

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G417	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5625 E 56TH ST INDIANAPOLIS, IN 46226
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W 000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: February 10, 11, 12, 13 and 16, 2015.</p> <p>Facility Number: 000931 Provider Number: 15G417 AIM Number: 100244550</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed February 23, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 additional client (client #8), the facility failed to implement their policy and procedures by failing to ensure a</p>	W 149	The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when	03/18/2015

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>complete and thorough investigation was completed within 5 working days.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 2/10/15 at 3:45 PM and included the following:</p> <p>A BDDS report dated 12/24/15 at 7:30 PM indicated client #8 was taken to an urgent care clinic for "signs of a common cold (coughing and wheezing)...." Client #8 was taken to the ER (emergency room) for further evaluation at the recommendation of the urgent care clinic and was admitted to the hospital for evaluation.</p> <p>A BDDS report dated 1/6/15 at 6:00 AM indicated client #8 "didn't respond to normal cues." Client #8 was assessed by staff and found to be without a pulse. Staff called 911 and started CPR (cardiopulmonary resuscitation). EMTs (emergency medical technicians) arrived and pronounced client #8 dead after their attempts at resuscitation failed.</p> <p>An attached investigation dated 1/15/15 to the above BDDS report indicated client #8's medical records, including the</p>		<p>the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director. The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough, the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. The Area Director will take corrective action if needed when investigation requirements have not been met. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation</p>	

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	<p>December, 2014 medication administration record (MAR) had been reviewed. A Time Line of Events indicated:</p> <p>12/23/14- client #8 indicated she was not feeling well and had a temperature of 98.9.</p> <p>12/24/14-the nurse was contacted and client #8 was taken to an urgent care center and was then referred to the ER and hospitalized for "flu-like symptoms."</p> <p>12/29/14-client #8 was discharged from the hospital and assessed by the nurse with a temperature of 98.8, respirations 20 with O2 (oxygen) sat (saturation) 93% with supplemental oxygen.</p> <p>12/31/14-"According (to a) Nursing Note [client #8] was doing well. Toileting herself. Ate dinner and had ice cream and cake. Temp (temperature) 98.7, BP (blood pressure) 130/76, pulse 94, respirations 20, O2 sat 94%.)"</p> <p>1/5/15-Follow-up with Primary Care Physician (PCP). Chest x-ray scheduled for 1/6/14 (sic) to rule out pneumonia. Started Azithromycin 500 mg (milligrams) day 1 and 250 mg for the next 4 days.</p> <p>1/6/15-"[Client #8] found unresponsive. Staff report calling 911 and starting CPR". The conclusion of the investigation indicated "Death certificate supports [client #8] died from hypoxia,</p>		<p>needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Staff: Program Director, Area Director, Quality Assurance Specialist</p>	

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	<p>influenza, schizophrenia...."</p> <p>The group home nurse was interviewed on 2/10/15 at 6:10 PM. She indicated client #8 had been seen by her PCP on 1/5/15 and the PCP had ordered a chest x-ray for 1/6/15. She indicated client #8 had been discharged from the hospital with oxygen via a nasal cannula (hose), and indicated client #8 had received the flu vaccine in September, 2014. She indicated client #8 had gotten up at 2:15-2:30 AM on 1/6/15 to toilet and was in no apparent distress.</p> <p>Nursing Notes regarding client #8 from 12/23/14-1/6/15 were reviewed on 2/12/15 at 11:00 AM. A nursing note dated 1/5/15 indicated client #8 had been seen by her PCP on 1/5/15 for a post hospitalization appointment. The note indicated client #8 was given an antibiotic and received a new order to obtain a chest x-ray on 1/6/15 "to rule out pneumonia." The note indicated client #8's vital signs indicated a temperature of 98.8, and O2 sat was 91%.</p> <p>Two copies of client #8's January, 2015 MAR were reviewed on 2/12/15 at 11:05 AM. One copy failed to indicate documentation that client #8 used O2 on 1/5/15 after 2:00 PM. Another copy indicated staff signatures in the</p>			

