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THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 000	INITIAL COMMENTS The survey team entered the facility on 6/8/2022 to conduct a complaint investigation and exited on 6/10/2022. Additional information was obtained on 6/13/2022 and 6/14/2022. Therefore, the exit date was changed to 6/14/2022. Two of the fifteen allegations were substantiated resulting in deficiencies. Intake #'s NC00189113, NC00188625, NC00188274.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview, Wound Nurse Practitioner interview, and Physician Assistant Interview the facility failed to 1) communicate effectively to assure clear treatment orders for a surgical wound were established and placed on the treatment record so nurses would know to change a surgical dressing 2) assure wound vac supplies were accessible so that a resident's wound vac could be changed per order. This was for one (Resident # 1) of one sampled resident with a surgical wound. The findings included:	F 684	Resident # 1 was discharged from the facility on 6/11/2022. Nurse #1 received education on obtaining wound vac supplies on 06/27/2022. For those residents who have the potential to be affected by the same deficient practice each resident will be assessed upon admission by a nurses to ensure orders are complete for surgical wounds. The Director of Health Services and/or Nurse Managers are going to audit	7/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/29/2022

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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Resident # 1 was admitted to the facility on 2/14/22. The resident had diagnoses of peripheral vascular disease, diabetes, and end stage renal disease.
Review of Resident # 1's hospital discharge summary, dated 2/14/22, revealed that prior to Resident # 1's facility admission, he had been hospitalized for a non -healing diabetic foot ulcer and osteomyelitis. While hospitalized, it had been recommended that Resident # 1 have a left leg amputation, but he had chosen not to have this amputation performed. He had undergone an amputation of his 5th toe and metatarsal head and an incision and drainage of the left foot diabetic ulcer. According to the discharge summary the resident had a wound vac to his left foot surgical wound following his surgery and the discharge summary noted the wound vac was currently on the resident's wound. There were no orders for wound care on the 2/14/22 discharge summary when Resident # 1 was discharged from the hospital to the facility; i.e. whether to continue the wound vac and at what pressure.

Resident # 1's admission Minimum Data Set Assessment, dated 2/17/22, revealed the resident was cognitively intact.

A nursing admission progress note, dated 2/15/22 at 2:11 AM, revealed Resident # 1 had arrived at the facility on 2/14/22 at 11:25 PM. The admitting nurse documented, "there was wound vac placemat on the left foot with incision and drainage but was discontinued on hospital discharge, the wound is bandaged with wet to dry dressing."

Review of Resident # 1's facility record revealed there were no wound care orders from the time of

F 684

admissions for the last 30 days to ensure appropriate orders are obtained for surgical wounds.

The Director of Health Services and/or Nurse Managers will review all admissions and re-admissions within 24 hours to ensure treatment orders for surgical sites are in place on the Treatment Records.

An audit will be performed by the Director of Health Services and/or Nurse Managers on any resident with a wound vac and ensure all supplies are readily available on 06/27/2022.

Education will be given by the Director of Health Services and/or Nurse Managers to all nurses on the admission process for residents with surgical wounds to include reading the discharge summary and notifying the MD for any clarification orders. Education began Monday 06/27/2022.

Education where wound supplies are located and where to obtain was also given to all nurses. Date started on 06/27/2022. Education will also be given to all new nurse hires during orientation.

The Director of Health Services will present the analysis of the education for admission orders for surgical wounds and for obtaining the wound vac supplies and their location during Monthly QAPI meetings until we have maintained 3 months of continued compliance.

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admission (2/14/22) through 3/2/22.

Review of Resident's 1's treatment admission records for February 2022 and March 2022 revealed no treatments were documented as performed between 2/14/22 and 3/2/22.

On 2/16/22 Resident # 1's Physician Assistant saw the resident and noted "L Foot wound post 5th ray amp (amputation) 1/17-W>D dressing (wet to dry dressing); NWB (non weight bearing)."

