

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/7, 10/8, 10/9, 10/10, and 10/17/2014.</p> <p>Facility Number: 000649 Provider Number: 15G112 AIMS Number: 100243110</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/30/14 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 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the governing body failed to exercise operating direction over the facility to complete maintenance and repairs for client #1, #2, #3, #4, #5, and #6's group home.</p>	W000104	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>Maintenance Team Leader met with contracted flooring company onsite on 11/5/14 and developed agreement for replacement</p>	11/16/2014

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>Findings include:</p> <p>On 10/7/14 from 3:30pm until 5:35pm, and on 10/8/14 from 5:25am until 7:25am, observations were conducted and clients #1, #2, #3, #4, #5, and #6 walked and/or accessed each room throughout the group home independently. During both observation periods the following maintenance items were observed with GHS (Group Home Staff) #1:</p> <p>-On 10/7/14 at 7:00am, in the dining room along an exterior wall was a bundle of red, blue, and green colored wires which were attached to the baseboard hole in the wall. At 7:00am, GHS #1 indicated the wires were exposed and she did not know if the wires were active or to an old smoke alarm that had been disconnected.</p> <p>-During both observation periods clients #1, #2, #5, and #6 accessed the upstairs bedrooms and bathroom. The carpet to the upstairs of the home had wrinkles which caused areas of the carpet to rise and separate from the floor. At 3:55pm, GHS #1 indicated clients #1, #2, and #6 were at risk to fall. GHS #1 stated the carpet upstairs was "worn" and "dirty." At 3:55pm, GHS #1 stated the upstairs carpet was "old" and had ripples in the carpet causing the carpet to separate from</p>		<p>flooring. Flooring is expected to be completed by 11/30/14 at the latest. If this timeline is exceeded, Group Home Director will contact survey supervisor directly for updated timeline. The wiring noted was an old junction box that was previously a part of the fire alarm system and had been hidden behind some equipment until recently. It was recovered on 10/18/14 after mention in survey exit.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>All rooms of the home were inspected and were found to be in good condition. However, one additional room had some slight buckling in the carpet. It will be replaced at the same time as the hall flooring.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Group Home managers and Team Leaders will review flooring in all facilities to ensure that all needed areas have been addressed. Group Home Director will do onsite</p>	
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W000192	<p>the floor.</p> <p>On 10/17/14 at 10:05am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) was conducted. The GHM/QIDP indicated client #1, #2, #3, #4, #5, and #6's group home was in need of repairs. The GHM/QIDP indicated the exposed wires were fixed on 10/8/14 after being noticed. The GHM/QIDP stated the upstairs carpet was in need of being cleaned, "stretched, and re-glued" to the floor. The GHM/QIDP stated the agency was "getting estimates" for replacing the carpet.</p> <p>9-3-1(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #2), the facility failed to ensure staff displayed knowledge and competence related to client #2's pain and medication administration.</p> <p>Findings include:</p>	W000192	<p>inspections monthly to note further developments and address them as needed.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p>	11/16/2014			

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	<p>On 10/7/14 from 3:30pm until 5:35pm and 10/8/14 from 5:25am until 7:25am, observations were conducted and client #2 expressed that she was having leg pain and discomfort. At 4:06pm, client #2 verbally told GHS (Group Home Staff) #1 she was having pain in her leg and GHS #1 told client #2 to lay down for awhile. At 4:25pm, Client #2 was laying in her upstairs bedroom and stated she was "having pain" in her leg. At 4:30pm, GHS #3 went upstairs and prompted client #2 to get her laundry out. Client #2 expressed that she was in pain and GHS #3 asked client #2 again to get out the laundry basket. Client #2 got up from her prone position on the bed to walk to her closet and retrieved the laundry basket. Client #2 was prompted by GHS #3 to carry the basket downstairs. Client #2's breathing could be heard as she stepped one at a time each step on the stairway. Client #2 again stated to GHS #3 she was having pain, her eye brows were wrinkled, and her face was sweaty. At 4:32pm, GHS #2 and GHS #3 both indicated client #2 was having leg pain. At 4:32pm, GHS #2 indicated she was going to call the nurse. At 4:42pm, GHS #2 administered client #2's "Acetaminophen 500mg (milligrams) 2 tab 1000mg 3 times daily as needed" pain medication. GHS #2 indicated the nurse</p>		<p>Staff are to be retrained during week of 11/10/14 regarding medication administration, PRN usage and documentation, and pain protocols for all residents in home. Nurse consultant developed pain protocols and trained staff on monitoring and responses to pain. Group Home QIDP will review all home stock of PRN medications to ensure the right dosing and current medication is present in the home.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Group Home Nurse Consultant will complete a monthly check of home PRN stock. Group Home Team Leader will weekly review the PRN documentation for any PRN medication administered.</p>	

