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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/05/2014 |
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| NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC | STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421 |
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| W000000 | <p>This visit was for the investigation of complaint #IN00153670.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the full recertification and state licensure survey completed on 6/25/14.</p> <p>Complaint #IN00153670 - Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W153, W154 and W331.</p> <p>Survey Dates: August 1, 2, 4 and 5, 2014</p> <p>Facility Number: 001165 Provider Number: 15G650 AIM Number: 100240230</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/11/14 by Ruth Shackelford, QIDP.</p> | W000000 | | |
| W000149 | <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement</p> | | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client B, the facility neglected to implement its policies and procedures to ensure staff immediately contacted the administrator to report an incident of neglect, submit the incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, and conduct an investigation of the incident.</p> <p>Findings include:</p> <p>On 8/1/14 at 1:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/27/14 (no time indicated), an email sent from staff #5 to the Qualified Intellectual Disabilities Professional (QIDP) indicated, in part, "Earlier today [client B] decided to take the trash out without staff knowledge. We saw her walk down the hall and assumed she was going to her room. I took [client A] to the bathroom, while in there I heard a door shut and thought it was [client B's] bedroom door. Once I had [client A] back in the front room [staff #8] came walking into the front door with [client B]. She said [client B] was standing at the back door waiting for it to open. This only lasted a matter of</p> | W000149 | <p>Addendum: W149 Facility Associate Manager who failed to report abuse and neglect along with encouraged staff to not report allegations is no longer employed with Stone Belt Current Associate Manager is aware of reporting protocol along with staff W153 Facility Associate Manager is no longer employed with the agency along with the house manager. Current manager and associate manager have been trained how to report abuse and neglect as well as staff W331 Facility staff have been trained and emailed an instructing video as resource to assist them in preparing nectar thick liquids All meal times are being monitored by staff who are working in the home and to report concerns if they witness another staff not following order W149 483.420(d)(1) STAFF TREATMENT OF CLIENTS Corrective action for resident(s) found to have been affected (Plan of correction): Staff were trained on prevention of abuse and neglect (attachment w149a w149b). Measures or</p> | 09/19/2014 | |

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| | <p>2-3 minutes. [Staff #8] told [staff #4 - Associate Manager] about this incident and he spoke to me and [staff #6] separately then informed us both that we are to not say anything to anyone. Not to other staff or [client D. He even said he had told [staff #8] the same thing to keep it quiet. He asked me why I didn't know [client B] went out and I told him I had [client A] in the bathroom and heard a door shut but didn't realize it was the back door and he asked [staff #6] why she didn't know and she stated that she heard the door but thought it was her bedroom door and she couldn't rush to get up because she had been jerked the day before by him and has had to wear a back brace just to move."</p> <p>The facility did not have documentation indicating a Stone Belt ARC Incident Report, a Bureau of Developmental Disabilities Services (BDDS) report or an investigation was completed.</p> <p>On 8/4/14 at 11:38 AM, there was no documentation in client B's record indicating the incident occurred.</p> <p>On 8/2/14 at 9:18 AM, staff #4 indicated he was not aware of any of the clients leaving the house unsupervised in the past few weeks.</p> | | <p>systemicchanges facility put in place to ensure no recurrence (Plan of prevention) Facility Qdip/ Coordinator received a warning concerning the failure to follow Stone Belt's policy concerning treatment of clients. Email was sent outspecifying the guidelines of reporting abuse and neglect along with chain ofcommand (attachment w149c). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will continue to review all reports /allegations of abuse and neglect. They will investigate issues and providesupport, training, and other changes as needed.</p> | | |

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| | <p>On 8/2/14 at 9:33 AM, staff #5 indicated on 7/27/14, she sent an email to the QIDP indicating staff #8 found client B standing at the back side door when staff #8 returned from dropping off another client at work. Staff #5 indicated she called the QIDP who asked staff #5 to send her an email with the information regarding the incident. Staff #5 indicated client B was outside for approximately 2 minutes in the fenced in back yard. Staff #5 indicated the side door could not be opened from the outside so when client B went out to take out the trash, she could not get back in. Staff #5 indicated she heard a door close but at the time thought it was client B's bedroom door and not the door to the outside. On 8/2/14 at 10:11 AM, staff #5 indicated staff #4 told her not to discuss the incident with anyone so staff #4 would not get into trouble.</p> <p>On 8/2/14 at 10:25 AM, staff #1 (Manager) indicated she was aware of the incident in which client B was found outside the group home by staff #8. Staff #1 indicated the QIDP was also aware of the incident. The Manager indicated she was not sure if an incident report was completed. The Manager indicated client B needed 24 hour supervision and the incident should have been documented on an incident report. The Manager</p> | | | | | | |

