STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495096	A. BUILDING _____ B. WING _____	05/25/2023

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WESTMINSTER-CANTERBURY OF RICHMOND	1600 WESTBROOK AVE RICHMOND, VA 23227

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/23/23 through 5/25/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/23/23 through 5/25/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 158 certified bed facility was 127 at the time of the survey. The survey sample consisted of 37 resident reviews.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		6/30/23

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

Electronically Signed | 06/09/2023

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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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff	F 582	1. Address how correction will be accomplished for those residents found to	

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F 582	Continued From page 2	F 582		

failed to continue skilled services and bill the Resident as requested on the SNF ABN notice (Skilled Nursing Facility Advance Beneficiary Notice) issued to 1 Resident (Resident #35) in a survey sample of 3 Residents, reviewed for such notices.

The findings included:

On 5/22/23, the facility Administrator was asked to provide a listing of Residents who were discharged from Medicare Part A services. From this listing a sample was selected which included Resident #35. The notices issued to these Residents were reviewed and revealed the following:

1. For Resident #35, the facility staff provided a SNF ABN notice prior to skilled care services ending. On the ABN form option 2 was selected which read, "I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed".

On 5/24/23 at 2:58 PM, an interview was conducted with Employee E, the therapy manager. The therapy manager confirmed that Resident #35 was skilled until 2/1/23, and then continued physical therapy at a lower frequency under Medicare Part B services. The therapy manager went into detail explaining that speech therapy and occupational therapy ended but physical therapy decreased the frequency to three times a week, which was no longer a skilled care level of care.

The therapy manager further confirmed that she

have been affected by the deficient practice:
a.) Resident #35 was no longer receiving skilled services as of 02/01/2023, and received an SNFABN of non-coverage on 01/30/2023. Resident #35 continued to receive Physical therapy under Medicare Part B, 3 days per week. Resident understood that he did not meet Medicare Part A skilled therapy criteria.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
a) Any resident utilizing their Medicare Part A benefits for skilled services, has the potential to be affected by this practice.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
a) The Medicare Notice of Non-Coverage Advanced Beneficiary Notice Policy will be reviewed by the QAPI committee for accuracy and completeness.
b) The Facility Social Workers and Director of Nursing/Designee will receive in-service training on the correct use of the SNFBN by an independent long term care consultant. Education to include:
1. Understand circumstances requiring use of the SNFABN
2. Explain proper completion of the SNFABN
3. Demonstrate understanding of the three choices for option boxes on the SNFABN
4. Understand proper notice

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F 582	Continued From page 3 was not aware that Resident #35 had selected that he wished for skilled therapy services to continue, and he would be financially responsible as per the ABN form. On 05/24/23 at 03:20 PM, Surveyor C met with Employee F, an accountant who provided copies of the UB04 [billing document submitted to Medicare for payment] for Resident #35. The UB04 was reviewed, and Employee F also confirmed that Resident #35 was skilled until February 1, 2023, and following that date only physical therapy was provided and billed to Medicare. On 05/24/23 at 04:04 PM, Surveyor C met with Employee H, the social worker. The social worker stated that, "the ABN is if they are not appealing and are planning to stay with us, they get the ABN form". The social worker was asked to explain the 3 options available for Residents to select and she said, "I've never seen the first one [option 1 selected] but it means they are appealing but maybe plan to stay and acknowledge if Medicare doesn't pay, they are still responsible. The second option is that they aren't appealing but want to stay with us beyond that day and the third option is that they wouldn't want the service and would be leaving". The social worker was shown the ABN form that Resident #35 signed and was asked who highlighted option 2. The social worker said, "I probably highlighted it to remind myself that was the one if he wasn't appealing". The facility policy titled; "Medicare Notice of Non-Coverage Advanced Beneficiary Notice" was reviewed. This policy read, "...The skilled nursing	F 582	concerning the SNFABN 5. Explain the care/reason Medicare may not pay boxes on the SNFABN and examine scenarios with proper language for those boxes. 6. Discuss the requirements for skilled therapy delivery that entitles a beneficiary to a Part A benefit in a SNF. 7. Understand proper use of Part B therapy services after a Part A stay in a SNF. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: a) An independent long term care consultant will preform a 25% audit of all SNFABNs completed monthly x 3 months. Variances discovered during the audit will be investigated and appropriate action taken. Findings from the audit will be reported to the QAPI committee for further recommendations at the next regularly scheduled meeting.	

