

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448
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W000000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Survey dates: April 14, 15, 16 and 17, 2014</p> <p>Facility number: 004000 Provider number: 15G715 AIM number: 200481990</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/23/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 3 of 3 clients living in the group home (#1, #2 and #3), the governing body failed to exercise operating direction over the facility by failing to ensure the ceiling in client #3's bedroom was repaired and the common areas (living room, kitchen, dining room, medication area, and hallway leading to clients #1 and #2's bedrooms) were repainted.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/14/14 from 2:33 PM to 5:03 PM and 4/15/14 from 6:04 AM to 7:41 AM. During the observations, client #3's bedroom</p>	W000104	<p>To correct the deficiencies, the walls in the living room, kitchen, dining room, medication area and hallway leading to client #1 and #2's bedrooms will be repainted and the ceiling in client #3's bedroom will be repaired. To ensure the deficient practice does not happen in the future, all maintenance requests are currently being reviewed by the Chief Executive Officer to ensure that repairs are made in a timely manner. The maintenance supervisor is currently sending a daily report to the CEO of the status of all maintenance requests or repairs. The Team</p>	05/17/2014

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>ceiling had a 4 feet long crack in the ceiling. The area surrounding the crack was lower than the surrounding ceiling. During the observations, the living room, kitchen, dining room, medication area and hallway leading to client #1 and #2's bedrooms walls were discolored, scuffed, marked and had holes where items were taken down from the walls. This affected clients #1, #2 and #3.</p> <p>On 4/15/14 at 6:14 AM, staff #3 indicated client #3's ceiling needed to be repaired due to the large crack in the ceiling. Staff #3 stated the crack and surrounding area were getting "worse." Staff #3 indicated the common areas including the living room, kitchen, dining room, medication area and hallway leading to client #1 and #2's bedrooms walls needed to be repainted.</p> <p>On 4/15/14 at 9:50 AM, the Home Manager (HM) indicated the living room, kitchen, dining room, medication area and hallway leading to client #1 and #2's bedrooms walls needed to be repainted. The HM indicated maintenance had painted the front living room and hallway and was going to be painting the rest of the home in the future.</p> <p>On 4/16/14 at 10:29 AM, the QIDP indicated the living room, kitchen, dining room, medication area and hallway leading to client #1 and #2's bedrooms walls needed to be repainted. The QIDP indicated the plan was to repaint the home but she was not sure which rooms were going to be painted. The QIDP stated, "they are doing it in pieces." The QIDP indicated client #3's ceiling was an on-going issue. The QIDP indicated maintenance staff have looked at the ceiling and determined it was not load bearing. The QIDP indicated the ceiling needed to be</p>		<p>Manager or ND/Q will also inform the Director of Residential Services of all maintenance requests for additional monitoring of repairs. To ensure the practice is maintained going forward, ongoing monitoring will occur as part of the QA process, and household maintenance issues/needs will be documented on the Team Manager monthly checklist, which is reviewed by the ND/ Q and Director of Residential Services. The Director of Residential Services and the CEO will review maintenance requests and their status with the maintenance supervisor monthly to set priorities and monitor progress. This will be reported on the monthly Residential Services report that is submitted to the Board of Directors.</p>	

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W000125	<p>patched.</p> <p>On 4/16/14 at 1:10 PM, the Maintenance Director (MD) indicated client #3's ceiling needed to be addressed. The MD indicated he was going to cut out the section of drywall and replace it. The MD stated maintenance was working on painting the rest of the house in "sections." The MD indicated maintenance would be back in the home by the end of this week to continue painting the home.</p> <p>9-3-1(a) 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 3 of 3 clients living in the group home (#1, #2, and #3), the facility failed to ensure the clients had the right to due process in regard to the locking of laundry and dishwasher detergent pods in a locked cabinet.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/14/14 at 11:27 AM and indicated the following incident of pica (ingesting non-nutritive items): The Bureau of Developmental Disabilities Services (BDDS) report, dated 4/11/14, indicated on 4/10/14 at 8:00 PM, client #3 was wandering around the house. The staff</p>	W000125	The deficient practice has been addressed by removing the laundry pods from the group home and replacing them with liquid detergent, which all clients have access to. The Director of Residential Services will retrain Network Directors to be cognizant that any and all restrictive measures must go through the agency Human Rights Committee(HRC) in order to protect customer's rights in the implementation of behavior support strategies, use of restrictive techniques and other human rights issues. Continued monitoring will be through monthly Network Director Audits, which include monitoring for	05/17/2014			

