

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

PRINTED: 02/09/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2007
NAME OF PROVIDER OR SUPPLIER ELKINS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2533 BEVERLY PIKE ELKINS, WV 26241-9401		
(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 279 SS=D	<p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>b) Resident #45</p> <p>Record review, on 04/25/07 at 8:20 a.m., revealed that Resident #45 had been experiencing pain since admission to the facility on 04/15/05. Further review of the medical record revealed that Resident #45 had a physician's order, dated 08/16/06, for Lortab (pain medication) 5/500 mg one (1) tablet three (3) times a day for joint pain.</p> <p>On 04/25/07 at 10:00 a.m., Resident #45 was interviewed in her room. Resident #45 stated, "I did not have pain until I came down here. Sitting all the time causes it." Furthermore, Resident</p>	F 279	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/25/07	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/22/2007

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.

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	<p>#45 stated, "Pills do not help. Can't even tell you took them."</p> <p>Further review of the medical record revealed a comprehensive plan of care, dated 04/27/07 through 07/27/07, which identified that the resident was tearful and complained of pain. The care plan failed to identify measurable goals and interventions (both pharmacologic and non-pharmacologic) for staff to follow to help relieve Resident #45's pain.</p> <p>Review of the facility policy titled "Pain Assessment / Management Program" (revised June 2006) revealed the following:</p> <ol style="list-style-type: none"> 1. On admission to the facility, the initial pain assessment will be completed by the care plan coordinator or her assistant. 2. Information will be communicated to the staff nurse regarding the resident's pain assessment. 3. The nurse will ensure that the resident's admission and initial orders contain an order for pain relief. 4. When the resident requires interventions for pain relief, the nurse will document the type of pain, treatment administered, and the resident's response to that intervention. 5. Should the intervention not provide relief for that resident, the nurse should intervene by re-evaluating the pain and the interventions made, and consider contacting the attending physician for further interventions. <p>The facility failed to follow their pain management policy and develop a individualized</p>			

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	<p>plan of care for Resident #45, who had experiencing chronic pain on a daily basis. Based on record review, resident interview, facility policy review, and staff interview, the facility did not develop a comprehensive plan of care for two (2) of nineteen (19) sampled residents that thoroughly and accurately met the needs of each resident. The care plan for Resident #96, who was receiving outpatient dialysis services, did not adequately reflect the needs associated with this process, and Resident #30, who was being treated with medications for chronic pain, had no care plan to direct staff in the use of nonpharmacologic methods to possibly relieve the pain. Resident identifiers: #96 and #30. Facility census: 108.</p> <p>Findings include:</p> <p>a) Resident #96</p> <p>The medical record of Resident #96 was reviewed on 04/26/07. The resident had been admitted to the facility on 03/21/07 and was receiving dialysis at an outpatient dialysis center three (3) times weekly. The resident's care plan, completed shortly following his admission, failed to describe the care and services necessary for this resident with respect to the dialysis. There was no mention of what transportation arrangements had been made, what time the resident was to leave the facility, when the resident's medications should be administered (prior to or after hemodialysis), the need for pre- and post-dialysis assessments, how his meal times would be affected, whether he needed to take a snack or a bagged meal with him, etc.</p> <p>The facility's assistant administrator (AA - Employee #12) was interviewed on 04/26/07 at</p>				

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F 309 SS=E	<p>11:00 a.m. related to the care plan. The AA confirmed that the details mentioned above were not addressed in the resident's care plan.</p> <p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>Based on medical record review, observation, resident interview, policy review, and staff interview, the facility failed, for five (5) of nineteen (19) sampled residents, to implement appropriate interventions to enhance overall quality of care and ensure that residents received appropriate interventions to achieved their highest practical potential.</p> <p>The facility failed to evaluate the effectiveness of Resident #45's medications in treating her daily chronic joint pain and failed to develop and implement alternative and/or non-pharmacologic interventions to promote pain relief. Resident #30 did not receive appropriate interventions following removal of a fecal impaction to help decrease the potential of reoccurrence. The facility failed to ensure, for Resident #96, that adequate communication was established and implemented between the dialysis center and the facility to ensure continuity of care. The facility also failed to administer Trental to Resident #61 in accordance with the manufacturer' recommendations; additionally, both Residents</p>	F 309	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/25/07	

