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W 0000 Bldg. 00	This visit was for a focused fundamental recertification and state licensure survey. Dates of Survey: 11/16/22, 11/17/22, 11/18/22 and 11/21/22. Facility Number: 000723 Provider Number: 15G193 AIM Number: 100234760 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/5/22.	W 0000		
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 3 sampled clients (#3), and 1 additional client (#7), the facility failed to ensure a full and complete accounting of clients #3 and #7's personal funds entrusted to the facility. Findings include: On 11/17/22 at 7:53 AM, a review of the clients' finances was completed. This affected clients #3 and #7. The review indicated the following: 1) Client #3's November 2022 financial ledger indicated a balance of $85.68. Client #3's actual cash on hand balance totaled $105.68. ($20.00 unaccounted for).	W 0140	To correct the deficient practice the ledgers will be reconciled correctly. If any discrepancies are found, they will be corrected or reimbursed as needed. All staff will be re-trained on the client finance procedures. Additional monitoring will be achieved by daily cash counts for a period of one month. As well as the lead will reconcile the funds weekly. To ensure no others were affected the AS will review all client's ledgers for the last three months to ensure no other issues are found. Ongoing monitoring will be	12/21/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick O'Heran	QIDP Manager	12/14/2022

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	2) Client #7's November 2022 financial ledger indicated a balance of $70.89. Client #7's actual cash on hand balance totaled $59.83. ($11.06 unaccounted for). On 11/17/22 at 1:48 PM, the Team Leader (TL) was interviewed. The TL was asked about the accounting of clients #3 and #7's personal funds entrusted to the facility. The TL stated, "I usually do the books. I'm usually the one that checks that". The TL indicated clients #3 and #7's personal funds should be accurately maintained and accounted for. The TL indicated further review and follow-up was needed. On 11/18/22 at 12:27 PM, the Qualified Intellectual Disabilities Professional (QIDP #1) was interviewed. The QIDP #1 was asked how clients #3 and #7's personal funds entrusted to the facility should be maintained and accounted for. The QIDP #1 stated, "It should be accounted for and maintained (accurately), yes". On 11/18/22 at 1:56 PM, the Program Manager (PM #1) was interviewed. The PM #1 was asked how clients #3 and #7's personal funds entrusted to the facility should be maintained and accounted for. The PM #1 stated, "They're supposed to count it weekly and bring the receipts back. They're supposed to balance the books (financial ledger) and any leftover money put in the safe or secured mailbox on the wall. They (staff) said they found the money, I trained them. They (staff) said it wasn't tracked appropriately". On 11/18/22 at 2:34 PM, the Program Manager (PM #2) was interviewed. The PM #2 was asked how clients #3 and #7's personal funds entrusted		achieved by the Lead reviewing the ledgers weekly and the AS reviewing monthly.	

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	to the facility should be maintained and accounted for. The PM #2 stated, "Checking it daily to do the checks and balances". The PM #2 indicated further follow up was needed with the TL to ensure accurate accounting was maintained. On 11/18/22 at 3:23 PM, the Qualified Intellectual Disabilities Professional (QIDP) #2 was interviewed. The QIDP #2 was asked how clients #3 and #7's personal funds entrusted to the facility should be maintained and accounted for. The QIDP #2 stated, "Each transaction should be itemized". The QIDP #2 was asked if clients #3 and #7's money should be maintained accurately. The QIDP #2 stated, "Yes, through the monthly audit and check the money once a week". The QIDP #2 indicated clients #3 and #7's personal funds entrusted to the facility should be accurately maintained and accounted for. 9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 3 sampled clients (#1 and #2), the facility failed to ensure the implementation of 1) client #1's dining plan to assist him with cutting his breads and meats into bite size pieces and 2) client #2's dining plan to encourage single servings and healthy food choices during his evening meal.	W 0249	To correct the deficient practice all site staff will be re-trained on all clients' dining plans and ISP goals. Additional monitoring will be achieved by the AS, QDIP, or the Nurse completing twice weekly mealtime observations for a period of one month. Ongoing monitoring	12/21/2022