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| | <p>stated the incident was "very unusual."</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated she was not aware of the incident. The Director indicated the staff did not contact her (the administrator). The Director indicated the incident should have been documented on a Stone Belt ARC Incident Report, a report submitted to BDDS and an investigation conducted.</p> <p>On 8/1/14 at 2:12 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity</p> | | | | | | |

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| | <p>and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as</p> | | | |

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| W000153 | <p>described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events."</p> <p>This federal tag relates to complaint #IN00153670.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client B, the facility failed to ensure staff immediately contacted the administrator to report an incident of neglect and submitted a report of the incident to the Bureau of Developmental Disabilities Services</p> | W000153 | <p>W153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law</p> | 08/11/2014 |

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| | <p>(BDDS) in a timely manner, within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 8/1/14 at 1:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/27/14 (no time indicated), an email sent from staff #5 to the Qualified Intellectual Disabilities Professional (QIDP) indicated, in part, "Earlier today [client B] decided to take the trash out without staff knowledge. We saw her walk down the hall and assumed she was going to her room. I took [client A] to the bathroom, while in there I heard a door shut and thought it was [client B's] bedroom door. Once I had [client A] back in the front room [staff #8] came walking into the front door with [client B]. She said [client B] was standing at the back door waiting for it to open. This only lasted a matter of 2-3 minutes. [Staff #8] told [staff #4 - Associate Manager] about this incident and he spoke to me and [staff #6] separately then informed us both that we are to not say anything to anyone. Not to other staff or [client D]. He even said he had told [staff #8] the same thing to keep it quiet. He asked me why I didn't know [client B] went out and I told him I had [client A] in the bathroom and heard a</p> | | <p>through established procedures.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction): Staff were trained on reporting abuse and neglect to administer and state report will be submitted in a timely manner (attachment w149a w149b).</p> <p>Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Facility Qdip/ Coordinator received a warning concerning the failure to follow Stone Belt's policy on reporting abuse and neglect to administer and submitting a report. Email was sent out specifying the guidelines of reporting abuse and neglect along with chain of command (attachment w149c).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will continue to review all reports / allegations of abuse and neglect. They will investigate issues and provide support, training, and other changes as needed.</p> | | | | |

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| | <p>door shut but didn't realize it was the back door and he asked [staff #6] why she didn't know and she stated that she heard the door but thought it was her bedroom door and she couldn't rush to get up because she had been jerked the day before by him and has had to wear a back brace just to move."</p> <p>The facility did not have documentation indicating a Stone Belt ARC. Incident Report, a Bureau of Developmental Disabilities Services (BDDS) report or an investigation were completed.</p> <p>On 8/4/14 at 11:38 AM, there was no documentation in client B's record indicating the incident occurred.</p> <p>On 8/2/14 at 9:18 AM, staff #4 indicated he was not aware of any of the clients leaving the house unsupervised in the past few weeks.</p> <p>On 8/2/14 at 9:33 AM, staff #5 indicated on 7/27/14, she sent an email to the QIDP indicating staff #8 found client B standing at the back side door when staff #8 returned from dropping off another client at work. Staff #5 indicated she called the QIDP who asked staff #5 to send her an email with the information regarding the incident. Staff #5 indicated client B was outside for approximately 2</p> | | | |

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| | <p>minutes in the fenced in back yard. Staff #5 indicated the side door could not be opened from the outside so when client B went out to take out the trash, she could not get back in. Staff #5 indicated she heard a door close but at the time thought it was client B's bedroom door and not the door to the outside. On 8/2/14 at 10:11 AM, staff #5 indicated staff #4 told her not to discuss the incident with anyone so staff #4 would not get into trouble.</p> <p>On 8/2/14 at 10:25 AM, staff #1 (Manager) indicated she was aware of the incident in which client B was found outside the group home by staff #8. Staff #1 indicated the QIDP was also aware of the incident. The Manager indicated she was not sure if an incident report was completed. The Manager indicated client B needed 24 hour supervision and the incident should have been documented on an incident report. The Manager stated the incident was "very unusual."</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated she was not aware of the incident. The Director indicated the staff did not contact her (the administrator). The Director indicated the incident should have been reported to BDDS.</p> | | | | | | |