On 2/17/22 at 6:59 AM Nurse # 2 documented "L foot wound seen by wound NP. Orders to follow."

On 2/17/22 at 6:14 PM, the facility wound nurse documented "Resident has an open incision to the lt (left) heel (lateral) and an amputated Lt 5th digit with sutures (lat). The Lt heel has light to moderate drainage. No noted smell or s/s (signs and symptoms) of infection. Site has beefy red tissue and noted fatty tissue. He denies pain to sites. Treatment to the Lt 5th digit and Lat foot is to clean with wound cleanser and leave open to air. Treatment to Lt heel (lateral) clean with wound cleaner then apply wet to dry until wound vac is available."

On 2/17/22 the Wound Nurse Practitioner saw Resident # 1 and documented the following assessment of his surgical wound. "The wound is poorly approximated with sutures. There is a moderate amount of serous drainage. The wound bed contains a combination of dusky granulation tissue and yellow-brown colored necrotic tissue. The wound will be treated with negative pressure wound therapy."

On 2/18/22, 2/19/22, and 2/27/22 nursing notes

Plan of correction (F 684): Date of Compliance□7/8/2022

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reflected the left foot dressing was intact. There was no notation the dressing was changed. Nurse # 6 noted on 2/27/22 Resident # 1 had refused the dressing change on her shift.

On 3/3/22 an order was initiated to clean the wound with wound cleanser, pat dry, apply black foam and transparent adhesive dressing, and then apply a wound vac. This wound vac order remained in effect until the date of 5/5/22. This 3/3/22 order was initiated on the TAR on 3/3/22 and noted to have been carried out by the facility wound nurse.

Resident # 1 was interviewed on 6/8/22 at 11:16 AM and again on 6/10/22 at 9:50 AM. Resident # 1 reported the following. When he was discharged from the hospital in February 2022, the hospital staff removed his wound vac right before transport to the facility. They told him the facility would need to place it back on his foot wound when he arrived. The facility did not have a wound vac when he arrived and it took them at least a week to get one. During the time he was awaiting the wound vac, the staff did not always change his dressing on his foot. Once the facility got the wound vac and applied it, there had been a week-end when it was not changed at all as ordered. On that week-end, Nurse # 1 had told him that the supplies had been locked up and the nurse could not get to them. Therefore, it was not changed that week-end. Resident # 1 reported at the current time he was not requiring a wound vac and the nurses were changing his wound dressing. Resident # 1 expressed his concern that the delay of not getting the wound vac and then not changing it over the week-end had caused a delay in his progress.

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Nurse # 3 had been the admitting nurse on 2/14/22 for Resident # 1. Nurse # 3 was interviewed on 6/10/22 at 12:40 PM and reported the following. Resident # 1 had arrived very late to the facility on 2/14/22 and was tired. At that time she noted he had a wet to dry dressing intact to his left foot, but she did not remove or change it because he wanted to rest. Someone else had already put the orders into the computer so she did not know there was not a wound dressing order entered for Resident # 1. According to the discharge summary there was no notation to continue the wound vac so she thought it was discontinued. She could not recall about dressing changes in the weeks following admission and prior to 3/3/22. She knew at some point the facility was trying to get a wound vac for the resident's foot.

The treatment nurse was interviewed on 6/9/22 at 10:30 AM and again on 6/10/22 at 11:20 AM and reported the following. She usually worked Monday through Friday as the treatment nurse, but at times she was pulled to work as a floor nurse instead. Therefore, just because she was present in the facility did not mean she had changed Resident # 1's dressing. When she worked as a hall nurse, then Resident # 1's assigned nurse was supposed to change his dressing. She thought there had been an order for a wet to dry dressing to Resident # 1's left foot when he first was admitted. She had not been present on the day of admission. On the days she worked as the wound nurse, she applied a wet to dry dressing until an order for a wound vac was obtained and the wound vac arrived. She could not recall the exact date the wound vac came in or when it was initially ordered. The wound nurse stated that when a wound vac was ordered it