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	Findings include: 1) Observations were conducted on 11/16/22 from 3:41 PM to 5:29 PM and on 11/17/22 from 6:12 AM to 8:05 AM. The observations indicated the following: -At 4:57 PM, client #1 joined his peers at the dining room table for the evening meal. Client #1 was served a whole piece of chicken which included the thigh and leg, a whole piece of buttered bread, mashed potatoes, mixed vegetables and Kool-Aid to drink. -At 5:02 PM, client #1 used a butter knife and attempted to cut his chicken into pieces. -At 5:03 PM, client #1 used his right hand to hold a fork and began eating his meal. -At 5:04 PM, the Qualified Intellectual Disabilities Professional (QIDP #2) placed gloves on and assisted client #1 with cutting his chicken up more. -At 5:08 PM, client #1 took a bite from his whole piece of buttered bread. Client #1's bread was not cut into pieces. -At 5:11 PM, client #1 used his fork to take another bite of his chicken. Client #1 then indicated to staff #1 he was full and placed his knife on his plate. Staff #1 verbally prompted client #1 to eat more of his mashed potatoes. -At 5:12 PM, staff #2 assisted client #1 with scraping off his remaining food items into the trash. Client #1 then returned his plate and utensils to the kitchen sink.		will be achieved the QIDP/AS completing at least weekly drop ins to ensure staff are following plans as written. p >	

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-At 5:23 PM, staff #1 was asked about client #1's dining supports and any concerns for him as a choking risk. Staff #1 indicated client #1 ate his meal at a slow pace. Staff #1 stated, "Not many prompts at all. He's a slow eater. He will take 30 minutes". Staff #1 was asked if the only modified diet texture required was for a peer of client #1's for ground meat. Staff #1 stated, "Yep". Staff #1 indicated client #1 was on a regular diet and did not require a lot of prompting during his meals.

Morning observation:

-At 6:12 AM, client #1 was at the dining room table preparing to eat his morning meal. Client #1's morning meal consisted of scrambled eggs, a biscuit, a sausage patty, orange juice and coffee to drink. Client #1's biscuit and sausage patty were served as whole food items. Client #1 continued his morning meal eating his sausage and biscuit as separate whole food items.

-At 6:24 AM, client #1 put jelly on his biscuit and took a bite.

-At 6:28 AM, client #1 sneezed multiple times. Client #1 indicated he was finished with his morning meal and did not want more to eat.

-At 6:29 AM, client #1 placed the remaining biscuit in the trash and took his plate and utensils to the kitchen sink.

-At 7:56 AM, the Team Leader (TL) was asked about client #1's dining supports and any concerns for him as a choking risk. The TL stated, "The only thing for him is to sit up straight. Keeping his head up". The TL indicated client #1 did not require much assistance during his meals

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	other than occasional verbal prompts to ensure client #1 would sit up straight while eating. On 11/16/22 at 2:24 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected client #1: -BDDS incident report dated 6/15/22 indicated, "It was reported [client #1] was eating dinner when he began to cough and spit out a piece of meat. [Client #1] was transported to [hospital] for a precautionary evaluation. [Client #1] was evaluated and released with discharge paperwork for Choking ...". Investigation Summary dated 6/15/22 indicated, "1. Briefly describe the incident, including where it occurred ... [Client #1] was at dinner and started coughing. Shortly after he spit out a piece of food ... 5. Has this consumer had a history of choking or swallowing difficulty and a dysphagia (swallowing disorder) diagnosis? He has a history of choking ... 7. Are there specific interventions required to assist consumer while eating? No ... 11. Was the meal prepared according to the consumer's current diet order and texture? Yes ... Recommendations: New dining plan per the [Urgent Care Facility] - [Client #1] has a regular diet and regular liquids but now bread items and other hard to chew items will be cut into smaller pieces. The nurse trained the staff on this new plan". On 11/17/22 at 2:09 PM, a focused review of client #1's record was conducted. The review indicated the following: -Individual Support Plan dated 4/21/22 indicated,			