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	<p>had called back to indicate that the pain medication be given. At 4:50pm, Client #2's 10/2014 MAR (Medication Administration Record) was reviewed and did not indicate the use of "Acetaminophen 500mg 2 tab 1000mg 3 times a day as needed" for pain." GHS #2 located an entry for 10/7/14 at 4:42pm, in client #2's 10/2014 MAR for "Tylenol 325mg, 2 tabs po (by mouth) q (every) 4hrs (four hours) PRN (as needed)" for pain which had GHS #2's initials. GHS #2 stated "the nurse indicated to give [client #2] Tylenol 325mg 2 tabs" for client #2's pain. GHS #2 stated "We don't have the Tylenol" in the group home "so I used [client #2's] Acetaminophen 500mg (medication) card." At 5:35pm, client #2 stated her pain "was better."</p> <p>On 10/8/14 at 5:50am, GHS #1 stated the facility "followed" Core A/Core B medication administration training. GHS #1 indicated if the label did not match the MAR the medication should not be administered. At 6:45am, GHS #1 told GHS #4 to call the nurse before leaving for workshop to administer to client #2 Tylenol 500mg before "we go" to workshop. Client #2 stated she told GHS #1 her leg was "hurting" this morning and she wanted something for the pain. At 7:05am, GHS #1 indicated the nurse said</p>			

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	<p>to give "House Stock (medication) of Ibuprofen 200mg 2 tab with food." At 7:05am, GHS #1 stated she added "Ibuprofen 200mg give 2 tabs PRN" to client #2's 10/2014 MAR and initialed 10/8/14 entry. Client #2's 10/14 MAR did not indicate if the Acetaminophen 500mg 2 tabs as needed pain medication was effective on 10/7/14. At 7:05am, the 10/7/14 entries in the "Staff Communication Notes" were reviewed and did not indicate client #2 was having leg pain. At 7:05am, GHS #1 indicated the group home did not have Tylenol house stock medication available at this time. At 7:20am, client #2 stated she was "still in pain" and left in the facility van for workshop.</p> <p>Client #2's record was reviewed on 10/9/14 at 10:40am. Client #2's 7/28/14, 4/21/14, and 1/21/14 nursing reviews did not address client #2's pain and did not address client #2's use of as needed medication. Client #2's 9/24/14 and 8/26/14 Physician's Order indicated an order for "Acetaminophen 500mg tab, give 2 tabs (or) 1000mg by mouth 3 times daily as needed" for pain ordered 5/8/2013. Client #2's record included a "OTC (Over The Counter) PRN (as needed) Medications" list signed by client #2's physician for "Problem: Fever> (greater than) 100mg (sic) or</p>						

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	<p>pain, Medication: Tylenol 325mg or equivalent or Ibuprofen 200mg or equivalent. Directions: 2 tabs po q 4hrs. PRN."</p> <p>Client #2's 9/4/14 physician visit indicated client #2 had fallen "the Monday before at the fair" and was having leg pain. Client #2's 9/16/14 Physician Visit indicated she was seen for a "check up" for her Hip Fracture. Client #2's physician's visit indicated client #2 had "left hip fx (fracture) 6 weeks ago...Precautions: prevent an increase in pain and swelling. [Client #2] is weight bearing as tolerated on the left leg."</p> <p>On 10/8/14 at 10:15am, an interview with the Agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated the facility followed Core A/Core B medication administration training. The LPN indicated the nurse had "authorized" 325mg 2 tabs for client #2's pain on 10/7/14. The nurse instructed the staff at the group home to add the medication to client #2's MAR. The LPN indicated the nurse had "authorized" Ibuprofen 200mg 2 tabs on 10/8/14 because the group home did not have the Tylenol available in the house stock. The LPN indicated client #2's "Acetaminophen 500mg" was available</p>						