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| W000154 | <p>This federal tag relates to complaint #IN00153670.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 8 incident/investigative reports reviewed affecting client B, the facility failed to conduct an investigation of an incident of neglect.</p> <p>Findings include:</p> <p>On 8/1/14 at 1:26 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/27/14 (no time indicated), an email sent from staff #5 to the Qualified Intellectual Disabilities Professional (QIDP) indicated, in part, "Earlier today [client B] decided to take the trash out without staff knowledge. We saw her walk down the hall and assumed she was going to her room. I took [client A] to the bathroom, while in there I heard a door shut and thought it was [client B's] bedroom door. Once I</p> | W000154 | <p>W154 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Corrective action for resident(s) found to have been affected (Plan of correction): Investigation was completed regarding allegation of abuse and neglect that was unsubstantiated (attachment 154a).</p> <p>Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Staff were trained on reporting abuse and neglect to administer and state report will be submitted in a timely manner (attachment w153b w153c). Facility Qdip/ Coordinator received a warning concerning the failure to follow Stone Belt's policy on reporting abuse and neglect to</p> | 08/11/2014 |

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| | <p>had [client A] back in the front room [staff #8] came walking into the front door with [client B]. She said [client B] was standing at the back door waiting for it to open. This only lasted a matter of 2-3 minutes. [Staff #8] told [staff #4 - Associate Manager] about this incident and he spoke to me and [staff #6] separately then informed us both that we are to not say anything to anyone. Not to other staff or [client D. He even said he had told [staff #8] the same thing to keep it quiet. He asked me why I didn't know [client B] went out and I told him I had [client A] in the bathroom and heard a door shut but didn't realize it was the back door and he asked [staff #6] why she didn't know and she stated that she heard the door but thought it was her bedroom door and she couldn't rush to get up because she had been jerked the day before by him and has had to wear a back brace just to move."</p> <p>The facility did not have documentation indicating a Stone Belt ARC Incident Report, a Bureau of Developmental Disabilities Services (BDDS) report or an investigation was completed.</p> <p>On 8/4/14 at 11:38 AM, there was no documentation in client B's record indicating the incident occurred.</p> | | <p>administer and submitting a report (w153c).</p> <p>How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Director will continue to review all reports / allegations of abuse and neglect. They will investigate issues and provide support, training, and other changes as needed.</p> | | | | |

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| | <p>On 8/2/14 at 9:18 AM, staff #4 indicated he was not aware of any of the clients leaving the house unsupervised in the past few weeks.</p> <p>On 8/2/14 at 9:33 AM, staff #5 indicated on 7/27/14, she sent an email to the QIDP indicating staff #8 found client B standing at the back side door when staff #8 returned from dropping off another client at work. Staff #5 indicated she called the QIDP who asked staff #5 to send her an email with the information regarding the incident. Staff #5 indicated client B was outside for approximately 2 minutes in the fenced in back yard. Staff #5 indicated the side door could not be opened from the outside so when client B went out to take out the trash, she could not get back in. Staff #5 indicated she heard a door close but at the time thought it was client B's bedroom door and not the door to the outside. On 8/2/14 at 10:11 AM, staff #5 indicated staff #4 told her not to discuss the incident with anyone so staff #4 would not get into trouble.</p> <p>On 8/2/14 at 10:25 AM, staff #1 (Manager) indicated she was aware of the incident in which client B was found outside the group home by staff #8. Staff #1 indicated the QIDP was also aware of the incident. The Manager indicated she</p> | | | |

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| W000331 | <p>was not sure if an incident report was completed. The Manager indicated client B needed 24 hour supervision and the incident should have been documented on an incident report. The Manager stated the incident was "very unusual."</p> <p>On 8/4/14 at 11:43 AM, the Director of Supervised Group Living indicated she was not aware of the incident. The Director indicated the staff did not contact her (the administrator). The Director indicated the incident should have been investigated.</p> <p>This federal tag relates to complaint #IN00153670.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (A), the facility's nursing services failed to ensure client A had a plan for staff to administer an as needed pain medication.</p> <p>Findings include:</p> | W000331 | <p>Addendum: Facility Qidp or house manager will monitor and document mealtimes - no less than 5 times weekly – to make certain staff are following dining plans asordered. This level of monitoring will be reviewed by team each quarter and maypossibly decrease.</p> | 08/11/2014 |