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	<p>(report did not specify the staff) heard her cough and went to check on her. The staff found her standing in the hallway with a laundry pod in her mouth. Client #3 had bitten into the pod releasing the laundry detergent. Staff removed the plastic coating from her mouth and rinsed her mouth with water. Staff called poison control and the nurse. Both instructed the staff to take client #3 to the emergency room (ER). The ER checked her lungs for the fluid using x-ray and found nothing of concern. Client #3 was released from the hospital with instructions to follow-up with her primary care physician, if needed. Staff checked on her throughout the night and noted no concerns. The BDDS report indicated, "Team Manager has removed the laundry detergent pods from the home and will purchase liquid detergent from now on, as [client #3] has never been known to attempt to ingest items like the liquid detergent."</p> <p>Observations were conducted at the group home on 4/14/14 from 2:33 PM to 5:03 PM and 4/15/14 from 6:04 AM to 7:41 AM. During the observations the laundry and dishwasher detergents were locked in a storage cabinet. This affected clients #1, #2 and #3.</p> <p>A review of client #1's record was conducted on 4/15/14 at 8:51 AM. Client #1's record did not contain documentation the laundry and dishwasher detergent needed to be locked.</p> <p>A review of client #2's record was conducted on 4/15/14 at 9:18 AM. Client #2's record did not contain documentation the laundry and dishwasher detergent needed to be locked.</p> <p>A review of client #3's record was conducted</p>		<p>undue restrictions. These audits will be submitted to the Director of Residential Services. Periodic reviews by the Director of Residential Services will also be conducted. The Network Director will update the customer's Behavior Support Plan and the agency nurse will update the customer's Nursing Care Plan. They will then train staff on these updates. In the future, if a new incident of pica occurs, the Interdisciplinary Treatment Team will meet to determine what actions should be taken, including a discussion of any restrictions that may impact other customers.</p>				

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	<p>on 4/15/14 at 8:33 AM. Client #3's record did not contain documentation the laundry and dishwasher detergent needed to be locked.</p> <p>On 4/15/14 at 9:36 AM, the Home Manager (HM) indicated she was not present during the incident in which client #3 ingested a laundry detergent pod. The HM indicated staff heard client #3 coughing and found out the coughing was due to ingesting a laundry detergent pod. The staff called the Qualified Intellectual Disabilities Professional (QIDP), the HM and the nurse. The staff washed out client #3's mouth and took her to the emergency room. Client #3 did not have an adverse reaction to ingesting the pod. The hospital took an X-ray and checked her vitals. Client #3 was taken to a follow up appointment with her primary care physician on 4/14/14. The HM indicated the facility was keeping the detergent locked in a medication cabinet until the pods were all gone.</p> <p>On 4/16/14 at 10:28 AM, the QIDP indicated the laundry and dishwasher detergents were available to the clients in liquid form. The QIDP indicated the laundry and dishwasher detergent pods were locked up after client #3 ingested a laundry detergent pod. The QIDP indicated she obtained verbal consent from client #3's guardian to lock up the pods however client #1 and #2's guardians had not been contacted yet. The QIDP indicated client #3's plan for pica would be updated to reflect the ingesting of the laundry pods.</p> <p>On 4/16/14 at 10:51 AM, the Home Manager (HM) indicated the liquid and pod detergents were locked up and the clients did not have access to them. The HM indicated she was going shopping today and ensure the clients would have access to the liquid detergents on</p>			