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	<p>documentation section of the MAR for the 1/5/15 shifts 2:00 PM-10:00 PM and from 10:00 PM until 6:00 AM.</p> <p>The Area Director was interviewed on 12/12/15 at 12:01 PM and indicated staff should have been marking client #8's use of oxygen on each shift. She indicated the investigation did not include the review of client #8's January, MAR unless indicated and the investigation was not completed within 5 business or working days.</p> <p>The Group Home nurse was interviewed on 2/12/15 at 3:25 PM and indicated staff should have marked the MAR for client #8's use of the oxygen. She indicated client #8 would initiate the use of the O2 independently even without the assistance of staff and had been using the oxygen when she assessed client #8 at 3:00 PM on 1/5/15.</p> <p>The facility's Quality and Risk Management policy dated April, 2011 was reviewed on 2/12/15 at 11:30 AM and indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process</p>			

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W 154 Bldg. 00	<p>identifying, evaluating and reducing risk to which individuals are exposed." Incidents reported to BDDS included, "Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...Failure to provide appropriate supervision, care or training...Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardized the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident." 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>			

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 additional client (client #8), the facility failed to ensure a complete and thorough investigation was completed.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 2/10/15 at 3:45 PM and included the following:</p> <p>A BDDS report dated 12/24/15 at 7:30 PM indicated client #8 was taken to an urgent care clinic for "signs of a common cold (coughing and wheezing)..." Client #8 was taken to the ER (emergency room) for further evaluation at the recommendation of the urgent care clinic and was admitted to the hospital for evaluation.</p> <p>A BDDS report dated 1/6/15 at 6:00 AM indicated client #8 "didn't respond to normal cues." Client #8 was assessed by staff and found to be without a pulse. Staff called 911 and started CPR (cardiopulmonary resuscitation). EMTs (emergency medical technicians) arrived and pronounced client #8 dead after their attempts at resuscitation failed.</p>	W 154	<p>The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director. The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary</p>	03/18/2015

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	<p>An attached investigation dated 1/15/15 to the above BDDS report indicated client #8's medical records, including the December, 2014 medication administration record (MAR), had been reviewed. A Time Line of Events indicated:</p> <p>12/23/14- client #8 indicated she was not feeling well and had a temperature of 98.9.</p> <p>12/24/14-the nurse was contacted and client #8 was taken to an urgent care center and was then referred to the ER and hospitalized for "flu-like symptoms."</p> <p>12/29/14-client #8 was discharged from the hospital and assessed by the nurse with a temperature of 98.8, respirations 20 with O2 (oxygen) sat (saturation) 93% with supplemental oxygen.</p> <p>12/31/14-"According (to a) Nursing Note [client #8] was doing well. Toileting herself. Ate dinner and had ice cream and cake. Temp (temperature) 98.7, BP (blood pressure) 130/76, pulse 94, respirations 20, O2 sat 94%.)..."</p> <p>1/5/15-Follow-up with Primary Care Physician (PCP). Chest x-ray scheduled for 1/6/14 (sic) to rule out pneumonia. Started Azithromycin 500 mg (milligrams) day 1 and 250 mg for the next 4 days.</p> <p>1/6/15-"[Client #8] found unresponsive.</p>		<p>changes will be made. The Area Director will take corrective action if needed when investigation requirements have not been met. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Staff: Program Director, Area Director, Quality Assurance Specialist</p>	

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	<p>Staff report calling 911 and starting CPR". The conclusion of the investigation indicated "Death certificate supports [client #8] died from hypoxia, influenza, schizophrenia...."</p> <p>The group home nurse was interviewed on 2/10/15 at 6:10 PM. She indicated client #8 had been seen by her PCP on 1/5/15 and the PCP had ordered a chest x-ray for 1/6/15. She indicated client #8 had been discharged from the hospital with oxygen via a nasal cannula (hose).</p> <p>Two copies of client #8's January, 2015 MAR were reviewed on 2/12/15 at 11:05 AM. One copy failed to indicate documentation that client #8 used O2 on 1/5/15 after 2:00 PM. Another copy indicated staff signatures in the documentation section of the MAR for the 1/5/15 shifts 2:00 PM-10:00 PM and from 10:00 PM until 6:00 AM.</p> <p>The Area Director was interviewed on 2/12/15 at 12:01 PM and indicated staff should have been marking client #8's use of oxygen on each shift. She indicated the investigation did not include the review of client #8's January, MAR unless indicated.</p> <p>9-3-2(a)</p>			