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facility advanced beneficiary notice (SNFABN) and the Advance Beneficiary Notice (ABN) will offer the Resident or Responsible Party the option of agreeing or disagreeing with the decision... SNFABN and ABN will provide information on the Resident's financial liability for non-covered services and provide the Resident's with the opportunity to have their services billed to Medicare for a determination...".

In the CMS document, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)". This instruction sheet read, "...There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box. If the beneficiary is physically unable to make a selection, the SNF may enter the beneficiary's selection at his/her request and indicate on the notice that this was done for the beneficiary. Otherwise, SNFs are not permitted to select or pre-select an option for the beneficiary as this invalidates the notice...".

The CMS instructions regarding when a resident selects option 2, read: "...When the beneficiary selects Option 2, the care is provided, and the beneficiary pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the beneficiary has no appeal rights. Note: Although Option 2 indicates that Medicare will not be billed, SNFs must still adhere to the Medicare requirements for submitting no pay bills. See Chapter 6 of the Medicare Claims Processing manual for SNF claim submission guidance. ...". Accessed online at:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN-

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F 582	Continued From page 5 On 5/25/23 at approximately 11:50 AM, the facility Administrator was made aware of the above findings. No further information was provided.	F 582		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		6/30/23

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F 625	Continued From page 6 by: Based on interview, clinical record review and facility documentation the facility staff failed to provide bed-hold notice at the time of transfer, for 1 Resident (#130) in a survey sample of 37 Residents. The findings included: For Resident # 130 the facility staff failed to provide the bed hold policy notice at the time of transfer from facility to the ER. Resident #130 was system selected as a closed record for transfer to hospital. On 5/25/23, a review of the clinical record revealed that on 3/21/23, Resident #130 was sent to the Emergency Room due to low oxygen saturation via rescue squad at 8:40 PM. A review of the clinical record revealed that the Resident had a bed hold policy signed on 3/13/23 (8 days prior to the transfer to the hospital). The clinical record contained the copy of the transfer sheet that went to the hospital with the Resident however no bedhold policy was given at the time of transfer. There was no documentation of verbal or phone conversation about bed hold at the time of transfer. On 5/25/23, during the end of day meeting, the Administrator was made aware of the concern and no further information was provided.	F 625	1. Address how correction will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #130 was transferred to the hospital via 911 and expired on 03/22/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: a) 100% of all current residents who are currently in the hospital or other facility, will be completed to ensure that resident/Resident representative have been provided a copy of the bed hold notice. If variances are found, a copy of the bed hold notice will be provided to the resident/resident representative. b) All new admissions will sign a bed hold form upon admission and will receive a copy of this policy if the resident is transferred/discharged to another facility. c) The Social Worker/Designee will explain the bed hold policy to the resident/ resident representative at the time of transfer/discharge, in person or via phone call, if there will be a fee associated with the bed hold, and if they want to hold the bed. A record of this conversation will be documented in the medical record. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a) A nurses note will indicate that a copy of the bed hold policy was given to and	

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F 625	Continued From page 7	F 625	sent with the resident/resident representative upon transfer out of the facility. b) The Social Worker/Designee will make a follow up phone call to the Resident Representative explaining the bed hold policy, for any resident who is not covered by a life care contract, and ask if they would like to hold the bed at the specified daily rate. c) A progress note will be made in the resident's medical record indicating that the Resident/ Resident Representative has either accepted or declined to hold the bed. d) The Facility Educator will educate Licensed Nursing staff on the bed hold policy and the need to give a copy of the bed hold policy to the resident / resident representative with any transfer/discharge from the facility. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: a) The QAPI Nurse/Designee will submit an audit showing 100% of the residents/ resident representatives have documentation in the medical record demonstrating that a copy of the bed hold policy was provided at the time of transfer/discharge, via the transfer template nurses note weekly x 4 weeks, then every other week x 3 months. These audits will be reviewed with the QAPI committee at the next regularly scheduled meetings for further recommendations as needed. b) The Facility Educator/ Designee will	