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| | <p>A review of client A's Medication Administration Record, dated June 2014, July 2014 and August 2014, was conducted on 8/2/14 at 9:23 AM. Client A received hydrocodone on 6/10/14, 6/14/14, 6/15/14 (twice), 6/16/14, 6/20/14, 6/21/14, 6/23/14, 7/1/14, 7/12/14, 7/13/14, 7/16/14, 7/18/14, 7/20/14, and 7/25/14.</p> <p>Client A's Medication Information Sheet (MIS), dated 7/23/14, indicated client A's medications include the use of hydrocodone (Norco) as needed for pain. The MIS did not include specific instructions to staff on when to administer the medication. Client A's Behavior Plan, dated 4/4/14, indicated client A had a targeted behavior of screaming/yelling. The plan indicated, in part, "Proactive or Preventative Strategies: Staff should be aware that if [client A] is exhibiting screaming/yelling this is many times her way of expressing that she is in pain. Staff can offer [client A] Tylenol or her PRN (as needed) medication for pain."</p> <p>On 8/4/14 at 1:35 PM, the Director of Supervised Group Living forwarded an email from the Licensed Practical Nurse to client A's interdisciplinary team. On 8/1/14 at 1:08 PM, the LPN indicated, "For all of you that were at the meeting</p> | | <p>W331 483.460(c) NURSING SERVICES The facility must provide clients with nursing 1) Corrective action for resident(s) found to have been affected (Plan of correction): MIS / HRP have been developed for staff to administer client A's medication for pain PRN (attachment w331a). Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention): Nurse has been trained to complete assessments on all clients to create accurate MIS/HRP plans. How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will review MIS/HRP - no less than 2 times weekly – to make certain staff are following plans and that they have been written correctly. This level of monitoring will be reviewed by team each quarter and may possibly decrease. 2) Corrective action for resident(s) found to have been affected (Plan of correction): Facility Director emailed staff immediately following the survey a link explaining what nectar sweet looks like and how to prepare it properly (attachment w159a). Measures or systemic changes facility put in place to ensure no recurrence (Plan of prevention) Staff have been</p> | |

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| | <p>today, I want to clarify that I DO NOT want [client A] to be in pain, I just want you to be more discriminant (sic). I am aware that many times [client A] has more pain the day AFTER she receives her patch. This is probably do (sic) to medication absorbtion (sic) issues due to her age. (Remember CORE B?) I just want you to be more aware and ask the following questions FIRST, (as discussed at the meeting:) When did she have her LAST Fentanyl patch? When does she receive the patch again? Is this REALLY 'breakthrough pain,' or she upset about something? How many doses of Hydrocodone has she received in the last 2 days? Is she just being loud? Once these questions have been asked AND you know it is safe to give her PRN, then you may proceed with giving her the medication." There was no documentation this information was included in a plan for administering client A's pain medication.</p> <p>On 8/4/14 at 2:46 PM, the Behavior Specialist indicated in an email to client A's interdisciplinary team, "The team is currently revising [client A's] plans to make it easier for staff identify when it is appropriate to give her a PRN for pain. As many of you have worked with [client A] much longer than I have, I wanted to ask you all about any warning signs that</p> | | <p>trained by DON at a staff meeting how to properly prepare client B's thick it – nectar thick (attachment w159b). How corrective actions will be monitored to ensure no recurrence (Plan of monitoring) Facility Qidp or house manager will monitor and document mealtimes - no less than 5 times weekly – to make certain staff are following dining plans as ordered. This level of monitoring will be reviewed by team each quarter and may possibly decrease.</p> | | | | |

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| | <p>let you know [client A] is in pain. How can you tell when [client A] is in pain and when she may just be exhibiting attention-seeking behaviors? How does she communicate that she is in pain? Does she show certain facial expressions or body language when she is in pain? Also, are there certain signs that suggest her screaming/yelling may be attention-seeking behavior? Does the behavior stop if it is ignored?...".</p> <p>On 8/4/14 at 1:33 PM, the Director of Supervised Group Living indicated client A should have a plan included on her Medication Information Sheet (MIS) for the use of the pain medication. The Director indicated the facility used the MIS as the risk plan therefore the use of client A's pain medication should be included on the MIS. The Director indicated the nurse sent her an email recently discussing client A's pain pill. The Director indicated the nurse had a conversation with the staff regarding when to administer client A's pain pill. The Director indicated the information presented to the staff in the email needed to be included in a plan. The Director indicated the staff needed written instructions defining when to administer the pain pill.</p> <p>On 8/5/14 at 11:00 AM, the Nurse</p> | | | |

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| | <p>Manager (NM) indicated he was not aware of written instructions to staff as to when the staff should administer client A's pain medication with the exception of the doctor's order (oral pain medication every 6 hours as needed for pain). The NM indicated the facility needed to get clarifying information from the physician to know when staff were to administer the medication. The NM indicated the order was subjective as when to given the medication. The NM indicated client A needed a plan for staff to follow to know when her pain medication should be administered.</p> <p>This federal tag relates to complaint #IN00153670.</p> <p>9-3-6(a)</p> | | | |