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	<p>#61 and #62 received crushed medications without a physician's order to crush, contrary to the facility's policy. Resident identifiers: #45, #30, #96, #61, and #62. Facility census: 108.</p> <p>Findings include:</p> <p>a) Resident #45</p> <p>Record review, on 04/25/07 at 8:20 a.m., revealed that Resident #45 had been experiencing pain since admission to the facility on 04/15/05. Further review of the medical record revealed that Resident #45 had a physician's order, dated 08/16/06, for Lortab (pain medication) 5/500 mg one (1) tablet three (3) times a day for joint pain.</p> <p>On 04/25/07 at 10:00 a.m., Resident #45 was interviewed in her room. Resident #45 stated, "I did not have pain until I came down here. Sitting all the time causes it." Furthermore, Resident #45 stated, "Pills do not help. Can't even tell you took them."</p> <p>Further review of the medical record revealed a comprehensive plan of care, dated 04/27/07 through 07/27/07, which identified that the resident was tearful and complained of pain. The care plan failed to identify measurable goals and interventions (both pharmacologic and non-pharmacologic) for staff to follow to help relieve Resident #45's pain.</p> <p>Review of the facility policy titled "Pain Assessment / Management Program" (revised June 2006) revealed the following:</p> <p>1. On admission to the facility, the initial pain assessment will be completed by the care plan</p>				

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	<p>coordinator or her assistant.</p> <p>2. Information will be communicated to the staff nurse regarding the resident's pain assessment.</p> <p>3. The nurse will ensure that the resident's admission and initial orders contain an order for pain relief.</p> <p>4. When the resident requires interventions for pain relief, the nurse will document the type of pain, treatment administered, and the resident's response to that intervention.</p> <p>5. Should the intervention not provide relief for that resident, the nurse should intervene by re-evaluating the pain and the interventions made, and consider contacting the attending physician for further interventions.</p> <p>The facility failed to follow their own policy for pain management, by failing to evaluate the effectiveness of the medication in relieving Resident #45's pain, and by failing develop and implement alternative and/or non-pharmacologic interventions to address Resident #45's chronic pain on a daily basis.</p> <p>d) Resident #61</p> <p>Observations, during the medication pass observation on 04/23/07 at 4:20 p.m., revealed that the medication nurse (Employee #118) crushed this resident's medications prior to giving them. The nurse crushed Sinemet 25/250 mg and Trental 400 mg prior to administering them.</p> <p>Review of the facility's list of medications not to be crushed found that Trental was not to be crushed due to its time release formulation.</p>			

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	<p>During an interview with the director of nursing (DON - Employee #79) on 04/26/07 at 10:00 a.m. it was confirmed that Trental was on the no-crush list and should not have been crushed prior to giving.</p> <p>e) Residents #61 and #62</p> <p>Observations, during the medication pass on 04/23/07 at 4:20 p.m., revealed that the medication nurse (Employee #118) crushed the medications given to these residents.</p> <p>The nurse crushed Trental 400 mg and Sinemet 25/250 mg prior to administering the medications to Resident #61. The nurse also crushed Calcium Carbonate 600 mg with Vitamin D prior to administering to Resident #62.</p> <p>Review of the April 2007 physician's orders revealed no order to crush medications for Residents #61 and #62.</p> <p>Interview with the assistant administrator (Employee #12), on 04/24/07 at 4:00 p.m., revealed that, according to facility policy, a physician's order is necessary before crushing medications.</p> <p>b) Resident #30</p> <p>The medical record of Resident #30 was reviewed on 04/24/07. This review disclosed that, according to a nurse's note on 10/30/06, the resident had been unable to pass bowel movement (BM). The documenting nurse had assisted the resident by manually attempting to remove the stool. The resident then had a large bowel movement.</p> <p>Further review of the record disclosed that, even</p>			