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W 156 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 additional client (client #8), the facility failed to ensure an investigation was completed within 5 business or working days.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 2/10/15 at 3:45 PM and included the following:</p> <p>A BDDS report dated 1/6/15 at 6:00 AM indicated client #8 "didn't respond to normal cues." Client #8 was assessed by staff and found to be without a pulse. Staff called 911 and started CPR (cardiopulmonary resuscitation). EMTs (emergency medical technicians) arrived and pronounced client #8 dead after their</p>	W 156	The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director. The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance	03/18/2015

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W 263 Bldg. 00	<p>attempts at resuscitation failed.</p> <p>An attached investigation dated 1/15/15 to the above BDDS report indicated client #8's medical records including the December, 2014 medication administration record (MAR) had been reviewed. The conclusion of the investigation indicated "Death certificate supports [client #8] died from hypoxia, influenza, schizophrenia...."</p> <p>The Area Director was interviewed on 2/12/15 at 12:01 PM and indicated the investigation was not completed within 5 business or working days.</p> <p>9-3-2(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal</p>		<p>Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. The Area Director will take corrective action if needed when investigation requirements have not been met. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Staff: Program Director, Area Director, Quality Assurance Specialist</p>		

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	<p>guardian.</p> <p>Based upon record review and interview, the facility failed for 2 of 3 sampled clients (#1 and #2), to ensure consent was obtained by their health care representative/guardians for their behavior plans which included restrictive interventions (psychotropic medication).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/12/15 at 9:35 AM. Client #1's record indicated he had a health care representative to assist him in making decisions. A Behavioral Support Plan dated March, 2014 indicated target objectives of verbal aggression, extreme irritability, manipulation/misleading statements, and intentional falls to gain attention. Client #1's plan included the use of escitalopram (anti-depressant) 10 mg (milligrams). A signature page indicated the facility's Human Rights Committee (HRC) had reviewed and approved the plan on 3/12/14. There was no evidence in the record client #1's health care representative (HCR) had signed consent for the plan.</p> <p>Client #2's record was reviewed on 2/12/15 at 11:30 AM. Client #2's ISP (Individual Support Plan) dated 2/20/14</p>	W 263	<p>The Program Director will receive retraining on ensuring that any updates or changes to consumers' Behavior Support Plans or psychotropic medications are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Ongoing the Program Director will ensure any updates or changes to consumers' Behavior Support Plans or psychotropic medications are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Program Director will ensure that documentation of guardian or client approval is available for review. Prior to any future Human Rights Committee meetings, the HRC will be reminded that they should not approve any changes to Behavior Support Plans or psychotropic medications without ensuring that guardian or client, if emancipated, approvals have been obtained.</p> <p>ResponsibleParty: Program Director, Human Rights Committee</p>	03/18/2015			

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	<p>indicated he was emancipated. A Behavioral Support Plan dated March, 2014 indicated targeted objectives of physical aggression and temper outburst. The plan included the use of Cymbalta 60 mg (anti-depressant). The signature page for the plan indicated client #2 signed consent for his plan (undated). Client #2's Informed Consent Skills list dated 12/10/14 indicated client #2 required assistance in making decisions.</p> <p>An Indiana Appointment of Health Care Representative dated 6/21/13 indicated client #2 had appointed a HCR. There was no evidence client #2's HCR had signed consent for his plan. A signature page indicated the facility's Human Rights Committee (HRC) had reviewed and approved the plan on 3/12/14.</p> <p>The Area Director was interviewed on 2/16/15 at 3:08 PM and indicated there was no evidence of informed consent from their HCRs for clients #1 and #2's plans.</p> <p>9-3-4(a)</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5625 E 56TH ST INDIANAPOLIS, IN 46226
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W 331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing services failed for 1 additional client (client #8) to ensure health care interventions were documented in the client record.</p> <p>Findings include:</p> <p>The group home nurse was interviewed on 12/10/15 at 6:10 PM. She indicated client #8 had been seen by her PCP (primary care physician) on 1/5/15 and the PCP had ordered a chest x-ray for 1/6/15. She indicated client #8 had been discharged from the hospital on 12/29/14 with oxygen via a nasal cannula (hose).</p> <p>Two copies of client #8's January, 2015 MAR (medication administration record) were reviewed on 2/12/15 at 11:05 AM. One copy failed to indicate documentation that client #8 used O2 (oxygen) on 1/5/15 after 2:00 PM. Another copy indicated staff signatures in the documentation section of the MAR for the 1/5/15 shifts 2:00 PM-10:00 PM and from 10:00 PM until 6:00 AM.</p> <p>The Area Director was interviewed on</p>	W 331	<p>All Direct Care staff, Home Manager, Program Director and Program Nurse will receive retraining on medication administration documentation including ensuring that all medication orders received from the Primary Care Physician are recorded on the Medication Administration Record and staff are trained on the physician orders. Retraining will also include ensuring that all staff are documenting administration/implementation of all physician orders as directed by the physician. For 4 weeks, HM, PD and/or Program Nurse will review the MAR a minimum of three times weekly to ensure staff are documenting administration/implementation of all physician orders as directed by the physician. Ongoing, after the initial four weeks the HM, PD and/or Program Nurse will review the MAR a minimum of twice weekly to ensure staff are documenting administration/implementation of all physician orders as directed by the physician.</p> <p>Responsible Party: Home Manager, Program Director, Program Nurse</p>	03/18/2015