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	"Priority Objectives: ... Preparation of meals ... [Client #1] will prepare his own lunch ... Immediate Objective: [Client #1] will prepare his own lunch with 1 verbal prompt 50% of opportunities per month by 6 months ... Methodology: Staff will verbally prompt [client #1] to obtain needed items for lunch (bread, lunch meat ...etc.), Staff will verbally prompt [client #1] to make his sandwich, Staff will verbally prompt [client #1] to put the sandwich into a bag ...". Client #1's mealtime objective did not indicate a step within the methodology for how staff are to assist and ensure client #1's bread, meat and/or sandwich food items are cut into bite size pieces as written within his dining plan. -Dining Plan dated 6/21/21 (sic) indicated, "Behavioral Concerns: [Client #1] has no behavioral issues in regard to mealtime and eating. [Client #1] needs encouragement at times to eat all of his meal. Choking Risk: [Client #1] may have difficulty with bread, staff need to monitor. [Client #1] will need assistance to cut food to bite size pieces. Food Texture: Regular Diet - will need assistance cutting breads/ meats/ sandwiches ...". Client #1 was served whole food items which included his chicken, buttered bread, biscuit and sausage patty during the evening and morning meals. With exception to QIDP #2 assisting client #1 with cutting up his chicken after client #1 requested assistance, client #1 did not receive supports to ensure his buttered bread, sausage patty and biscuit were cut into pieces as written within his dining plan's section for restrictions. On 11/17/22 at 2:10 PM, the Qualified Intellectual Disabilities Professional (QIDP) #2 was interviewed. The QIDP #2 was asked if client #1 had a current dining plan to review. The QIDP #2 indicated she was not sure and would need to			

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	follow up with QIDP #1. The QIDP #2 stated, "It (client #1's dining plan) needs reviewed". The QIDP #2 indicated she had assisted client #1 with cutting up his chicken during the evening meal because client #1 had asked for help and did not receive immediate assistance. The QIDP #2 indicated further follow up was needed to determine the effective implementation of client #1's dining plan for mealtime supports to assist him with cutting up his food items. On 11/18/22 at 10:46 AM, the Nurse was interviewed. The Nurse was asked about client #1's incident which required precautionary medical evaluation for choking, the need for assistance during meals for cutting food items, and the lack of implementation for his dining plan to cut breads and meats into bite size pieces during both the evening and morning meals. The Nurse stated, "I revised his dining plan (6/21/22). It does have him as a choking risk and positioning is a concern. It says he will need assistance. Staff is saying that he (client #1) asked for help (cutting up his chicken). Maybe I need to do an in-service on how to plate (his foods). Will do some more training and individualize his plan". On 11/18/22 at 12:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed. The QIDP #1 was asked about implementation of client #1's dining plan to ensure his bread and meat food items were cut into pieces as indicated within his ISP and dining plan. The QIDP #1 stated, "It should have been done. I agree". On 11/18/22 at 1:56 PM, the Program Manager (PM #1) was interviewed. The PM #1 was asked about implementation of client #1's dining plan to ensure his bread and meat food items were cut			

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	into pieces as indicated within his ISP and dining plan. The PM #1 stated, "It should be implemented as written. It should be family style dining". The PM #1 indicated further review was needed to determine if client #1's bread and meat items should be cut as part of the meal preparation and/or the assistance needed to support client #1 with cutting up his bread and meat food items as serving bowls are passed around prior to the start of the meal when food is being placed on his plate. On 11/18/22 at 2:34 PM, the Program Manager (PM #2) was interviewed. The PM #2 was asked about implementation of client #1's dining plan to ensure his bread and meat food items were cut into pieces as indicated within his ISP and dining plan. The PM #2 stated, "I would think they should (assist client #1 with cutting bread and meat food items)". The PM #2 was asked how client #1's dining plan should be implemented. The PM #2 stated, "As written. If they (staff) have questions ask the writer of the plan (Nurse)". The PM #2 was asked if client #1's dining plan should have been implemented to ensure his bread and meat food items were cut into pieces as written within the ISP and dining plan. The PM #2 stated, "Absolutely". On 11/18/22 at 3:23 PM, the QIDP #2 was asked in a subsequent interview about implementation of client #1's dining plan to ensure bread and meat food items were cut into pieces as indicated in his dining plan. The QIDP #2 stated, "It needs to be clarified with Nursing on how to assist [client #1] with cutting his foods. Do we wait until he asks or does [client #1] need help to get through that process as precautionary. Should staff be doing it? I don't know what she (nurse) would want". The QIDP #2 was asked if client #1's bread and			