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F 684	Continued From page 5 usually would arrive on the day the facility ordered it. If she had not been present on a day a wound vac was needed then the other staff could have called and obtained a wound vac from the facility's equipment supply company. According to a staffing sheet supplied by the facility, Nurse # 2 had cared for Resident # 1 nine times between the dates of 2/15/22 and 3/3/22 on the 7 PM to 7 AM shift. Nurse # 2 was interviewed on 6/10/22 at 12:30 PM and could not recall she had cared for Resident # 1 or anything about his dressings prior to 3/3/22. According to the staffing sheet supplied by the facility, Nurse # 1 had cared for Resident # 1 eight times between 2/15/22 and 3/2/22. Nurse # 1 was interviewed on 6/10/22 at 11:20 AM and reported the following. He did not recall about dressing changes prior to 3/3/22. Nurse # 1's interview did corroborate Resident # 1's statement that the wound vac was not changed one Saturday when it was due. Although Nurse # 1 did not recall the exact date, he did recall that he needed tubing to go to the suction part of the wound vac. The tubing was not on the treatment cart and was locked up in the wound nurse's office. He did not have keys and there was no supervisor. Therefore, he had not been able to change the dressing and wound vac when it was due. He did not recall if he had reported it to the oncoming nurse but recalled thinking that the wound nurse would change it when she arrived on Monday. Nurse # 4 had cared for Resident # 1 on 2/21/22 during the dayshift. Nurse # 1 did not recall anything about Resident # 1's dressing. According to Nurse # 1 if there had not been an	F 684		

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order on the TAR (Treatment Administration Record) then she would not have known a dressing was due to be changed by her if it had been her responsibility.

Nurse # 5 had cared for Resident # 1 on 2/22/22. Nurse # 5 was interviewed on 6/10/22 at 11:40 AM and did not recall anything about Resident # 1's dressing.

According to the staffing sheet supplied by the facility, Nurse # 6 had cared for Resident # 1 four times between the dates of 2/14/22 and 3/3/22. Nurse # 6 was interviewed on 6/13/22 at 2:45 PM and reported the following. She only did the dressing if the wound nurse was not there. If there had not been an order, then she would have changed the dressing and followed what the wound nurse had put on before. If there had been a wet to dry and the date on the dressing signified it needed to be changed, then she would have changed it if the wound nurse was not working. On the day of 2/27/22 when she had documented that Resident # 1 refused the dressing, she recalled she wanted to wash his leg before the dressing change. He did not like to bathe and would often refuse bathing assistance. Resident # 1 got upset and told her to get out of the room and leave him alone.

On 6/10/22 at 10:15 AM, the Wound Nurse Practitioner was interviewed and reported the following. When she first saw Resident # 1 on 2/17/22, his wound was poorly approximated and dusky in color. From his history she saw that he had a history of noncompliance with wound care. She had discussed compliance with him. Resident # 1 had told her that he had been told at the hospital that he needed a wound vac and it

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F 684	Continued From page 7 was supposed to be continued at the facility. Therefore, she had put in her notes that the wound vac would be the treatment. The Wound NP stated if a wound vac was needed and not available within two hours, then typically a wet to dry dressing is an appropriate measure. The Wound NP stated she did not write an order for the wound vac or other type of dressing because Resident # 1 was a surgical resident and typically wound orders would be obtained from the surgeon. Following the date of 2/17/22 she did not see Resident # 1 again until 3/11/22 and at that time he did have the wound vac. On 6/10/22 at 11:55 AM Resident # 1's Physician's Assistant (PA) was interviewed and reported the following. It was her understanding that wet to dry dressings were being done when Resident # 1 was first admitted. There was no mention of what treatment orders would be continued at time of discharge within the hospital discharge summary. She did not write an order because the facility wound nurse typically did that. Resident # 1 kept saying he needed a wound vac and they started investigating that and eventually a wound vac was ordered. She thought there had bee some delay in getting the wound vac but was not sure about the specifics of the delay. The PA stated that in general wound vacs can help heal wounds quicker, but in Resident # 1's case, it was not felt that his wound would heal regardless of treatment. Therefore, the PA reported any delay or problems with a wound vac would not have caused the resident a negative outcome. On 6/9/22 at 11:30 AM Resident # 1's left foot was observed as the facility treatment nurse changed the dressing. The resident's left lateral foot appeared to have whitish-yellowish tissue.	F 684		