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F 625	Continued From page 8	F 625	report on the education provided to Licensed Nursing staff on completing the nursing transfer note template and required charting to show a copy was given to and sent with the resident/resident representative. The Facility Educator will report any feedback or recommendations to the QAPI committee for further recommendations as needed.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure that Residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to	F 688	1. Address how correction will be accomplished for those residents found to have been affected by the deficient practice: a) Licensed Nurses and Direct care staff	6/30/23

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F 688	Continued From page 9 prevent further decrease in range of motion, for 1 Resident (#122) in a survey sample of 37 Residents. The findings included: For Resident # 122 the facility staff failed to ensure that the Resident's elbow protectors and resting hand splint were applied correctly as ordered by the physician. On 5/23/23 at approximately 11:30 am, an observation was made of Resident #122 in her wheelchair. Resident #112 was asleep, fully dressed, and she had elbow protectors on both elbows and a resting left hand splint applied over the elbow protector. A cork board in her room displayed written directions for the correct application of the splint as well as a photo Resident #122's left arm with the splint correctly applied. The instruction sheet and photo indicated that the elbow protector was to be over the splint not under the splint as it was observed. On 5/23/23 at 11:30 AM, Resident #122 was observed in her room dozing, eyes closed. Resident #122 had obvious contracture to her left arm and hand. She had elbow protectors on and a blue left hand splint applied over the elbow protector. On 5/23/23 at approximately 4:00 PM, Resident #122 was observed in her room with the splint in the same position over the elbow protector. On 5/24/23 at approximately 9:45 AM Resident # 122 was observed in her room with just palm protectors in her hands no elbow protectors or resting hand splint were applied.	F 688	for resident #122 were educated on the proper application, times and pictures associated with proper placement of the Posey elbow protectors, resting left hand splint and palm protectors for this resident on 5/25 & 05/26/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: a) The Unit Managers/ Designee will perform a 100% chart audit and identify any resident using adaptive/medical equipment that must be applied by staff to the residents body. b) The Unit Manager/ Designee will ensure that any resident identified will have clear instructions of application and management outlined in the medical record/ care plan. c) The Unit Manager/ Designee will ensure that any resident with a splint has a photo and clear instructions of how the splint is to be applied displayed in the residents room for staff to refer to. d) Any resident who does not have a picture with instructions of proper application of any splint, will be reported to the Director of Rehab, and obtain this information and ensure it is posted in the residents room. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a) The Facility Educator/Designee will educate nursing staff on the importance of proper splint placement and follow	

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F 688	Continued From page 10 On 5/24/23 at approximately 2:20 PM Resident #122 was observed again with just palm protectors no splint or elbow protectors. A review of the clinical record revealed the following orders for the splint application: "Posey Elbow protectors to bilateral elbows at all times (as tolerated) - remove every shift for skin check and reapply - Every shift (12 hr. shifts)." A review of the clinical record revealed no mention of refusal or resistance to care. Resident #122 is nonverbal and has a BIMS (Brief Interview of Mental Status) of ninety-nine. On 5/23/23 at approximately 4:15 PM, an interview was conducted with RN B who stated that the picture and instruction sheet were the correct way to apply the splint and elbow protectors. When asked who placed that information on the board RN B stated that the OT (Occupational Therapy) department did that so that nurses would apply it correctly. On 5/24/23 at 2:06 PM, an interview was conducted with LPN C and she was asked who applies the splint for Resident #122. LPN C stated it was the nurses responsibility to apply the splints. On 5/24/23 at 2:45 PM, an interview was conducted with Employee E (OT) who was asked why the elbow protectors go over the splint. Employee E stated when we had them under the splint the pressure of the splint made the elbow protectors leave marks, like the elastic of a sock after you have been wearing it all day. When	F 688	instructions inside closet door in bathroom (or where the care plan identifies it will be located). 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: a) The Unit Managers/Designee will randomly check 3 residents on each unit with adaptive/medical equipment for proper documentation, complete instructions, and correct placement at proper times twice a week x 3 weeks, then weekly x 3 weeks, then monthly x 2 months. b) The Unit Managers/ Designee will randomly check 3 residents (If applicable) on each unit for proper splint placement photos times twice a week x 3 weeks, then weekly x 3 weeks, then monthly x 2 months. c) The Unit Managers/ Designee will investigate and report any variances discovered during the audit and appropriate actions taken. Findings from the audit will be reported to the QAPI committee for further recommendations at the next regularly scheduled meeting. d) The Unit Managers/ Designee will report any variances, on the presence of photo□s related to splint application, posted in residents rooms to the QAPI committee for further recommendations at the next regularly scheduled QAPI meeting.	