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	meat should have been cut into pieces during the evening and morning meals as indicated in his dining plan. The QIDP #2 stated, "Yes". The QIDP #2 was asked if client #1 received assistance to ensure his bread and meat had been cut into pieces during those meals. The QIDP #2 stated, "No". The QIDP #2 indicated client #1's dining plan had not been implemented as written and further follow up was needed. 2) An observation was conducted on 11/16/22 from 3:41 PM to 5:29 PM. The observation indicated the following: -At 4:57 PM, client #2 joined his peers at the dining room table for the evening meal. Client #2 was served a whole piece of chicken which included the thigh and leg, a whole piece of buttered bread, mashed potatoes, mixed vegetables and Kool-Aid to drink. -At 5:02 PM, staff #1 used a butter knife to assist client #2 with cutting his chicken up into pieces. -At 5:05 PM, client #2 took a large bite which included the skin from both the thigh and leg from the baked chicken. -At 5:06 PM, staff #1 used a verbal prompt to indicate to client #2 to slow down his pace of eating. -At 5:07 PM, staff #1 used the butter knife a second time to cut client #2's chicken into more pieces. -At 5:08 PM, client #2 took a large bite of chicken. -At 5:09 PM, client #2 had a slight cough to clear his throat. Client #2 took another bite of chicken			

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	followed by a drink of his Kool-Aid. -At 5:10 PM, staff #1 used a verbal prompt and stated to client #2, "How about some potatoes? You still have some potatoes". -At 5:12 PM, staff #1 used another verbal prompt with client #2 to indicate he had food remaining on his plate. Client #2 indicated to staff #1 he wanted more potatoes and bread. Staff #1 used a third verbal prompt and stated, "You still have some on your plate". -At 5:15 PM, staff #1 used a verbal prompt with client #2 and stated, "Finish chewing what's in your mouth. You're eating too fast tonight". Staff then asked client #2 if he wanted more potatoes since he had finished eating the potatoes on his plate. Client #2 then used the spoon in the serving bowl to obtain a second serving of the mashed potatoes. -At 5:17 PM, client #2 got a second serving of bread and ate it with his second serving of potatoes. -At 5:22 PM, client #2 finished eating and took his plate and utensils to the kitchen sink. -At 5:23 PM, staff #1 was asked about client #2's dining support needs. Staff #1 stated, "[Client #2] needs monitoring. He has a history of choking". Staff #1 then indicated the level of supports client #2 needed to ensure his health and safety. Staff #1 stated, "Slow down, smaller bites, take sips in between bites". On 11/17/22 at 7:56 AM, the Team Leader (TL) was interviewed. The TL was asked about client #2's dining support needs and the lack of			

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	implementation of his dining plan to encourage healthy food choices and single servings as indicated in client #2's dining plan. The TL stated, "My staff was probably thinking rights. I think they told us if he wanted more he could". The TL was asked if client #2 should be encouraged to make healthy choices. The TL stated, "Yes". On 11/17/22 at 1:40 PM, a focused review of client #2's record was conducted. The review indicated the following: -Dining Plan dated 8/23/22 indicated, "Dietary Restrictions or Supplements: Single servings at meals, Healthy snacks ...". -Dietary Consult dated 9/8/22 indicated, "Goal: Maintain stable wt (weight) ... gradual weight loss 1-2# (pounds) per week as desired ... Suggestions: Continue current plan of care. Encourage healthy choices ...". On 11/18/22 at 10:46 AM, the Nurse was interviewed. The Nurse was asked about client #2's dining plan implementation and the restriction of single servings and to encourage healthy food choices. The Nurse stated, "I trained on the dining plan. [Staff #1] and [staff #2] said they panicked. We should have offered seconds on vegetables and not starchy foods". On 11/18/22 at 12:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed. The QIDP #1 was asked about the implementation of client #2's dining plan and the lack of encouragement for a healthier choice when client #2's dining plan indicated a restriction to single servings. The QIDP #1 stated, "I agree, to give healthier options of other things". The QIDP indicated client #2's dining plan was not			