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W000227	<p>but not listed on client #2's MAR, and "was not authorized" by the nurse. The LPN indicated medication administered should match the MAR. The LPN indicated it would be considered a medication error.</p> <p>On 10/17/14 at 10:05am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) was conducted. The GHM/QIDP indicated the facility staff did not follow Core A/Core B when administering client #2's as needed pain medication.</p> <p>On 10/8/14 at 10:15am, a record review of the facility's 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated the staff should contact the nurse for guidance if the medication labels did not match the medication record.</p> <p>9-3-3(a)</p> <p>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>			

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	<p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #2), the facility failed to develop a plan in regards to the Dietician's recommendation for whole milk and CIB (Carnation Instant Breakfast), and failed to address client #2's weight loss needs.</p> <p>Findings include:</p> <p>On 10/7/14 from 3:30pm until 5:35pm, and on 10/8/14 from 5:25am until 7:25am, observations were conducted and client #2 did not receive whole milk or CIB.</p> <p>Client #2's record was reviewed on 10/9/14 at 10:40am. Client #2's "Quarterly Nursing Physical Assessment" indicated the following weights: 9/2014 was 105 lbs.(pounds), 8/2014 was 105.2 lbs., 7/2014 was 106 lbs., 6/2014 was 106 lbs., 5/2014 was 108 lbs., 4/2014 was 106 lbs., 3/2014 was 111 lbs., 2/2014 was 115 lbs., 1/2014 was 118.5 lbs., 12/2013 was 123 lbs., 11/2013 was 124 lbs., 10/2013 was 125 lbs., 9/2013 was 128 lbs., 8/2013 was 128 lbs., 7/2013 was 133 lbs., 6/2013 was 135 lbs., 5/2013 was 136 lbs., 4/2013 was 134 lbs., 3/2013 was 143 lbs., 2/2013 was 152 lbs., and 1/2013 was 154 pounds. Client #2's 7/28/14, 4/21/14, and 1/21/14 nursing reviews did not address client #2's weight loss. Client #2's</p>	W000227	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>Order was implemented as indicated by physician. All staff were trained on supplemental nutrition needs for Client #2. She will be weighed weekly and reported to nurse consultant and physician. Any further weight loss will be reported to dietician and physician immediately. While in her appropriate weight range, any continued loss will be addressed. All other dining and meal orders were reviewed and currently implemented as ordered.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Group Home Director, Team Leader and Nurse Consultant receive quarterly nutritional reviews from dietician. All reviews will be addressed by IDT and implemented as ordered. Current systematic</p>	11/16/2014			

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	<p>6/18/14 "Quarterly Nutrition Review" indicated "Overall weight down this quarter by 5# (five pounds), weight down by 6# x (times) 90 (ninety) days, since 01/14 weight has decreased 12# continues with progressive weight loss. AWR (Average Weight Range) =103-127#, IBW (Ideal Body Weight) =115#, weight is WNL (Within Normal Limits) of AWR, but below IBW. Goal to prevent further weight loss, feel that [client #2] needs a nutritional supplement to promote weight gain. Diet is appropriate...Recommendations: Request MD (personal physician) order for 8 oz. (ounces), CIB made with whole milk two times a day for weight gain. Follow dining plan, update for supplement order. Notify nurse and RD if weight decreases 5-10# in one month. Request for Physician Order and Justification for Request: Request MD order for 8 oz. CIB with whole milk two times a day for weight gain (signed by the Registered Dietician)." Client #2's 9/24/14 and 8/26/14 Physician's Order did not indicate an order for CIB or whole milk twice a day for weight gain. No plan was available for review which addressed client #2's weight loss.</p> <p>On 10/17/14 at 10:05am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual</p>		changes are not indicated as defective. Group Home Director will continue routine nursing chart audits to further mitigate any missed orders.				