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	<p>though the resident had experienced this unpleasant experience, staff had failed to implement steps (such as the administration of stool softeners) to prevent the experience from reoccurring.</p> <p>The facility's director of nurses was questioned on 04/25/07 and could provide no evidence that staff had pursued steps to prevent the reoccurrence of this severe constipation.</p> <p>c) Resident #96</p> <p>The medical record of Resident #96 was reviewed on 04/26/07. The resident had been admitted to the facility on 03/21/07 and was receiving outpatient dialysis three (3) times weekly. The resident's medical history stated that he had an arterial-venous (AV) shunt on his left arm by which the dialysis procedure was completed.</p> <p>The nursing assistant, assigned to this resident on 04/26/07 at 11:00 a.m., was questioned related to any precautions that may be necessary when obtaining this resident's blood pressure. The nursing assistant stated that she was not aware of any such precautions.</p> <p>The resident's room was toured, and no posted precautions were observed.</p> <p>The facility's assistant administrator (AA - Employee #12) was asked, on 04/26/07 at 12 noon, how direct care staff would be made aware of any special directives related to this resident. The AA stated that information related to the precautions necessary due to his AV shunt were posted in his room at the time of admission, but the AA confirmed that this information was not</p>			

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F 329 SS=D	<p>posted at this time and that the information was not available in any other location for the nursing assistants caring for this resident.</p> <p>483.25(l) UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on medical record review, staff interview, and facility policy review, the facility failed, for two (2) of nineteen (19) sampled residents, to ensure that medications were not given in an excessive dosage and/or without adequate indications for use. Resident #45 had the potential to receive an excessive dosage of</p>	F 329	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/25/07	

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	<p>acetaminophen (higher than the recommended maximum daily dosage). Resident #30 was receiving Ambien without adequate indications for use. Facility census: 108.</p> <p>Findings include:</p> <p>a) Resident #45</p> <p>Record review, on 04/25/07 at 8:20 a.m., revealed that Resident #45 had several orders for medication containing acetaminophen. The following orders were reviewed:</p> <ul style="list-style-type: none"> - 08/18/06 - Lortab (pain medication) 5/500 mg one (1) tablet every six (6) hours as needed for joint pain. (Lortab 5/500 mg contains 500 mg of acetaminophen.) - 08/18/06 - Lortab 5/500 mg one (1) tablet three (3) times a day for joint pain. <p>In combination, these two (2) orders presented the potential for Resident #45 to receive a total of 3500 mg of acetaminophen in a twenty-four (24) hour period.</p> <p>Further review of the medical record revealed that the facility had standing orders which included acetaminophen two (2) tablets by mouth every four (4) hours as needed for pain or elevated temperature. [Acetaminophen tablets are available in dosages ranging from 80 mg to 650 mg; the facility's standing order failed to specify the dosage of each tablet of acetaminophen to be administered.]</p> <p>Administration of all possible ordered doses of Lortab in combination with the acetaminophen available through standing orders presented the</p>				