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On 6/14/22 at 11:20 AM the two hospital case managers, who had arranged for Resident # 1's discharge to the facility on 2/14/22, were interviewed. They reported the following. The discharge summary had noted that Resident # 1 was currently receiving treatment by way of a wound vac upon discharge. As part of their placement services, they give nursing homes a provider link that they can access and view the care needs of residents who are being discharged. For Resident # 1, they had placed in the provider link the information that Resident # 1 would need a wound vac and outpatient dialysis. The facility should have had access to this information when they accepted him. They had also talked to an admissions coordinator at the facility. When a resident with a wound vac is discharged to a facility, then the facility is called and asked if the facility staff want the hospital to clamp the vac or remove the whole dressing and put a wet to dry dressing on before transport because they do not send the wound vac with the resident. It was the case managers' understanding that the wound vac order originated because the hospital wound/ostomy team were following the resident and providing treatment for his wounds. They generally made suggestions to the physicians who then approved the orders.

The facility's Director of Nursing (DON) was interviewed on 6/9/22 at 5:00 PM. The DON had not been employed at the time of Resident # 1's admission. The DON reported it would be her expectation that orders would be obtained for wound care and then the order would be transcribed to the treatment administration record.

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F 684	Continued From page 9 The Administrator was interviewed on 6/14/22 at 4:32 PM. The Administrator reported that the facility's admission staff members could no longer access the provider link which the hospital case managers noted would have had the information that Resident # 1 needed a wound vac. The Administrator, who was not employed at the time of Resident # 1's admission, reported it would be an expectation that orders be clarified for wound treatment. During the interview with the Wound Care Nurse which had taken place on 6/10/22 at 11:20 AM, the wound nurse had reported if week-end staff were missing supplies for a wound vac, then they could call her or someone else in an administrative position for the keys to access the supplies.	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		7/8/22

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F 755	Continued From page 10 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview, and pharmacy consultant interview for two of eight sampled residents, the facility failed to assure medications which needed to be administered with or before meals in order to be most effective or to avoid side effects were administered accordingly. This was for two (Residents # 1 and #8) of eight sampled residents. The findings included: 1 a. Resident # 8 was admitted to the facility on 6/8/22. Resident # 8 had a diagnosis of diabetes. Resident # 8 had an order, dated 6/8/22, for blood sugar checks to be performed four times per day and for Novolog Insulin to be administered based on the blood sugar result per a sliding scale. The sliding scale was for: 200-250-2 units 251-300- 4units 301-400- 8 units >400 10 units and call physician	F 755	Resident # 1 was discharged from the facility on 6/11/2022. Resident #8□s sliding scale insulin order was adjusted on 06/09/2022 to be given before meals. Nurse #7 was in-serviced by the Director of Health Services on 06/27/2022 on medication administration time frames and notification of MD if outside of the required timeframes for administration. An audit will be conducted on 06/27/2022 by the Director of Health Services and/or Nurse Managers with four nurses during Medication Pass to observe compliance for administering medications within the time frame. All nurses will be given an in-service by the Director of Health Services and/or Nurse Managers beginning 06-27-2022	