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W000331	<p>Disabilities Professional) was conducted. The GHM/QIDP indicated no action was completed for client #2's RD recommendation for 8 oz. of whole milk and CIB twice a day for client #2's identified weight loss. The GHM/QIDP indicated whole milk and CIB were not available in the group home. The GHM/QIDP indicated no plan for client #2's weight loss had been developed.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients #1 and #2), the facility's nursing services failed to provide oversight of client #1's as needed medication, failed to develop pain assessments, and failed to develop protocols to manage client #1 and #2's pain.</p> <p>Findings include:</p> <p>1. On 10/7/14 from 3:30pm until 5:35pm, and on 10/8/14 from 5:25am until 7:25am, observations were conducted and client #2 expressed that she was having leg pain and discomfort. At 4:06pm, client #2 verbally told GHS</p>	W000331	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>Staff are to be retrained during week of 11/10/14 regarding medication administration, PRN usage and documentation, and pain protocols for all residents in home. Nurse consultant developed pain protocols and trained staff on monitoring and responses to pain during week after survey comment. Protocols will be reviewed for effectiveness during</p>	11/16/2014			

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	(Group Home Staff) #1 she was having pain in her leg and GHS #1 told client #2 to lay down for awhile. At 4:25pm, Client #2 was laying in her upstairs bedroom and stated she was "having pain" in her leg. At 4:30pm, GHS #3 went upstairs and prompted client #2 to get her laundry out. Client #2 expressed that she was in pain and GHS #3 asked client #2 again to get out the laundry basket. Client #2 got up from her prone position on the bed to walk to her closet and retrieved the laundry basket. Client #2 was prompted by GHS #3 to carry the basket downstairs. Client #2's breathing could be heard as she stepped one at a time each step on the stairway. Client #2 again stated to GHS #3 she was having pain, her eye brows were wrinkled, and her face was sweaty. At 4:32pm, GHS #2 and GHS #3 both indicated client #2 was having leg pain. At 4:32pm, GHS #2 indicated she was going to call the nurse. At 4:42pm, GHS #2 administered client #2's "Acetaminophen 500mg (milligrams) 2 tab 1000mg 3 times daily as needed" for pain medication. GHS #2 indicated the nurse had called back to indicate that the pain medication be given. At 4:50pm, Client #2's 10/2014 MAR (Medication Administration Record) was reviewed and did not indicate the use of "Acetaminophen 500mg 2 tab 1000mg 3 times a day as		<p>upcoming training meeting. Group Home QIDP will review all home stock of PRN medications to ensure the right dosing and current medication is present in the home.</p> <p>Order was implemented as indicated by physician. All staff were trained on supplemental nutrition needs for Client #2. She will be weighed weekly and reported to nurse consultant and physician. Any further weight loss will be reported to dietician and physician immediately. While in her appropriate weight range, any continued loss will be addressed. All other dining and meal orders were reviewed and currently implemented as ordered.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Group Home Nurse Consultant will complete a monthly check of home PRN stock. Group Home Team Leader will weekly review the PRN documentation for any PRN medication administered.</p> <p>Group Home Director, Team Leader and Nurse Consultant receive quarterly nutritional reviews from</p>				

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	<p>needed" for pain. GHS #2 located an entry for 10/7/14 at 4:42pm, in client #2's 10/2014 MAR for "Tylenol 325mg, 2 tabs po (by mouth) q (every) 4hrs (four hours) PRN (as needed)" for pain which had GHS #2's initials. GHS #2 stated "the nurse indicated to give [client #2] Tylenol 325mg 2 tabs" for client #2's pain. GHS #2 stated "We don't have the Tylenol" in the group home "so I used [client #2's] Acetaminophen 500mg (medication) card." At 5:35pm, client #2 stated her pain "was better."</p> <p>On 10/8/14 at 5:50pm, GHS #1 stated the facility "followed" Core A/Core B medication administration training. GHS #1 indicated if the label did not match the MAR the medication should not be administered. At 6:45am, GHS #1 told GHS #4 to call the nurse before leaving for workshop to administer to client #2 Tylenol 500mg before "we go" to workshop. Client #2 stated she told GHS #1 her leg was "hurting" this morning and she wanted something for the pain. At 7:05am, GHS #1 indicated the nurse said to give "House Stock (medication) of Ibuprofen 200mg 2 tab with food." At 7:05am, GHS #1 stated she added "Ibuprofen 200mg give 2 tabs PRN" to client #2's 10/2014 MAR and initialed 10/8/14 entry. At 7:05am, GHS #1 stated client #2 "did not have a pain</p>		<p>dietician. All reviews will be addressed by IDT and implemented as ordered. Current systematic changes are not indicated as defective. Group Home Director will continue routine nursing chart audits to further mitigate any missed orders.</p>		