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	<p>potential for Resident #45 to receive above the recommended maximum daily dosage of 4 grams acetaminophen.</p> <p>On 04/25/06 at 11:50 a.m., the facility director of nursing (DON) reviewed the orders and identified that there was a potential for Resident #45 to receive an excessive dosage of acetaminophen. b) Resident #30</p> <p>The medical record of Resident #30 was reviewed on 04/24/07. This review disclosed that the resident had been receiving the hypnotic medication Ambien 10 mg one (1) tab at bedtime as needed for insomnia since 09/08/06.</p> <p>Review of the medication administration records (MARs) for this resident revealed that she had received the medication on two (2) occasions in February 2007, seven (7) occasions in March 2007, and two (2) occasions in April 2007. On each of the eleven (11) occasions, the medication had been administered at 9:00 p.m. Nurses notes on all seven (7) occasions in March and two (2) occasions in April contained no evidence that the resident was experiencing insomnia and no indication that the resident had voiced an inability to sleep.</p> <p>The resident's most recent minimum data set (MDS) assessment, completed on 03/19/07, indicated that the resident had experienced no insomnia in the thirty (30) day period prior to the completion of the MDS. MDS documents completed in December 2006 and June 2006 also indicated that the resident had experienced no insomnia.</p> <p>A facility assistant administrator (AA - Employee #12) was interviewed related to these findings.</p>			

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F 386 SS=A	<p>The AA was able to provide behavior monitoring sheets describing an occasional episode of insomnia but could not provide consistent evidence that the resident was experiencing insomnia each time the medication was administered. The AA further was in agreement that 9:00 p.m. was not typically a time in the evening when insomnia would be diagnosed.</p> <p>483.40(b) PHYSICIAN VISITS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>Based on record review and staff interview, the attending physician, for one (1) of nineteen (19) sampled residents, failed to review the resident's total program of care by signing and dating all orders at the time of each resident visit. Resident identifier: #104. Facility census: 108.</p> <p>Findings include:</p> <p>a) Resident #104</p> <p>The medical record of Resident #104 was reviewed on 04/24/07. The review disclosed that the resident's attending physician had made a visit to the resident on 03/17/07. At the time of this visit, the physician wrote and dated a</p>	F 386	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/25/07	

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NAME OF PROVIDER OR SUPPLIER ELKINS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2533 BEVERLY PIKE ELKINS, WV 26241-9401		
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F 387 SS=D	<p>progress note. The physician did not review and sign telephone orders given since the previous visit on 01/17/07. These telephone orders dated back to 02/01/07, and continued until the time of the 03/17/07 visit.</p> <p>483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and staff interview, it was determined that physician's visits for one (1) of twenty-two (22) sampled residents were not done at a frequency of least once every sixty (60) days on two (2) occasions. Resident identifier: #63. Facility census: 108.</p> <p>Findings include:</p> <p>a) Resident #63</p> <p>The medical record for Resident # 63 was reviewed at 9:20 a.m. on 04/23/07. It revealed that the physician's visits occurred on 03/14/06, 05/18/06, 06/17/06, 09/10/06, 11/18/06, 01/18/07, and 04/06/07.</p> <p>Between the visits on 06/17/06 and 09/10/06, eighty-five (85) days had passed; between the visits on 01/18/07 and 04/06/07, eighty-nine (89)</p>	F 387	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/15/07	

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F 428 SS=D	<p>days had passed. Allowing for a ten (10) day grace period, these visits were out of compliance by fifteen (15) and nineteen (19) days respectively.</p> <p>During an interview with the director of nursing (DON) and assistant administrator (Employee #12) at 3:00 p.m. on 04/24/07, both confirmed that the visits were out of compliance. Both also agreed that the process to remind the physicians of when visits are due was aggressive and began at least two (2) weeks before the due dates. They stated that the prompts began with letters to the physicians followed by phone calls. The DON stated that the medical director was not in the habit of visiting residents when their primary physicians were not available or willing to do so, but that she would assist with the prompting to get them to make the visits. In the case of Resident #63, the facility asked a third physician to see the resident, which he did, but the visit was outside the sixty (60) day window.</p> <p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on medical record review and staff interview, the consultant pharmacist failed to</p>	F 428	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/31/07	