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	implemented as written. On 11/18/22 at 1:56 PM, the Program Manager (PM) #1 was interviewed. The PM #1 was asked about the implementation of client #2's dining plan and the lack of encouragement for a healthier choice when client #2's dining plan indicated a restriction to a single serving of potatoes and bread. The PM #1 stated, "Yes, we trained on the dining plans this morning. It should be implemented as written". On 11/18/22 at 2:34 PM, the Program Manager (PM) #2 was interviewed. The PM #2 was asked about the implementation of client #2's dining plan, the lack of encouragement for a healthier choice when client #2's dining plan indicated a restriction to a single serving of potatoes and bread, and how staff should implement client #2's dining plan. The PM #2 stated, "As written, if they (staff) have questions ask the writer of the plans". The PM #2 was asked if client #2's dining plan should be implemented as written. The PM #2 stated, "Absolutely". On 11/18/22 at 3:23 PM, the Qualified Intellectual Disabilities Professional (QIDP) #2 was interviewed. The QIDP #2 was asked about the implementation of client #2's dining plan for single servings when a second serving of mashed potatoes and bread had occurred during the evening meal. The QIDP #2 stated, "Staff should have offered the vegetables first before allowing more of the potatoes and bread". The QIDP #2 indicated one of client #2's peers had not joined during the evening meal because he was going on an outing with family and his portion of potatoes and bread had remained at the table as a temptation to client #2. The QIDP #2 stated, "That (remaining potatoes and bread) should have been			

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	15G193	A. BUILDING 00 B. WING	11/21/2022

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	removed. If there was a situation (client #2 requesting a second serving), they could start off by offering the healthier options". The QIDP #2 indicated client #2's dining plan had not been implemented to encourage healthy choices and limit to single servings as written within client #2's program plan and dining plan. 9-3-4(a)			
W 0365 Bldg. 00	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 1 additional client (#6), the facility failed to ensure client #6's Flunisolide nasal spray was documented at the time it was administered. Findings include: An observation was conducted on 11/17/22 from 6:12 AM to 8:05 AM. At 7:15 AM, the Team Leader (TL) prepared client #6's morning medicines for administration. At 7:18 AM, client #6 was administered and took four medications in tablet/capsule form with water. Client #6 then left the medication administration room. Client #6's did not use his Flunisolide nasal spray during the observed medication administration routine. On 11/17/22 at 1:16 PM, a reconciliation of client #6's medication administration observation was conducted. Client #6's current electronic Physician Orders dated 11/17/22 were used to reconcile the observation of his medication administration. Client #6's Physician Orders indicated, "Flunisolide SPR (spray) 0.025% Use 2 sprays in each nostril twice daily ... Schedule: Daily at 07:00 (AM) ...". Client #6 did not use his	W 0365	To correct the deficient practice all site staff will be re-trained on medication pass and documentation procedures. Additional monitoring will be achieved by the AS, QDIP, or the Nurse completing twice weekly medication observations for a period of one month. Ongoing monitoring will be achieved the Nurse QIDP, or AS completing at least monthly medication pass audits to ensure staff are following the procedures.	12/21/2022

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	nasal spray while in the medication administration room. On 11/17/22 at 1:25 PM, a focused review of client #6's record was conducted. The review indicated the following: -Electronic Medication Administration Record (MAR) dated 11/17/22 indicated, "Admin (administration) History for [Client #6] - Flunisolide... Scheduled: 11/17/22 7:00 AM. Administered: 11/17/22 7:04 AM ...". On 11/17/22 at 1:48 PM, the TL was interviewed. The TL was asked about client #6 not being administered the nasal spray during his morning medication administration routine and his Physician Orders indicating a nasal spray should have been administered at 7:00 AM. The TL stated, "I'm not sure if that was dc'd (discontinued) or not". The TL indicated further follow up was needed in regard to client #6's nasal spray. On 11/18/22 at 10:46 AM, the Nurse was interviewed. The Nurse was asked about client #6's reconciliation through the use of his Physician Orders to indicate his nasal spray had not been administered. The Nurse stated, "I touched base with staff. [Client #6's] I don't feel is a med (medication) error. It's documentation". The Nurse indicated client #6's nasal spray was completed last as a part of client #6's morning routine. The Nurse stated, "[TL] said he saw him take that, the issue is they clicked the MAR and in fact there's 10 to 15 minutes later when he (client #6) gets that (nasal spray). I came down to [group home] this morning to train. Documentation errors lead to med errors. Moving forward we would have to document that at the time he (client #6)			

