

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G555	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2014
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NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1139 BOLLMAN DECATUR, IN 46733
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 24, 25, 30, October 1, 3 and 7, 2014.</p> <p>Facility number: 001069 Provider number: 15G555 AIM number: 100245430</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 20, 2014 by Dotty Walton, QIDP.</p>	W000000	<p>Bollman Annual Recertification & Licensure Survey Plan of Correction</p> <p>Survey Event ID 1ZT111</p> <p>October/November 2014</p>	
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon record review and interview, the facility failed for 1 additional client (client #8), to investigate an injury of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities</p>	W000154	<p>W154-Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated. BCS was found to be deficient in not meeting this standard as evidenced by failure to assure that an injury of unknown origin (IOU) was investigated. BCS has a system in place for any IUO to be investigated and a format for</p>	11/06/2014

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>Services (BDDS) were reviewed on 9/24/14 at 4:08 PM. A BDDS report dated 5/8/14 indicated client #8 had a "faint dark bruise on the top of her right hand. It measures 3 inches by 2 inches. There is no sign of pain upon palpitation...." Corrective action indicated a bruise protocol was followed and tracking would be completed until the bruise healed. Client #8 "will be reminded to be aware of her distance from objects when moving her hands, and staff will continue to assist her to do so...." There was no evidence of an investigation into the cause of client #8's bruising.</p> <p>The Program Director was interviewed on 9/25/14 at 3:30 PM and indicated the bruise had not been investigated.</p> <p>9-3-2(a)</p>		<p>such. All Injury/Illness (I/I) reports are reviewed by the Medical Department and recommendations made for follow-up(F/U) or closure. The I/I is then routed through a series of staff pertinent to the consumer including, but not limited to administrative team, residential management team, Day Services (DS) Coordinator &/or Workshop Manager. At some point in the review/routing process BCS dropped the ball in assuring that the IUO investigation was started and completed for consumer #8.</p> <p>A) Corrective Action and Follow-Up Specific to Client #8 (hereafter referred to as C8):</p> <p>1.C8's bruise was monitored by direct care staff (DCS) through bruise tracking & following the bruise protocol. RN monitored the bruise for healing over the course of five days. C8 did not experience any pain &/or swelling as a result of this injury. Bruise on right hand healed by 5/13/14 and I/I closed that date. It is the opinion of staff working closely with C8 across all settings that it is likely that she hit her hand when navigating from point A to point B and swinging her hand/arms close to walls, doorways & tables, especially in crowded locations/areas. Environmental changes (padding) have been made in the past to prevent bruising on her legs when swinging them against table legs.</p>				

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			<p>2.C8's ISP was reviewed with recommendations for revisions on 10/23/14 by QIDP & Program Director. Changes implemented effective 10/24/14.</p> <p>3.Consumer Specific Training (CST) and Risk Plans for C8 will be reviewed and revised by the Residential Management Team (RMT), Program Director & RN and all recommendations made will in place and all staff working with C8 across all settings trained on revisions by Nov. 6th 2014.</p> <p>4.For C8's protection and for that of all our group home residents, all staff working with C8 & all group home residents will be retrained on completing the I/I with indication that communication has been started on possibilities for the origin of the injury/how injury occurred so that prevention measures can be put into place. Retraining will occur across all settings by 11/6/14.</p> <p>5.All RMT's, Administrative staff, medical department and supervisors working with residential consumers across settings will be retrained on item A.4, as well as completing IUO investigations as they occur. Retraining will be completed no later than 11/6/14. Persons responsible: Medical department, Bollman RMT, Program Director (PD), Residential Administrator (RA), targeted supervisors and Administrative Assistant for Quality Assurance (AAQA).</p>		

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W000249	<p>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.</p> <p>Based upon observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #3), to ensure</p>	W000249	<p>Target completion date: 11/6/14 B) Corrective Action as it relates to BCS practices agency wide: 1.All supervisory staff agency wide including Supported Living Management Team members will be retrained on items A.4 & 5 above. They in turn will be responsible for retraining their staff on the same. SLMT, RMT's, Medical Department, identified supervisory staff and administrative team will be trained on 10/29/14. 2.All staff working with residential consumers across all settings will be trained on A.4 by 11/6/14. All SL DCS will be retrained at the next scheduled house/staff meetings by the SLMT members. Persons responsible: Administrative Team; RMT's, DS Coordinator, Bluffton Workshop (BWS) Manager and SLMT's. Target completion date: 11/6/14</p> <p>W249-Program Implementation As soon as the Individual SupportTeam (IST) has formulated a client's Individual</p>	11/06/2014	