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F 755	Continued From page 11 This order had been transcribed to the MAR (Medication Administration Record) to be completed at 9 AM; 1 PM, 5 PM and 9 PM. On 6/9/22 at 9:50 AM Nurse # 7 was observed to perform the blood sugar check that the Novlog Insulin amount would be based upon. Resident # 1's blood sugar registered 205. On 6/9/22 at 10:03 AM, Nurse # 7 was observed to administer 2 units of Novolog Insulin to Resident # 8. Nurse # 7 reported Resident # 8 had his breakfast earlier around 8:15 AM that day. The Director of Nursing (DON) was interviewed on 6/9/22 at 5:00 PM. This interview revealed that her expectation was that the order should have been entered into the computer for blood sugar checks and Insulin administration times that corresponded to before meals and at bedtime. The DON reported Nurse # 7 was new and had not realized the day before when the order was entered into the computer, that the times of administration should have been customized to reflect times before meals. When the order was entered, it was entered as four times per day and therefore the computer had automatically populated the times of administration to be at 9 AM; 1 PM; 5 PM and 9 PM. Interview with the facility's pharmacy consultant on 6/9/22 at 3:45 PM revealed that rapid acting Insulins, such as Novlog, typically are scheduled before meals and not after a meal. 1 b. Resident # 8 had an order for Metformin 1000 milligrams to be administered twice per day with meals. Review of the Medication Administration Record revealed Resident # 8's AM dose of Metformin was due at 8:00 AM.	F 755	on medication administration regarding MD notification if medication is not given in the required timeframe. Education will also be given to all new nurse hires during orientation. Four random audits will be conducted weekly for 4 weeks, then 4 every 2 weeks then 4 monthly to observe compliance for medication administration by the Director of Health Services and/or Nurse Managers. Analysis of the audits will be brought to monthly QAPI by the Director of Health Services until we have maintained 3 months of continued compliance. Date of Compliance-- 07/08/2022	

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	345009	A. BUILDING ______ B. WING ______	C 06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	**513 EAST WHITAKER MILL ROAD** **RALEIGH, NC 27608**

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F 755	Continued From page 12 Nurse # 7 was observed to administer the Metformin at 9:50 AM. The nurse stated breakfast had been served around 8:15 AM that morning to Resident # 1. Interview with the facility's pharmacy consultant on 6/9/22 at 3:45 PM revealed Metformin is typically given at a meal in order to avoid stomach upset. 2. Resident # 1 was admitted to the facility on 2/14/22. Resident # 1 had a diagnosis of end stage renal failure and received dialysis three times per week. Resident # 1's admission Minimum Data Set Assessment, dated 2/17/22, revealed the resident was cognitively intact. Resident # 1 had a current order, which originated on 3/4/22, for Sevelamer HCL 1600 milligrams to be administered three times per day. There were special instructions on the MAR (medication administration record) to administer the Sevelamer with meals. (Sevelamer is a medication used to bind phosphate in food before it can be absorbed by a person's body and is used to control phosphorus levels in individuals with chronic renal failure.) During an interview with Resident # 1 on 6/8/22 at 11:16 AM and again on 6/10/22 at 9:50 AM, the resident reported that the nurses did not always administer his Sevelamer with food. Resident # 1 reported on his Monday, Wednesday, and Friday dialysis days he ate lunch early at around 10 AM and then he did not get back until around 5:45 PM on those days.	F 755		

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F 755	Continued From page 13 Review of Resident # 1's March, April, May, and June 2022 Medication Administration Records revealed the Sevelamer was scheduled to be given at 8:00 AM; 12:00 PM; and 5:00 PM on all days; including his dialysis days on which he ate an early lunch. The following notations were made about Resident # 1's Sevelamer 3/4/22 at 5:00 PM- Nurse # 1 noted not administered; drug not available 3/7/22 at 5:45 PM-Nurse # 6 noted not administered; Resident unavailable 3/11/22 at 12:58 PM- Nurse # 11 noted not administered; Resident unavailable 3/11/22 at 6:06 PM-Nurse # 11 noted not administered; Resident unavailable 3/16/22 at 1:17 PM- Nurse # 6 noted not administered; out of facility to dialysis 3/25/22 at 2:28 PM-Nurse # 6 noted not administered; Resident unavailable 3/30/22 at 12:00 PM- Nurse # 6 noted not administered; Resident unavailable 3/30/22 at 5:00 PM- Nurse # 6 noted not administered; Resident unavailable 3/31/22 at 5:00 PM- Nurse # 6 noted not administered; Resident unavailable 4/4/22 at 6:33 PM- Nurse # 6 noted not administered; Resident unavailable 4/8/22 at 12:00 PM- Nurse # 6 noted not administered; Resident unavailable 4/8/22 at 5:22 PM- Nurse # 6 noted not administered; Resident unavailable 4/11/22 at 12:52 PM Nurse # 10 noted not administered; Resident unavailable 4/11/22 at 4:51 PM Nurse # 8 noted not administered; Resident unavailable; the resident was at dialysis 4.13/22 at 4:34 PM Nurse # 9 noted not	F 755		

