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	345377	A. BUILDING _____ B. WING _____	C 02/20/2014

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GREENFIELD PLACE	**2575 W 5TH STREET GREENVILLE, NC 27834**

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to develop a goal and interventions on the Nursing Care Plan to address limited range of motion for one of one resident, Resident #80. Resident #80 is a 95 year old who was admitted to the facility on 07/11/2012 with cumulative diagnoses which included but were not limited to anemia, hypertension, and hypothyroidism. A review of the quarterly Minimum Data Set (MDS) assessment dated 09/22/2013 revealed	F 279	1. Resident #80 was actively dying and expired on 2-28-14. 2. All residents in the facility will be screened by the Therapy Department by 3-14-14 to identify residents with limited range of motion to assure that they receive the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. The screenings will be documented on the Resident Range of Motion Audit Log. The MDS Department	3/20/14

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

Electronically Signed | 03/14/2014

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F 279	Continued From page 1 Resident #80 required extensive assistance with the aid of one person for the resident's bed mobility, transfers, and toilet use. A review of the quarterly MDS assessment dated 12/15/13 revealed the resident's functional status had declined since the previous 09/22/2013 assessment and that she required total assistance for her bed mobility, transfers and toilet use. The MDS assessment dated 12/15/13 also revealed that the resident did not receive Physical Therapy or Restorative Nursing services between 09/22/13 and 12/15/13. The resident's nursing care plan last updated on 12/23/13 was reviewed, and there were no goals or interventions in the care plan related to the resident's limited range of motion or for contracture management. In the resident's medical record, a Physician's Order dated 08/26/2013 was noted as follows: "PT (Physical Therapy) clarification orders for skilled PT services 5 times per week for 4 weeks to include therex (therapeutic exercise), theract (therapeutic activity), positioning, diathermy (electrically induced heat therapy), and e-stim (electrical stimulation) for contracture management." Additional review of the Physician's Orders revealed an order on 09/20/13 to discontinue skilled PT services. A review of the resident's Special Treatments record revealed there were no Physical Therapy, Occupational Therapy, or Restorative Nursing services provided for the resident from 09/20/13 through 02/10/14.	F 279	will update the care plans of the identified residents based on the findings of these screens by 3-20-14 and document on the Resident Range of Motion Audit Log that the care plan has been updated. All new residents admitted to the facility will be screened by the Therapy Department within 48 hours of admission to identify any limited range of motion to assure that a plan is put into place to assure they receive the appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. These screenings will be documented on the Resident Range of Motion Audit Log. All new residents identified with limited range of motion will have their care plan updated to include goals and interventions. Once the care plan is updated it will be documented on the Resident Range of Motion Audit Log. 3. The Therapy Department will recommend and/or initiate treatment/services for those residents identified as having limited range of motion to increase range of motion and/or prevent further decrease in range of motion. When the resident has been discharged from therapy the Therapy Department will initiate a Rehab Instruction Record and inservice the nursing/restorative staff regarding the interventions and goals recommended. The Therapy Department will then forward a copy of this form to the Assistant Director of Nursing/Restorative Manager. The Assistant Director of Nursing/Restorative Manager will then	

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F 279	Continued From page 2 In an observation of the resident on 02/19/14 at 11:05 AM, the resident was lying in bed on her right side in bed with a foam box shaped pillow between her knees and lower legs. The foam pillow had large holes through which her left foot was placed. Both of the resident's legs were in the flexed position at her knees and hips, both arms were flexed at the elbows, and both her hands were flexed at her knuckles. An observation of the resident on 02/20/14 revealed the Resident #80 was lying on her back in bed with the head of the bed elevated, arms and legs in the flexed position, and the large square foam pillow between her lower legs. The resident's left foot was placed through a large hole in the pillow in a float position. In an interview on 02/19/14 with Nurse #4 at 11:11 AM she stated that the resident's legs have been in the flexed position for at least five months, perhaps more. She further stated that her arms could be extended to a degree, but that her legs were very difficult to extend. In addition, she stated that the resident used to sit up in a chair for part of the day during the early fall months of 2013. In an interview on 02/19/14 with Nurse #4 at 11:11 AM she stated that the resident's legs have been in the flexed position for at least several months, perhaps more. She further stated that her arms could be extended to a degree, but that her legs were very difficult to extend. In addition, she stated that the resident used to sit up in a chair for part of the day during the early fall months of 2013.	F 279	forward a copy of this form to the MDS Department so that the residents care plan can be updated with the goals and interventions. Copies of any Physician orders written will be reviewed by the Assistant Director of Nursing/Restorative Manager and the MDS team to assure compliance with this procedure. 4. Copies of the Resident Range of Motion Audit Log will be submitted to the Interdisciplinary Team weekly. Random audits of at least 5 of the residents listed on the Resident Range of Motion Audit Log will be done weekly x 4 then monthly x 3 by Nursing Management to assure compliance with the goals and interventions identified. The results of these audits will be taken to the facility QA&A Committee. The committee will make recommendations based on the findings of these audits.	

