The vascular referral was based on R4's lower extremity cellulitis to check for blood flow. On [DATE] at 2:35 PM, Surveyor contacted RN H to verify through R4's medical record when the appointment for the Doppler study had been made. RN H states, The Doppler study appointment was made on [DATE]. Surveyor asked RN H were there any cancellations prior to [DATE]? RN H states No. Surveyor asked RN H, when was the echocardiogram appointment made? RN H states, Today, [DATE]. On [DATE] at 2:52 PM, Surveyor contacted RN D at MD J's office. Surveyor asked RN D, is there any documentation regarding physician notification that the echocardiogram and vascular referral were not completed? RN D states, No, Surveyor asked RN D, is there any documentation that the facility knew about the orders? On [DATE] at 3:00 PM, Surveyor noted a progress note in R4's facility record dated [DATE] and written by DON B that states, .MD J put in a reveral [sic] for vascular and an order for a [sic] echo . On [DATE] at 3:15 PM, Surveyor showed NHA the progress note of [DATE] and asked NHA A Do you think the facility had information regarding the echocardiogram and vascular referral? NHA A stated, Oh, yes, it looks like we missed it. On [DATE] at 3:35 PM, Surveyor showed DON B the progress note of [DATE] and asked DON B, Did you have information about the echocardiogram and vascular referral orders for R4? DON B replied, Yes, I guess I missed it. Surveyor asked DON B, Do you have the vascular referral report? DON B stated, I'm having trouble printing it from the hospital electronic medical records. The facility failed to provide timely assistance in making appointments for diagnostic testing per physician's orders. This delay put R4 at risk and may have delayed treatment.