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	<p>implementation of Individual Support Plan (ISP) objectives.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 9/24/14 from 5:10 PM until 6:20 PM. Client #3 was pushed in her wheelchair to the living room where she sat in front of a TV. Client #3 did not watch the TV and flipped her seat belt back and forth in her hand and made vocalizations until staff #4 moved her wheelchair out of the way so she could make room for a standing device for client #4 to use. Client #3 continued to flip her seat belt back and forth without engaging in meaningful activity until 6:20 PM.</p> <p>Client #3's record was reviewed on 10/3/14 at 1:40 PM. Her ISP dated 5/1/14 included objectives to mix hot and cold water temperature while bathing, exit during fire drills, make a purchase, use vocalizations, "hand squeeze," or other physical gestures to communicate "yes or no," participate in group activities and participate in community activities.</p> <p>The Program Director was interviewed 10/3/14 at 3:55 PM and indicated client #3's ISP objectives should have been implemented.</p>		<p>Support Plan (ISP), each consumer 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 ISP. BCS failed to ensure implementation of Client #3's ISP objectives. During internal audits of the Bollman group home, it became apparent the ISP's, RP's and other pertinent assessments have not been completed in a timely manner, reviewed &/or revised with input from the IST's and that some plans had just date changes with no data review. As a result the previous RMT is no longer working for BCS effective late September 2014. The Program Director and AAQA have reviewed ISP's for individualized services, accurate data and plan revisions for several of the Bollman consumers. A new residential manager and QIDP are now in place and the administrative team will work closely with them to assure that they have the training and support they need to do their jobs effectively, assure that consumers are receiving the training, services & supports consistent with their ISP's, and that active treatment is occurring across all settings in a consistent manner. In addition, the RMT will assure staff interactions with consumers are functional in</p>				

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	9-3-4(a)		<p>nature, as well as respectful. The new RMT is at an advantage as both of the individuals have worked with the consumers at Bollman group home in the past and they both have strong knowledge of the consumers & their needs as well as the consumers being genuinely fond of them. We feel that this Plan of Correction (POC) is timely and will assist in moving forward in better meeting the consumer's needs & wants/desires.</p> <p>A) Corrective Action and Follow-Up Specific to Consumer #3 (hereafter referred to as C8):</p> <p>1.C3 will have a Functional Assessment completed and available for IST review by 10/31/14.</p> <p>2.C3's ISP, RP's & CST are being reviewed by RMT, RN, Health Care Representative and input from DCS & C3's mother in order to assure that the plan is appropriate for her needs. Any revisions/changes will be identified and made, all staff working with C3 across all settings will be trained on changes to program plan and revised plan implemented no later than 11/6/14.</p> <p>3.All staff working with C3 acrossall settings, as well as staff working with all residential consumers will be retrained on the importance of ISP implementation, active treatment & assuring an understanding of what that means, consistency in</p>		

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			<p>implementation and activities that support the accomplishment of the ISP objectives. All staff working with residential consumers across all settings will be retrained no later than 11/6/14.</p> <p>4.All RMT's, Medical Department,Administrative Team, DS Coordinator & BWS Manager will be trained on item A.3 above, as well as the expectations of facility practices as it relates to Program Implementation on 10/29/14.</p> <p>5.RMT will complete regular home observations (HO) to assure that active treatment and program implementationare occurring as per SDOH standards, as well as BCS quality assurance standards.</p> <p>6.The Administrative Team (AT) will be available to teach & train the new QIDP and support the RMT in their efforts. The AT will also complete HO by 10/31/14 and 11/6/14 to assure that progress is being made and any requests for training/supports will be honored. Person's Responsible: AT, RMT and medical department. Target Completion Date: 11/6/14</p> <p>B) Corrective Action as it relates to BCSpractices agency wide:</p> <p>1.All SLMT & any other identified supervisory staff will be trained on A.3 & 4 above on 10/29/14. They will then be responsible for training SL DCS on A.3 at their next staff/house meetings. Person's</p>		