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F 279	Continued From page 3 In an interview with the Assistant Director of Nursing (ADON) on 02/20/14 at 10:45 AM, she stated that Resident #80 was receiving Restorative Nursing Services sometime in September 2013 and that records from that time had been probably been "boxed up." She explained that the restorative range of motion exercises were probably discontinued due to her declining health, and that she would follow up to determine when restorative care was provided for Resident #80. In addition, she stated that if the nursing care plan did not include any goals and interventions related to her limited range of motion, it was an oversight. In a later interview with the ADON on 02/20/14 at 3:27 PM, she stated that a fill-in Physical Therapist had ordered treatment for 08/26/13 for therapeutic exercise, therapeutic activity, positioning, diathermy, and electrical stimulation for contracture management for Resident #80. She explained that the order was referred back to the Physical Therapist because her order for "positioning" for the Restorative Nursing services needed to be clarified. She further explained that "positioning" is not a Restorative Nursing Modality and that an altered order was needed to comply with the Restorative Services guidelines. In addition, she stated that the fill-in Physical Therapist completed a Rehabilitation Instruction Record for Resident #80 for Positioning/Splints 6 -7 times per week, to position in upright in chair, neutral spine with abductor wedge for 2 - 4 hours. The Physical Therapist also recommended on the Rehabilitation Instruction Record that Special Programs should include range of motion to bilateral hip, knee, and ankle joints (passive) to prevent further contractures. The ADON stated that the fill-in Physical Therapist left during shortly	F 279		

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F 279	Continued From page 4 after her order was written and that an altered order was never received for Restorative Nursing Services. In a third interview with the ADON at 5:00 PM on 02/20/14, she stated that the Rehabilitation Instruction Record came to her office at some point in late August 2013 or early September 2013, and she was planning to follow up to obtain a revised Restorative Nursing order, but that she never did. She also explained that typically, when an order is written for Restorative Services, a Rehabilitation/Restorative Service Delivery Record (RRSDR) is completed and that the Restorative Aide would follow the interventions listed on that form. She stated that in this case, she never completed the RRSDR and never obtained a clarified Restorative Nursing order, and that Resident #80 did not receive Restorative Nursing Services. She stated she simply forgot to follow up to obtain a revised order after the fill-in Physical Therapist left, and that a nursing care plan regarding restorative services or contractures was never developed.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility did not provide	F 312	1. The toenails for resident #36 were cleaned and trimmed on 2-20-14. The	3/20/14

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F 312	Continued From page 5 grooming services for 1 of 1 sampled dependent residents (Resident #36) who had facial hair on the upper lip and long toenails on both feet. Findings included: Resident #36 was re-admitted to the facility on 02/05/14. Cumulative diagnoses included chronic obstructive pulmonary disease, atrial fibrillation and anemia. The most recent Admission Minimum Data Set (MDS) of 12/30/13 noted Resident #36 had no cognitive deficits and required extensive assistance with dressing, bathing and hygiene. The resident was frequently incontinent of bladder and continent of bowel. The Care Area Assessment (CAA) detail summary indicated the resident required staff assistance for activities of daily living and was to be addressed in the care plan. A treatment progress note written by the treatment nurse of 02/06/14 indicated Resident #36 was re-admitted to the facility with a diagnosis of congestive heart failure. It was noted that the resident's toenails were thick and long. Resident #36's care plan of 02/13/14 indicated the resident required assistance with activities of daily living and the nursing staff was to assist as needed. During an interview with Resident #36, on 02/19/14 at 11:30 AM, the resident reported the nurse aide had provided morning care and she was waiting to go to therapy. It was noted that the resident had numerous long white hairs on the upper lip and down each side of the mouth.	F 312	facial hair was removed on 2-20-14. 2. An audit was completed by the Nursing Department of all residents in the facility to determine residents who were in need of immediate nail care on 3-14-14. Interventions were taken as need at that time. An audit was completed by the Nursing Department of all residents in the facility to determine residents who were in need of removal of unwanted facial hair on 3-14-14. Interventions were taken as needed at that time. 3. Nail care and shaving will be performed daily during the daily bath and as needed. Residents identified as needing medical attention for toenail care will be referred to a Podiatrist as needed. Inservices were held with the Nursing Department regarding the importance of keeping the residents nails clean and trimmed and the importance of keeping unwanted facial hair removed. 4. Random audits of at least 20 residents will be completed by the Nursing Department weekly x 4 weeks then monthly x 3 to assure that nails are kept trimmed and clean and that any unwanted facial hair is removed. The results of these audits will be taken to the facility QA&A Committee. The committee will make recommendations based on the findings of these audits.	