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	<p>2/12/15 at 12:01 PM and indicated staff should have been marking client #8's use of oxygen on each shift.</p> <p>The group home nurse was interviewed on 2/12/15 at 3:25 PM and indicated staff should have been marking client #8's use of oxygen on each shift.</p> <p>Notes from client #8's visit to her PCP on 1/5/15 were reviewed on 2/16/15 at 3:08 PM and indicated "get chest x-ray, may be pneumonia." There was no evidence a chest x-ray had been obtained on 1/5/15.</p> <p>The Area Director was interviewed on 2/16/15 at 3:08 PM and indicated the unsigned section in regards to client #8's use of oxygen on the MAR for 1/5/15 may have been the documentation taken to her PCP for review for her visit at 12:00 PM that day. She was uncertain as to why a chest x-ray had not been obtained for client #8 on 1/5/15. She indicated she would check with the nurse in regards to the discrepancy in client #8's MAR and for the delay in client #8 obtaining a chest x-ray. No further explanation was provided.</p> <p>9-3-6(a)</p>			

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W 369 Bldg. 00	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 16 medications administered involving client #1 to ensure medications were dispensed according to physician's orders.</p> <p>Findings include:</p> <p>Medication administration for client #1 was observed at the group home on 2/11/15 at 7:08 AM. Staff #2 did not give client #1 Polyethylene Glycol 17 gr (grams) mixed in 8 ounces of water during the medication administration.</p> <p>The MAR (medication administration record) was reviewed on 2/11/15 at 7:15 AM and indicated client #1 was to receive Polyethylene Glycol (bowel aid) 17 gr (grams) mixed in 8 ounces of water at 7:00 AM.</p> <p>Staff #2 was interviewed on 2/11/15 at 7:15 AM and indicated she had not given</p>	W 369	<p>All direct care staff will receive retraining on medication administration to ensure that medications are being given as directed by the physician on the MAR. This includes correct medication, correct time, correct route and correct dosage. For 4 weeks the HM and/or Program director will complete medication administration observations a minimum of three times weekly to ensure that direct care staff are preparing and administering medications as directed by the consumers Physician. Ongoing after the 4 weeks the HM and/or Program director will complete medication administration observations a minimum of three times weekly to ensure that direct care staff are preparing and administering medications as directed by the consumers Physician. Responsible Party; Program Nurse, Home Manager, Program Director</p>	03/18/2015

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	<p>client #1 the Polyethylene Glycol as client #1 was experiencing diarrhea.</p> <p>Client #1's record was reviewed on 2/12/15 at 9:35 AM. Client #1's physician's orders dated January, 2015 indicated client #1 was to receive Polyethylene Glycol 17 gr (grams) mixed in 8 ounces of water daily.</p> <p>The group home nurse was interviewed on 2/12/15 at 3:25 PM and indicated client #1's order for Polyethylene Glycol was not an as needed order and staff should have administered the medication unless she had obtained approval from the nurse or client #1's physician.</p> <p>9-3-6(a)</p>			