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W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based upon observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #3), to promote dignity by failing to ensure her excessive salivation was addressed and to speak to her before moving her wheelchair.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 9/24/14 from 5:10 PM until 6:20 PM. Client #3 was wheeled to the living room in her wheelchair where she sat with saliva and food dripping from her mouth down her chin. Periodically client #3 would make a chewing motion with her mouth and more food would come from her mouth. Client #3 was not prompted to use a napkin to wipe her mouth or was assisted by staff to wipe her mouth during the remainder of the observation. At 6:10 PM, client #3's wheelchair was moved by staff #3 without client #3 being asked or spoken to make room for a standing device for client #4 to use.</p>	W000268	<p>Responsible: AT & SLMT Target Completion Date: 11/6/14</p> <p>W268-Conduct Toward Client Policies and procedures must promote the growth, development and independence of the client. BCS failed to promote dignity by not ensuring that Client #3's excessive salivation was addressed or speaking to her before moving her wheelchair. As noted in the W249 tag, we feel that the change in management team will be a positive step forward in assuring quality of care, supports and encouragement of growth, development and independence of Client #3 as well as all of the consumers living at the Bollman group home. Several of the corrective actions for Client #3 are also a part of W249 tag actions. A) Corrective Action and Follow-Up Specific to Consumer #3 (C3): 1. Corrective actions indicated in the W249 tag (A.1-6 inclusive) are also pertinent to this conduct toward C3 corrective action. 2. All staff working with C3 across all settings will be retrained on promoting growth, development and independence.</p>	11/06/2014

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	<p>The Program Director was interviewed 10/3/14 at 3:55 PM and indicated client #3's saliva and food on her face should have been addressed by staff. She indicated client #3 should be spoken to prior to moving her wheelchair.</p> <p>9-3-5(a)</p>		<p>Training specifically as it relates to her dignity and respect will include:</p> <ol style="list-style-type: none"> a. That drooling (saliva &/or food) will be addressed consistently throughout her day & across all settings. b. That she is spoken to & alerted of being moved in her wheelchair rather than just moving her without telling her what you are going to do. c. That she will be engaged in functional activities that promote growth, development & greater independence. <p>3. All DCS working with C3 & all residential consumers across all settings will be retrained on promoting growth, development and independence. In addition, an overview of agency expectations for dignity & respect for all consumers will be provided by 11/6/14.</p> <p>4. All staff working with C3 & residential consumers across all settings will beretrained on the SDOH Facility Practices related to the W268 tag by 11/6/14.</p> <p>5. All RMT's, Medical Department, AT and supervisory staff working with consumers in programming areas will be retrained on items A.1-4 above on 10/29/14. Person's Responsible: AT and RMT's Target Completion Date: 11/6/14</p> <p>B) Corrective Action as it relates to BCS practices agency wide: 1.SLMT & any other identified</p>		

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based upon record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #4) and for 1 additional client (client #7) to ensure medications were dispensed with the physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/24/14 at 4:08 PM and indicated the following:</p> <p>A report dated 3/26/14 indicated client #4 did not receive her first dose of Monistat vaginal suppository at bedtime. She was to receive the medication for seven days. Corrective action indicated staff would</p>	W000368	<p>supervisory staff working with consumers in programming areas will be trained on items A.2-4 above as well as the W249 tag A.3 & 4 on 10/29/14. They will then be responsible for training SL DCS at their next scheduled staff/house meetings. Person's Responsible: AT & SLMT Target Completion Date: 11/6/14</p> <p>W368-Drug Administration The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. BCS did not meet this standard as evidenced by failure to assure that three of eight consumer's medications were administered according to their physicians' orders. Our agency RN's do an excellent job of teaching/training staff and take very seriously the responsibility for training all staff agency wide on the State mandated drug administration course "Living in the Community" Core A & B. The Medical Caseworker is actively involved with Direct Care Staff (DCS) working with residential consumers across all settings and provides open communication and supports in providing pertinent information</p>	11/06/2014	

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	<p>be reminded to administer treatments.</p> <p>A report dated 3/6/14 indicated client #7 received omeprazole (anti-acid) 20 mg (milligrams) which was prescribed to another client (unidentified). Corrective action indicated the error would be reviewed by the Medication Error Review Team (MERT) and the staff who made the error was not wearing prescribed corrective lenses and would now wear corrective lenses for each medication administration to prevent future errors.</p> <p>A report dated 5/21/14 indicated client #2 received Zantac (anti-acid) 150 mg (milligrams) which belonged to another client (unidentified) resulting in a missed dose of Keppra (seizures) 500 mg. Corrective action indicated client #2's physician was notified of the error and the facility's MERT would review the error and their recommendations would be followed to prevent future errors. Staff were retrained on medication administration procedures.</p> <p>A report dated 9/22/14 indicated client #2 was given only half her dose of Pot (potassium) Chloride (low level of potassium) administering her one tab instead of two. Corrective action indicated the packaging was changed due</p>		<p>regarding changes to consumers' medications and other priority health related needs included in consumers MAR/TAR's & Risk Plans. Residential Management Teams (RMT) along with the Administrative Team will work closely with the nurses and Medical Caseworker to assist with monitoring of ensuring that staff administers medications/treatments per physician's orders. As noted in the W249 Program Implementation narrative, lack of supervision by the previous management team resulted with lack of communication & isolation with medical department. There was some question if disciplinary action &/or staff retraining actually took place as it related to medication errors and recommendations and if so not in a timely manner. New management team in place works well with the medical department & other staff working with Bollman consumers across all settings. Although we have several safeguards in place for assuring that medications are administered per physician's orders: including but not limited to Medication Error Review Team (MERT), Medication Administration Guidelines, Medication Administration Mentors (MAM), Check List for Transcribing Orders, Buddy Check System, Proper Med Pass Observation by RN's, Group Home Medication</p>				