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F 312	Continued From page 6 Resident #36 was observed again on 02/20/14 at 8:45 AM. The facial hair remained to the upper lip and mouth area. The resident stated the aide had not provided the bed bath as yet. On 02/20/14 at 9:10 AM, Nurse Aide #3 (NA #3) reported she had completed morning care for Resident #36. Upon observation, the same facial hair remained to the upper lip and mouth area. Resident #36 was resting in bed resident in bed on 02/20/14 at 1:40 PM. The resident was noted to be pulling at the long white hairs on each side of her mouth. When questioned as to whether she liked having the facial hair on her upper lip and mouth area the resident responded that she would like it to be shaved. She uncovered her feet and stated that she wanted her toenails cut. She stated they hadn't been cut in a long time and were too long. Upon observation it was noted that the toenails on both feet were thick and extending past the tips of her toes. NA #3 was interviewed on 02/20/14 at 1:42 PM. She stated she usually shaved the female residents about every other day or when she noticed facial hair growth. When questioned about Resident #36, she stated she did not notice the resident's upper lip today when she provided care. NA #3 stated she was not allowed to cut toenails. The Assistant Director of Nurses (ADON) was interviewed on 02/20/14 at 3:10 PM. She stated she had not been in Resident #36's room since the resident was readmitted. The ADON stated an appointment could be arranged if a resident needed to be seen in between the time the	F 312		

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F 312	Continued From page 7 podiatrist came out. She reported that the nurse aides were responsible for shaving the female residents during the morning bath. She added that facial hair should be removed as soon as it was noticeable unless the resident refused. The ADON also stated toenails should be kept short as well. She commented she would make sure the resident's toenails were cut and the facial hair removed today. Nurse #1 was interviewed on 02/20/14 at 3:15 PM. She stated she had noticed this morning that Resident #36 had long toenails and had commented to Resident #36 that her toenails needed to be cut but she did not cut them.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to assess 1 of 1 sampled residents (Resident #4) for participation in a scheduled toileting program. Findings included:	F 315	1. Resident #4 was started on a toileting program on 2-20-14. He is to be toileted after meals to help prevent urinary tract infections and to restore as much bladder function as possible.	3/20/14

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F 315	Continued From page 8 Resident #4 was re-admitted to the facility on 06/10/10. Cumulative diagnoses included gout, glaucoma and depression. The Annual Minimum Data Set (MDS) assessment of 11/17/13 noted Resident #4 had no cognitive deficits. The resident required extensive assistance with transfers, toilet use and hygiene. The resident was incontinent of bowel and bladder. The Care Area Assessment for the 11/17/13 MDS identified the resident as being at risk for skin breakdown due to urinary incontinence and would be addressed in the care plan. A bladder evaluation completed on 11/18/13 indicated Resident #4 was incontinent of bowel and bladder. There was no recommendation for a scheduled toileting program. Resident #4's care plan, last revised on 02/18/14, identified a problem of potential for urinary tract infections related to bladder incontinence. An intervention was to encourage and/or assist the resident to the bathroom after meals. During in interview with Nurse #3 on 02/19/14 at 2:50 PM, she stated Resident #4 was totally dependent on staff for activities of daily living. She stated the resident ate the majority of the meals in the dining room and always needed to use the bathroom after meals. Nurse #3 commented staff were busy feeding and assisting other residents during meals and did not have time to toilet the residents if they needed to go to the bathroom during meal times. Nurse #3 also commented that Resident #4 had complained to her about not being taken to the bathroom when requested. She also reported that she had	F 315	2. Assessments will be completed on the other residents in the facility by 3-14-14 to identify those in need of a scheduled toileting program. Any residents identified as a result of these assessments will be referred to the Restorative Nursing Program. 3. All new admissions will be assessed on admission to see if they meet the criteria for a scheduled toileting program. Those identified will be referred to the Restorative Nursing Program. 4. Random audits (25% sampling)of the residents placed on a scheduled toileting program will be completed monthly x 4. The results of these audits will be taken to the facility QA&A committee. The committee will make recommendations based on the findings of these audits.	

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F 315	Continued From page 9	F 315		

written Resident #4 ' s request on the daily report sheet 5 or 6 times over the last 2 months and no one had addressed it. Nurse #3 commented Resident #4 would benefit by scheduled toileting after meal times since that was when the resident needed to use the bathroom.