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W000159	<p>this date.</p> <p>9-3-2(a) 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 2 of 2 clients in the sample (#1 and #2) and one additional client (#3), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the clients' progress on their program plans was reviewed regularly.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/15/14 at 8:51 AM. Client #1's record did not contain documentation the QIDP or other facility staff reviewed the client's program data to ensure progress was being made on his training objectives during the past 12 months. On 4/15/14 at 3:44 PM, the QIDP indicated in an email, "These are the most current tallies I have. They are also behind." The QIDP attached to the email copies of the Monthly Review from April 2013 to October 2013. There was no documentation the facility conducted Monthly Reviews from November 2013 to March 2014.</p> <p>A review of client #2's record was conducted on 4/15/14 at 9:18 AM. Client #2's record did not contain documentation the QIDP or other facility staff reviewed the client's program data to ensure progress was being made on her training objectives during the past 12 months. On 4/15/14 at 3:44 PM, the QIDP</p>	W000159	To correct the deficient practice, all monthly tallies will be up-to-date by May 5, 2014. To ensure that the deficient practice does not continue, the Team manager will henceforth be responsible for completing tallies monthly and forwarding them to the Network Director by the 5th of each month. The Network Director will then complete monthly reviews and forward them to the Director of Residential Services for review by the 10th of each month. The Director of Residential Services will maintain a checklist to track compliance. Additionally, the agency has identified a new Network Director for the Park Lane home. This will reduce the work load for the current Network Director and further ensure that tallies and monthly reviews will be completed in a timely fashion.	05/17/2014			

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W000227	<p>indicated in an email, "These are the most current tallies I have. They are also behind." The QIDP attached to the email copies of the Monthly Review from April 2013 to October 2013. There was no documentation the facility conducted Monthly Reviews from November 2013 to March 2014.</p> <p>A review of client #3's record was conducted on 4/15/14 at 8:33 AM. Client #3's record did not contain documentation the QIDP or other facility staff reviewed the client's program data to ensure progress was being made on her training objectives during the past 12 months. On 4/15/14 at 3:44 PM, the QIDP indicated in an email, "These are the most current tallies I have. They are also behind." The QIDP attached to the email copies of the Monthly Review from April 2013 to October 2013. There was no documentation the facility conducted Monthly Reviews from November 2013 to March 2014.</p> <p>On 4/16/14 at 10:28 AM, the QIDP indicated she had not completed the Monthly Reviews for clients #1, #2 and #3 from November 2013 to March 2014. The QIDP stated, "they are late." The QIDP stated, "I know they are late and can't get to them."</p> <p>9-3-3(a) 483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 1 of 2 clients in the sample (#1),</p>	W000227	To correct the deficient practice, the Team Manager and Network Director will compose a social story to be utilized with the	05/17/2014			

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	<p>the facility failed to ensure client #1 had a plan addressing placing objects into his ear.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/14/14 from 2:33 PM to 5:03 PM. At 3:39 PM, client #1 took a pen from the bulletin board and stuck it in his ear. The Home Manager (HM) observed client #1 remove the pen and attempted to redirect him prior to sticking the pen in his ear. The HM talked to client #1 about why he should not stick items in his ear and told him it was not funny. The Qualified Intellectual Disabilities Professional (QIDP) asked the HM if this behavior occurred frequently. The HM stated, "yes." The QIDP asked the HM if client #1 needed a social story (plan) addressing sticking items in client #1's ear. The HM stated, "yes." At 4:12 PM, client #1 attempted to put a plastic stake (from a children's horseshoe set) in his ear. The QIDP redirected client #1 from sticking the object in his ear. Client #1 then attempted to place the plastic stake in the QIDP's ear. The QIDP asked the HM if the behavior had been seen before. The HM indicated it was a known behavior. The QIDP asked the HM to write up a social story addressing the behavior.</p> <p>A review of client #1's record was conducted on 4/15/14 at 8:51 AM. Client #1's Individual Program Plan, dated 6/13/13, and Replacement Skills Plan, dated June 2013, did not address client #1 sticking objects into his ears. There was no documentation in client #1's record addressing sticking objects into his ears.</p> <p>On 4/15/14 at 9:50 AM, the HM indicated she</p>		<p>customer to address this behavior. The Network Director will begin tracking the behavior in order to ascertain its frequency. She will update the customer's Behavior Support Plan and train staff on the new plan at the next staff meeting. To ensure no others were affected by the deficient practice, the ND/Q will review behavior support plans for all others at the next staff meeting. In the event that other maladaptive behaviors are identified that are not currently addressed, the ND/Q will develop a plan to address those behaviors as well. To ensure the deficient practice does not continue, all staff will be retrained on discussing any new or unusual behaviors with the Support Team, in order for those things to be addressed in a more formal way. The Team Manager or ND/Q will observe implementation of the new plan mentioned above at least 3 times per week for no less than one month to ensure compliance, as well as additional training and support to staff as needed. Ongoing monitoring will be accomplished by twice-weekly observations conducted by the Team Manager or ND/Q. Additional ongoing monitoring will be through regular discussion at monthly team meetings.</p>		