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F 755	Continued From page 14 administered; Resident unavailable 4/15/22 at 12:55 PM Nurse # 12 noted not administered; Resident unavailable 4/20/22 at 1:01 PM Nurse # 13 noted not administered; Resident unavailable; the resident was at dialysis 4/22/22 at 5:00 PM Nurse # 6 noted not administered; Resident unavailable 4/25/22 at 1:29 PM Nurse # 10 noted not administered; Resident unavailable 4/29/22 at 12:13 PM Nurse # 1 noted not administered; Resident unavailable 5/2/22 at 6:06 PM Nurse # 6 noted not administered; Resident unavailable 5/4/22 at 12:29 PM Nurse # 1 noted not administered; Resident unavailable 5/16/22 at 1:16 PM Nurse # 6 noted not administered; Resident unavailable 5/16/22 at 5:42 PM Nurse # 6 noted not administered; Resident unavailable 5/20/22 at 5:52 PM Nurse # 6 noted not administered; Resident unavailable 5/25/22 at 6:04 PM Nurse # 6 noted not administered; Resident unavailable 5/30/22 at 11:44 AM the wound nurse noted not administered; Resident unavailable; at dialysis 6/8/22 at 5:23 PM Nurse # 6 noted not administered; Resident unavailable Nurse # 8 was interviewed on 6/9/22 at 2:40 PM and reported when she worked on 4/11/22 she had not given Resident # 1 his Sevelamer on 4/11/22 when it was due at 5:00 PM because he did not get back until around 6:30 PM from dialysis. The time for the administration had already passed. Nurse # 1 was interviewed on 6/10/22 at 11 AM and reported on the times he worked and put	F 755		

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Continued From page 15

"unavailable," he had not given the Sevelamer because the resident was at dialysis. The problem was not that the drug was not available but the resident was not available when the medication came up on the electronic MAR as due.

Nurse # 10 and Nurse # 6 were interviewed together on 6/9/22 at 2:50 PM. They reported the resident went to dialysis at a neighboring city and often got back late at a time which did not match the administration times of the Sevelamer. Nurse # 6 stated although she had put she did not administer the doses due at the evening meal, she had tried to give it when Resident # 1 got back from dialysis but the computer system would not allow her to document the administration. Nurse # 6 did not recall the details of the midday doses that were due at the lunch meal and had been documented as not given by her.

At attempt was made to interview Nurse # 13 on 6/14/22 at 1:55 PM and she could not be reached. Nurses # 8 and # 11 were no longer nurses available for interview per the Administrator.

Interview with the facility pharmacy consultant on 6/9/22 at 3:45 PM revealed Sevelamer is best given at a meal because it binds the phosphate in the food.

Interview with the Administrator on 6/9/22 at 4:20 PM revealed the times on the MAR needed to be adjusted for Resident # 1's dialysis days so that the medication would flag to the nurses to be given with his meals when he was available and eating. The Administrator stated the resident was

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F 755	Continued From page 16 currently receiving his lunch around 10:00 AM on dialysis days and was picked up at 12:00 PM (the time the Sevelamer was scheduled to be given) to go to dialysis. His dialysis chair time was until 5 PM (the time when his evening Sevelamer dose was due) and he then was transported back.	F 755		