Resident #4 was observed sitting on the side of the bed on 02/20/14 at 9:05 AM. When interviewed, Resident #4 reported that usually he knew when he needed to use the bathroom but couldn't always control it. The resident reported having to wait long time periods to be taken to the bathroom especially during meal times. Resident #4 commented that his wheelchair was too large and would not fit through the bathroom door in his room so he had to go to the shower room to be toileted. Resident #4 also reported being dependent upon staff for transfers and was not able to go to the bathroom alone. Resident #4 reported needing to use the bathroom most of the time after meals especially after the lunch meal and there was no staff available to assist with those needs. Resident #4 commented staff did not offer to toilet him and usually depended upon him to let them know when he needed to use the bathroom or needed to be changed. The resident expressed a desire to be taken to the bathroom after meals on a regular basis.

The Assistant Director of Nurses (ADON) was interviewed about scheduled toileting on 02/20/14 at 10:45 AM. She stated there was one resident who was currently on a scheduled toileting program. She stated usually scheduled toileting was an intervention for residents who fell while trying to use the bathroom. The ADON stated Resident #4 was capable of assisting staff with toileting. She commented Resident #4 had a

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F 315	Continued From page 10 daily routine and didn't usually alter the routine and felt would benefit from a scheduled toileting program. The ADON stated she would arrange for staff to assist Resident #4 with toileting after meals. Nurse Aide #1 was interviewed on 02/20/14 at 11:00 AM. She stated Resident #4 always asked to be toileted after meals. She added that the aides who were feeding residents were instructed not to stop feeding residents to take other residents to the toilet. Nurse Aide #1 commented the residents had been instructed to wait until after the meal trays had been picked up before asking to be toileted. She stated Resident #4 was transferred using the stand up lift and it would not be a problem to toilet him. Nurse Aide #1 also stated his wheelchair was too large to fit through the bathroom door in his room so he was taken to the shower room for toileting. She stated Resident #4 was capable of holding onto the side rails in the shower room while staff assisted him with his clothing. Nurse Aide #1 stated Resident #4 could tell staff when he needed to use the toilet and felt scheduled toileting would be of benefit.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		3/20/14

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F 318	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide Restorative Nursing Services for contracture management for one of one resident, Resident #80. Resident #80 is a 95 year old who was admitted to the facility on 07/11/2012 with cumulative diagnoses which included but were not limited to anemia, hypertension, and hypothyroidism. A review of the quarterly Minimum Data Set (MDS) assessment dated 09/22/2013 revealed Resident #80 required extensive assistance with the aid of one person for the resident's bed mobility, transfers, and toilet use. A review of the quarterly MDS assessment dated 12/15/13 revealed the resident's functional status had declined since the previous 09/22/2013 assessment and that she required total assistance for her bed mobility, transfers and toilet use. The MDS assessment dated 12/15/13 also revealed that the resident did not receive Physical Therapy or Restorative Nursing services between 09/22/13 and 12/15/13. The resident's nursing care plan dated 12/23/13 was reviewed and there were no goals or interventions included regarding the resident's limited range of motion or for contracture management. In the resident's medical record, a Physician's Order dated 08/26/2013 was noted as follows: "PT (Physical Therapy) clarification orders for skilled PT services 5 times per week for 4 weeks	F 318	1. Resident #80 was actively dying and expired on 2-28-2014. 2. All residents in the facility will be screened by the Therapy Department by 3-14-14 to identify residents with limited range of motion to assure that they receive the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. The screenings will be documented on the Resident Range of Motion Audit Log. The MDS Department will update the care plans of the identified residents based on the findings of these screens by 3-20-14 and document on the Resident Range of Motion Audit Log that the care plan has been updated. All new residents admitted to the facility will be screened by the Therapy Department within 48 hours of admission to identify any limited range of motion to assure that a plan is put into place to assure they receive the appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. These screenings will be documented on the Resident Range of Motion Audit Log. All new residents identified with limited range of motion will have their care plan updated to include goals and interventions. Once the care plan is updated it will be documented on the Resident Range of Motion Audit Log. 3. The Therapy Department will recommend and/or initiate	