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W000259	<p>was going to draft a social story to address client #1 sticking objects in his ear. The HM indicated the behavior was not frequent but client #1 did engage in the behavior when visitors were in the home to get attention. The HM indicated client #1 needed a plan to address sticking objects in his ears.</p> <p>On 4/16/14 at 10:28 AM, the QIDP indicated it was the first time she had observed client #1 stick objects in his ear. The QIDP indicated she was not aware of the behavior. The QIDP indicated client #1 needed a plan to address the behavior and she was going to informally track the behavior to ascertain the frequency of the behavior.</p> <p>9-3-4(a) 483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (#2), the facility failed to ensure client #2's functional assessment was reviewed for relevancy at least annually and updated as needed.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 4/15/14 at 9:18 AM. Client #2's current functional assessment was dated 11/26/12. There was no documentation client #2's assessment had been reviewed and updated as needed since 11/26/12.</p> <p>On 4/15/14 at 3:44 PM, the Qualified</p>	W000259	To correct the deficient practice, client #2's functional assessment will be updated. To ensure no others were affected by the deficient practice, the current ND/Q will review functional assessments for all others and will update as needed. To ensure the deficient practice does not recur, the Network Director will be retrained on the process for monitoring and updating program assessments in a timely fashion. Ongoing monitoring will be through the use of centralized calendar that will allow the Director of Residential Services to track due dates and completion of	05/17/2014			

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W000260	<p>Intellectual Disabilities Professional (QIDP) indicated in an email, "[Client #2] Functional Assessment - I thought I had reviewed these in the fall when I came back to this area and I apparently didn't get them completed. I was unable to locate a current one also."</p> <p>On 4/16/14 at 10:28 AM, the QIDP indicated client #2's functional assessment should be reviewed at least annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (#2), the facility failed to ensure client #2's Individual Program Plan (IPP) was revised at least annually.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 4/15/14 at 9:18 AM. Client #2's current IPP was dated 3/23/13. There was no documentation client #2's IPP was revised since 3/23/13.</p> <p>On 4/15/14 at 9:20 AM, the Home Manager (HM) indicated client #2's IPP had not been reviewed since 3/23/13. The HM indicated client #3 had a recent annual meeting at the school however the group home plan was not reviewed at the time.</p> <p>On 4/16/14 at 10:28 AM, the Qualified</p>	W000260	<p>all ISPs. The Director of Residential Services will review the calendar with the Network Director at a bi-weekly meeting to ensure all plans are updated as needed. Additionally, the agency has identified a new Network Director for the Park Lane home. This will reduce the work load for the current Network Director and further ensure that all functional assessments will be completed in a timely fashion.</p> <p>To correct the deficient practice, client #2's individual program plan will be revised. To ensure no others were affected by the deficient practice, the Network Director will review program plans for all others and will update any other outdated plans. To ensure the deficient practice does not recur, the Network Director will be retrained on the process for monitoring and updating program assessments in a timely fashion. Ongoing monitoring will be through the use of centralized calendar that will allow the Director of Residential Services to track due dates and completion of all ISPs. The Director of Residential Services will review the calendar with the Network Director at a bi-weekly meeting to ensure all plans are updated as</p>	05/17/2014			