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	<p>identify irregularities in the medication regimens of one (1) of nineteen (19) sampled residents, and the physician failed to act on a recommendation from the consultant pharmacist for one (1) of nineteen (19) sampled residents. Resident identifiers: #45 and #30. Facility census: 108.</p> <p>Findings include:</p> <p>a) Resident #45</p> <p>Record review, on 04/25/07 at 8:20 a.m., revealed that Resident #45 had several orders for medications containing acetaminophen; the resident had the potential to receive above the recommended maximum daily dosage of 4 grams of acetaminophen in a twenty-four (24) hour period. (See also citation at F 329.)</p> <p>Review of the monthly consultant pharmacist's medication regimen review and recommendations revealed that the pharmacist failed to identify this as an irregularity.</p> <p>On 04/25/07 at 11:50 a.m., the facility's director of nursing acknowledged that the consultant pharmacist failed to identify the potential for Resident #45 to receive an excessive dosage of acetaminophen.</p> <p>b) Resident #30</p> <p>The medical record of Resident #30 was reviewed on 04/24/07. This review disclosed that the resident had been receiving the hypnotic medication Ambien 10 mg as needed at bedtime for insomnia since 09/08/06. The facility's consultant pharmacist had recognized the need to attempt a gradual dose reduction for this medication and, on 02/22/07, submitted a</p>				

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F 514 SS=A	<p>recommendation to the resident's attending physician requesting that the physician either attempt a gradual dose reduction or provide documentation of the clinical rationale describing why a dose reduction was contraindicated with this resident.</p> <p>The physician, on 03/30/07, declined the recommendation to attempt a dose reduction but also did not provide any rationale to describe why a dose reduction was contraindicated.</p> <p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on medical record review and staff interview it was determined that the facility failed to ensure that the clinical records of three (3) of nineteen (19) sampled residents were documented in accordance with accepted professional standards that were complete and accurately documented. Residents # 42, 32 and 90 had physician's orders that had dates that did not have the year included on entire pages. Resident identifiers: # 42, 32, and # 90. Facility census: 108</p>	F 514	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION.	05/25/07	

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	<p>Findings include:</p> <p>a) Resident # 42</p> <p>During the review of physician's telephone orders it was discovered that orders had been transcribed by the nurse which the date did not include the year.</p> <p>During the review of the orders it was discovered that this resident had telephone orders dated 3/13 and 3/15 with no year included.</p> <p>Further review of the orders revealed that the nurse had not included the complete date and the physician had not dated the order when counter signed.</p> <p>During the review of the entire page of physician telephone orders it was discovered that a complete date had not been recorded.</p> <p>During an interview with the director of nursing (employee # 79), on 04/24/07, at 4:00 p.m., it was confirmed that each telephone order should contain complete dates, and the physician should sign and date each order.</p> <p>b) Resident # 32</p> <p>During the review of physician's telephone orders it was discovered that orders had been transcribed by the nurse which the date did not include the year.</p> <p>During the review of the orders it was discovered that this resident had telephone orders dated 3/15, 3/19, and 3/19 which had no year included</p>			

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	<p>Further review of the orders revealed that the nurse had not included the complete date and the physician had not dated the order when counter signed.</p> <p>During the review of the entire page of physician telephone orders it was discovered that a complete date had not been recorded.</p> <p>During an interview with the director of nursing (employee # 79), on 04/24/07, at 4:00 p.m., it was confirmed that each telephone order should contain complete dates, and the physician should sign and date each order.</p> <p>c) Resident # 90</p> <p>During the review of physician's telephone orders it was discovered that orders had been transcribed by the nurse which the date did not include the year.</p> <p>During the review of the physician's orders it was discovered that this resident had two (2) pages of telephone orders dated 3/14, 3/15, 3/27 and 3/29 which had no year included</p> <p>Further review of the orders revealed that the nurse had not included the complete date and the physician had not dated the order when counter signed.</p> <p>During the review of two (2) entire pages of physician telephone orders it was discovered that a complete date had not been recorded.</p> <p>During an interview with the director of nursing (employee # 79), on 04/24/07, at 4:00 p.m., it</p>			

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	was confirmed that each telephone order should contain complete dates, and the physician should sign and date each order.			