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	345377	A. BUILDING _____ B. WING _____	C 02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 12 to include therex (therapeutic exercise), theract (therapeutic activity), positioning, diathermy (electrically induced heat therapy), and e-stim (electrical stimulation) for contracture management." Additional review of the Physician's Orders revealed an order on 09/20/13 to discontinue skilled PT services. A review of the resident's Special Treatments record revealed there were no Physical Therapy, Occupational Therapy, or Restorative Nursing services provided for the resident from 09/20/13 through 02/10/14. In an observation of the resident on 02/19/14 at 11:05 AM, the resident was lying in bed on her right side in bed with a foam box shaped pillow between her knees and lower legs. The foam pillow had large holes through which her left foot was placed. Both of the resident ' s legs were in the flexed position at her knees and hips, both arms were flexed at the elbows, and both her hands were flexed at her knuckles. An observation of the resident on 02/20/14 revealed the Resident #80 was lying on her back in bed with the head of the bed elevated, arms and legs in the flexed position, and the large square foam pillow between her lower legs. The resident's left foot was placed through a large hole in the pillow in a float position. In an interview with the Rehabilitation Manager at 12:00 noon on 02/18/14, she stated that the resident had just begun diathermy during mid-February 2014 to help loosen her contractures in her legs and that she would be	F 318	treatment/services for those residents identified as having limited range of motion to increase range of motion and/or prevent further decrease in range of motion. When the resident has been discharged from therapy the Therapy Department will initiate a Rehab Instruction Record and inservice the nursing/restorative staff regarding the interventions and goals recommended. The Therapy Department will then forward a copy of this form to the Assistant Director of Nursing/Restorative Manager. The Assistant Director of Nursing/Restorative Manager will then forward a copy of this form to the MDS Department so that the residents care plan can be updated with the goals and interventions. Copies of any Physician orders written will be reviewed by the Assistant Director of Nursing/Restorative Manager and the MDS team to assure compliance with this procedure. 4. Copies of the Resident Range of Motion Audit Log will be submitted to the Interdisciplinary Team weekly. Random audits of at least 5 of the residents listed on the Resident Range of Motion Audit Log will be done weekly x 4 then monthly x 3 by Nursing Management to assure compliance with the goals and interventions identified. The results of these audits will be taken to the facility QA&A Committee. The committee will make recommendations based on the findings of these audits.	

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F 318	Continued From page 13	F 318		

receiving range of motion exercises, as well. She also stated that Physical Therapy (PT) progress notes or evaluations from any dates since admission should be located in her chart, and that if any records were not in her chart, she would provide them.

In an interview on 02/19/14 with Nurse #4 at 11:11 AM she stated that the resident's legs have been in the flexed position for at least several months, perhaps more. She further stated that her arms could be extended to a degree, but that her legs were very difficult to extend. In addition, she stated that the resident used to sit up in a chair for part of the day during the early fall months of 2013.

In an interview with the Assistant Director of Nursing (ADON) on 02/20/14 at 10:45 AM, she stated that Resident #80 was receiving Restorative Nursing Services sometime in September 2013 and that records from that time had been probably been "boxed up." She explained that the restorative range of motion exercises were probably discontinued due to her declining health, and that she would follow up to determine when restorative care was provided for Resident #80.

In a second interview with the ADON on 02/20/14 at 3:27 PM, she stated that a fill-in Physical Therapist had ordered treatment for 08/26/13 for therapeutic exercise, therapeutic activity, positioning, diathermy, and electrical stimulation for contracture management for Resident #80. She explained that the order was referred back to the Physical Therapist because her order for " positioning " for the Restorative Nursing services needed to be clarified. She further explained that

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F 318	Continued From page 14 "positioning" is not a Restorative Nursing Modality and that an altered order was needed to comply with the Restorative Services guidelines. In addition, she stated that the fill-in Physical Therapist completed a Rehabilitation Instruction Record for Resident #80 for Positioning/Splints 6 -7 times per week, to position in upright in chair, neutral spine with abductor wedge for 2- 4 hours. The Physical Therapist also recommended on the Rehabilitation Instruction Record that Special Programs should include range of motion to bilateral hip, knee, and ankle joints (passive) to prevent further contractures. The ADON stated that the fill-in Physical Therapist left during shortly after her order was written and that an altered order was never received for Restorative Nursing Services. In a third interview with the ADON at 5:00 PM on 02/20/14, she stated the Rehabilitation Instruction Record came to her office at some point in late August 2013 or early September 2013, and that she was planning to follow up to obtain a revised Restorative Nursing order, but never did. She also explained that typically, when an order is written for Restorative Services, a Rehabilitation/Restorative Service Delivery Record (RRSDR) is completed and that the Restorative Aide would follow the interventions listed on that form. She stated that in this case, she never completed the RRSDR and never obtained a clarified Restorative Nursing order, and that Resident #80 did not receive Restorative Nursing Services. She explained she simply forgot to follow up to obtain a revised order after the fill-in Physical Therapist left.	F 318		