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W000340	<p>Intellectual Disabilities Professional (QIDP) stated she did not know client #2's IPP had "expired." The QIDP indicated client #2's IPP should be revised annually.</p> <p>9-3-4(a)</p> <p>483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on observation and interview for 2 of 2 clients who had pill crushers (#1 and #3), the facility failed to ensure the staff washed the pill crushers after each use.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/14/14 from 2:33 PM to 5:03 PM and 4/15/14 from 6:04 AM to 7:41 AM. On 4/14/14 at 3:48 PM, client #3 received her medications from staff #4. Client #3 received two medications (Calcium and Carbamazepine) which were crushed in a pill crusher. Prior to staff #4 using the pill crusher, the pill crusher was noted to have pill residue in the container. Staff #4 indicated, on 4/14/14 at 3:48 PM, she did not know how often the pill crusher was washed. Staff #4 indicated the morning staff may wash the pill crusher but the evening shift staff did not wash it. On 4/15/14 at 6:37 AM, client #3 received her medications from staff #3. Client #3's pill crusher was used to crush</p>	W000340	<p>needed. Additionally, the agency has identified a new Network Director for the Park Lane home. This will reduce the work load for the current Network Director and further ensure that all individual plans will be completed in a timely fashion.</p> <p>To correct the deficient practice, all pill crushers were immediately washed and new pill crushers purchased to enable a systematic cleaning schedule to be implemented. A new system will be implemented using the Silent Night Pill Crusher. This devise enables tablets to be held in a strong durable plastic pouch while being crushed. It will not tear and it prevents incidental dosing. No clean-up is required, as the plastic pouch is disposable. The plastic pill crushers will be utilized as a back-up plan should the Silent Night devise be broken. The Medical Coordinator and Team Manager will train staff in its use and in the process for cleaning and monitoring the back-up system. The Team Manager will increase her medication administration observations to twice weekly for the period of one month and will</p>	05/17/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G715		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 523 PARK LN NASHVILLE, IN 47448			
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W000369	<p>Abilify, Calcium, Carbamazepine, Child Chew vitamin, and Loratadine. Prior to using the pill crusher, the pill crusher was noted to have pill residue from previous medication passes. On 4/14/14 at 7:01 AM, staff #3 stated, regarding washing the pill crusher, "Try to wash once a week." On 4/15/14 at 6:43 AM, client #1's pill crusher was examined. Client #1's pill crusher had pill residue on the inside of the container.</p> <p>On 4/15/14 at 9:55 AM, the Home Manager (HM) stated client #1 and #3's pill crushers were washed "about once a week."</p> <p>On 4/16/14 at 10:28 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the pill crusher should be washed after every use. The QIDP indicated she was not aware the staff were not washing the pill crushers after each use.</p> <p>9-3-6(a) 483.460(k)(2) DRUG ADMINISTRATION 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 for 1 of 12 medications administered to client #3 during the morning medication pass, staff #3 failed to administer client #3's cream as ordered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/15/14 from 6:04 AM to 7:41 AM. At 6:37 AM, staff #3 administered client #3's</p>	W000369	<p>add an observation of pill crushing to her written audit form. Medication administration audits will decrease to bi-monthly, if there are no concerns.</p> <p>To correct the deficient practice, the doctor's orders were clarified and re-written to indicate that the medication should be applied to dry areas as needed. The Nurse will retrain staff on the importance of administering all medications as ordered. The Team Manager will increase her observations of medication passes to twice weekly for a period of one month, ensuring that all medications are administered as</p>	05/17/2014			

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	<p>medications. Staff #3 was observed to apply Clotrimazole Betamethasone cream to client #3's knees. The cream was not applied to client #3's feet and above her buttocks.</p> <p>A review of client #3's Physician's Orders, dated 2/26/14, was conducted on 4/15/14 at 8:34 AM. The Physician's Orders indicated, in part, "Clotrimazole-Betamethasone crm (cream) - IE (that is) Lotrisone Cream apply topically to sacral area (area above buttocks), feet and above buttocks twice daily."</p> <p>On 4/15/14 at 8:28 AM, the Medical Coordinator (staff #3) indicated she did not apply the cream as ordered.</p> <p>On 4/15/14 at 8:46 AM, the Home Manager indicated the cream should be applied as ordered.</p> <p>On 4/16/14 at 10:28 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the cream should be applied as ordered.</p> <p>9-3-6(a)</p>		<p>ordered and providing re-training in the moment as necessary. Medication administration audits will decrease to bi-monthly, if there are no concerns.</p>		