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	took the med (Nasal Spray)". On 11/18/22 at 12:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed. The QIDP #1 was asked about documentation of client #6's nasal spray prior to client #6 being administered the medication. The QIDP #1 stated, "The med should be documented when given, so it's not forgotten". On 11/18/22 at 1:56 PM, the Program Manager (PM) #1 was interviewed. The PM #1 was asked about documentation of client #6's nasal spray prior to client #6 being administered the medication. The PM #1 stated, "He (TL) should not document that way. He (TL) should not post (document on the MAR) that until he (client #6) gets it (nasal spray)". On 11/18/22 at 2:34 PM, the Program Manager (PM) #2 was interviewed. The PM #2 was asked about documentation of client #6's nasal spray prior to client #6 being administered the medication. The PM #2 stated, "Sounds like a technique to be a convenience to [client #6]. That's not the right way". The PM #2 indicated client #6's medication administration should be documented at the time when client #6 received his nasal spray and not prior to the actual administration of it. On 11/18/22 at 3:23 PM, the Qualified Intellectual Disabilities Professional (QIDP) #2 was interviewed. The QIDP #2 was asked about documentation of client #6's nasal spray prior to client #6 being administered the medication. The QIDP #2 stated, "Meds are kept in the medication administration room, and you (staff) don't check off (document) the med until you've seen them take it. Regardless of his (client #6's) routine, staff			

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	should not document until it's administered". 9-3-6(a)			
W 0369 Bldg. 00	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. Based on observation, record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's Deep Sea Spray was administered according to his physician orders without error. Findings include: An observation was conducted on 11/17/22 from 6:12 AM to 8:05 AM. At 7:24 AM, the Team Leader (TL) prepared client #3's morning medications for administration. At 7:31 AM, client #3 was administered twelve medications in tablet/capsule form with water. Client #3 then left the medication administration room. Client #3 did not use his Deep Sea nasal spray during the observed medication administration routine. On 11/17/22 at 1:16 PM, a reconciliation of client #3's medication administration observation was conducted. Client #3's current electronic Physician Orders dated 11/17/22 were used to reconcile the observation of his medication administration. Client #3's Physician Orders indicated, "Deep Sea SPR (spray) 0.65% Use 2 sprays in each nostril once daily ... Schedule: Daily at 7:00 (AM)". Client #3 did not use his nasal spray while in the medication administration room.	W 0369	To correct the deficient practice all site staff will be re-trained on medication pass and documentation procedures. Additional monitoring will be achieved by the AS, QDIP, or the Nurse completing twice weekly medication observations for a period of one month. Ongoing monitoring will be achieved the Nurse QIDP, or AS completing at least monthly medication pass audits to ensure staff are following the procedures.	12/21/2022

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	On 11/17/22 at 12:58 PM, a focused review of client #3's record was conducted. The review indicated the following: -Electronic Medication Administration Record (MAR) dated 11/17/22 indicated, "Admin (administration) History for [Client #3] - Deep Sea... Scheduled: 11/17/22 7:00 AM. Administered: 11/17/22 7:17 AM ...". Client #3's MAR indicated the Deep Sea nasal spray was not available since 11/12/22. Client #3's MAR indicated on 11/12/22 and 11/13/22, "Medication Not In Home". On 11/17/22 at 1:48 PM, the TL was interviewed. The TL was asked about client #3 not being administered the nasal spray during his morning medication administration routine and his Physician Orders indicating a nasal spray should have been administered at 7:00 AM. The TL stated, "[Client #3's] is out of the office. I ordered it. It was out of the facility. I've ordered it". On 11/18/22 at 10:46 AM, the Nurse was interviewed. The Nurse was asked about the administration of client #3's Deep Sea nasal spray and his MAR indicating it was out of the home since 11/12/22. The Nurse indicated she needed time to investigate client #3's nasal spray further to be able to provide clarification. On 11/18/22 at 1:38 PM, the Nurse provided further feedback through another interview. The Nurse indicated client #3's nasal spray had not been in the home. The Nurse stated, "I did an incident report and retrained. The fact of the matter is he charted (documented) the med given. It was a med (medication) error". The Nurse was asked how long client #3 had gone without his Deep Sea nasal spray. The Nurse indicated client #3 had not received his morning nasal spray since			

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	staff #1 had documented on 11/12/22 the medication was not in the home. The Nurse stated, "I've educated [staff #1] about putting the med is not in the home, but not notifying or doing anything to get more meds. So, four full days missed. It would be a missed med from 11/12/22 through 11/17/22". The Nurse indicated client #3's Deep Sea nasal spray should have been administered according to his physician orders and without error. 9-3-6(a)			