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	<p>management plan" or protocol. Client #2's 10/14 MAR did not indicate if the Acetaminophen 500mg 2 tabs as needed pain medication was effective on 10/7/14. At 7:05am, the 10/7/14 entries in the "Staff Communication Notes" were reviewed and did not indicate client #2 was having leg pain. At 7:05am, GHS #1 indicated the group home did not have Tylenol house stock medication available at this time. At 7:20am, client #2 stated she was "still in pain" and left in the facility van for workshop.</p> <p>Client #2's record was reviewed on 10/9/14 at 10:40am. Client #2's 7/28/14, 4/21/14, and 1/21/14 nursing reviews did not address client #2's pain and use of as needed medication.</p> <p>Client #2's 9/24/14 and 8/26/14 Physician's Orders indicated an order for "Acetaminophen 500mg tab, give 2 tabs (or) 1000mg by mouth 3 times daily as needed" for pain ordered 5/8/2013. Client #2's record included a "OTC (Over The Counter) PRN (as needed) Medications" list signed by client #2's physician for "Problem: Fever> (greater than) 100mg (sic) or pain, Medication: Tylenol 325mg or equivalent or Ibuprofen 200mg or equivalent. Directions: 2 tabs po q 4hrs. PRN."</p>			

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	<p>Client #2's 9/4/14 physician visit indicated client #2 had fallen "the Monday before at the fair" and was having leg pain. Client #2's 9/16/14 Physician Visit indicated she was seen for a "check up" for her Hip Fracture. Client #2's physician's visit indicated client #2 had "left hip fx (fracture) 6 weeks ago...Precautions: prevent an increase in pain and swelling. [Client #2] is weight bearing as tolerated on the left leg."</p> <p>Client #2's 2/5/2013 "Risk Plans" did not include a plan for client #2's left leg pain and was not updated after her left hip fracture in 9/2014.</p> <p>On 10/8/14 at 10:15am, an interview with the Agency LPN (Licensed Practical Nurse) was conducted. The LPN stated "No" assessment was completed and "no" plan had been developed to address client #2's pain. The LPN indicated the facility followed Core A/Core B medication administration training. The LPN stated the nurse had "authorized" 325mg 2 tabs for client #2's pain on 10/7/14 and "instructed" the staff at the group home to add the medication to client #2's MAR. The LPN stated the nurse had "authorized" Ibuprofen 200mg 2 tabs on 10/8/14 because the group home did not have the Tylenol available in the house</p>			

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	<p>stock. The LPN indicated client #2's "Acetaminophen 500mg" was available but not listed on client #2's MAR. The LPN indicated medication administered should match the MAR. The LPN indicated it would be considered a medication error.</p> <p>On 10/17/14 at 10:05am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) was conducted. The GHM/QIDP indicated no plan had been developed and no assessment had been completed to manage client #2's pain.</p> <p>2. Client #1's record was reviewed on 10/9/14 at 12:25am. Client #1's 7/28/14, 4/21/14, and 1/21/14 nursing reviews did not address client #1's pain and use of pain medication. Client #1's diagnoses included but were not limited to: History of Breast Cancer and Chronic Lung Disease. Client #1's 9/24/14 and 8/26/14 Physician's Orders indicated an order for "Acetaminophen 500mg tab, give 1 tabs by mouth 3 times daily" for pain ordered 8/29/2013. Client #1's record did not include a plan for client #1's pain. Client #1's 9/12/14 physician's visit indicated "Past Medical History: History of joint pain, localized in the shoulder."</p>			

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	<p>On 10/8/14 at 10:15am, an interview with the Agency LPN (Licensed Practical Nurse) was conducted. The LPN stated "No" assessment was completed and "no" plan had been developed to address client #1's pain. The LPN stated client #1 was receiving "routine" pain medications for her generalized pain.</p> <p>On 10/17/14 at 10:05am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) was conducted. The GHM/QIDP indicated no plan had been developed and no assessment had been completed to manage client #1's pain.</p> <p>9-3-6(a)</p>				