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F 688	Continued From page 11 asked how long the splints were to be applied she stated as the physician ordered unless the Resident is not tolerating them. When asked what should be done if the Resident is resistant or not tolerating them she stated that the nursing staff should document that so that PT/OT and the MD will know. On 5/25/23 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided.	F 688		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495096	A. BUILDING _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER-CANTERBURY OF RICHMOND	1600 WESTBROOK AVE RICHMOND, VA 23227

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F 842	Continued From page 12	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 13 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure an accurate medical record for 1 Resident (#69) in a survey sample of 37 Residents. The findings included: For Resident #69 the facility staff failed to correctly enter an order for morphine. On 5/25/23 during the clinical record review it was noted that on 12/11/22 an order was put in the system for Morphine 20 mg every hour PRN. The order stayed on the MAR (Medication Administration Record) as a valid order until 1/4/23 when a pharmacy review was conducted. At the time of the pharmacy review the pharmacy sent a notice that read: "***Clinically Urgent Recommendation Prompt Response Requested****" "[Resident #69 name redacted] medication administration record (MAR) or prescriber order sheets (POS) items that need clarification: Current order on the MAR for PRN Morphine = 20 mg every hour PRN. Pharmacy records indicate Morphine 20 mg / ml give 0.25 ml q hour PRN. Recommendation: Please clarify with MD and adjust the dose on the MAR." The facility corrected the dose on 1/4/23 after being notified by the pharmacy. The correct dose should have been 0.25 ml (5 mg) not 20 mg every	F 842	1. Address how the correction will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #69 was found to have had an order for morphine entered on 12/11/22 without a dosage included. The order was written for morphine 20mg/1ml. The order was originally ordered by the physician as Morphine 20mg/ml give 0.25ml Q 1 hour PRN. The order was reviewed by the consulting pharmacist on 1/4/23 when the transcription error was noted. The consulting pharmacist notified the nurse on duty who corrected the order on 1/4/23. The resident had never received the medication during that time. 2. Address how the facility will identify other resident having the potential to be affected by the same deficient practice: a) Medication orders for current residents will be reviewed and clarifications obtained from the practitioner if needed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a) The clinical educator/designee will educate LPNs and RNs on order entry including review and transcription of the order into the computer order entry system (MatrixCare). b) The Facility Educator/designee will educate LPNs and RNs on completion of	

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F 842	Continued From page 14 hour. On 5/25/23 at 11:00 AM interview was conducted with RN B who stated that she did not know how the mistake was made but that it was a transcription error, and she was glad the medication was not given. She stated had the medication been given it would have been an overdose of an opiate. When asked what could have happened with an opiate overdose, she stated the Resident could become lethargic, sleepy, have depressed respirations and become unresponsive. On 5/25/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 842	24-hour chart checks which double check for order accuracy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: a) A 100% audit will be completed by the QAPI nurse or designee on all oral concentration of medications for residents admitted to the facility on date of survey exit. Findings from the audit will be reported to the QAPI committee for further recommendations at the next regularly scheduled meeting. b) The unit managers or designee will review all new medication orders for their units within 72 hours of the order entry daily x 7, weekly x 2, every other week x 2 for accuracy in transcription and that the order includes all required information such as drug name, time of administration, dosage, concentration, etc.	