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	<p>to a fire at the pharmacy resulting in confusion by staff and staff would be retrained.</p> <p>The Program Director and the group home nurse were interviewed on 10/3/14 at 3:55 PM and indicated there were new procedures in place to prevent future medication errors.</p> <p>9-3-6(a)</p>		<p>Tracking Procedure, Medication Storage Protocol for DS & Sheltered Workshops and Medication Monitoring and Management Procedures for DS & Workshops it is apparent that we need to re-organize ourselves in such a manner as to assess and address concerns relating to the number of errors still occurring so as to assure that medications &/or treatments are administered in compliance with physician's orders. Effective September of 2013, the Bollman group home began use of multi-dose medication packs, reducing the number of medication errors, but obviously not eliminating them. Our protocols and other safeguards have been reviewed and revisions were identified for change(s)/additions. Additions include MERT Corrective Action Guidelines and a Quarterly &/or Semi-Annual Medication Error Report Card for all DCS working in residential group homes provided by agency RN's. Other supports, including emar's and additional pharmacy protections will be identified in the Corrective Action & Follow-Up sections below. The review emphasized the importance of our need to aggressively pursue and implement ongoing monitoring & implementing of safeguards with outcome focus on ending recurrence of medication errors.</p> <p>A) Corrective action &</p>		

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			<p>follow-up specific to Consumers #2, 4 & 7 relating to Medication Administration: The following actions and follow-up (F/U) are identified for each of the three consumers that had medication errors due to DCS failure to ensure that medications were administered according to physician's orders & without error. In addition, actions & F/U regarding individual employees involved in the medication errors is identified.</p> <p>Consumer#4 (C4): C4 had one medication error during March 1st –October 7th 2014. ·On 3/25/14, C4 did not receive her 1st of seven day HS doses of Monistat Vaginal Suppository. C4 did not suffer any adverse effects from the missed dose. The medication was continued as prescribed by her physician for seven days. BDDS IR was submitted on 3/26/14 & closed at time of submission. Staff who did not administer the medication received a verbal warning from her supervisor on 3/27/14 per Medication Error Review Team (MERT) recommendations as well as individual training on following through with treatments and documentation of such. All corrective action & training was completed by 3/28/14.</p> <p>Consumer#7 (C7): C7 had one medication error between March 1st andOctober 7th. ·On 3/6/14, C7 received one dose of Omeprazole 20 mg in the</p>		

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			AM which was prescribed to another consumer. Poison control was contacted & they stated that the medication effects would be benign and would not cause any adverse effects. No further instructions were given. BDDS IR submitted on date of error & closed at time of submission. Staff monitored C7 throughout the rest of day to assure that there were no ill effects. Her PCP was notified of error on same date with no further recommendations. The staff person responsible for administering the wrong medication was not wearing her glasses with corrective lenses at the time of the error & was alerted that she will need to wear her prescription glasses whenever she is administering medications to prevent further potential of errors. Per MERT recommendations, the staff was pulled from med administration due to having four med errors within a six month period, two of the errors involved giving the wrong med to the wrong consumer. A written warning was completed by her supervisor on 3/13/14 with the understanding that she would not resume passing medications for the consumers safety until the following were completed 1) observation of peer completing a proper medication pass, 2) a Medication Administration Mentor (MAM) & residential manager		

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			<p>monitoring her in two proper medication passes. All training & observations were completed by 3/21/14.</p> <p>Consumer#2 (C2): C2 had two medication errors from March 1st through October 7th 2014.</p> <p>·On 5/20/14, C2 received a dose of Zantac 150 mg which was another consumer's prescribed medication which resulted in a missed dose of her Keppra 500 mg 3 pm dose. The medication error was not discovered until the following day. A BDDS IR was submitted at date/time of knowledge & closed at time of submission. Her PCP was notified and offered no recommendations other than resuming medications as prescribed at her next scheduled medication pass. There were no adverse effects from taking the wrong medication (Zantac) or missing a dose of her seizure medication(s). Although this was the 1st medication error by the staff administering medications, the concern about giving the wrong medication to the wrong person & missed dose of prescribed medication was severe enough that the MERT recommended a written warning, retraining on the 6 rights & proper medication administration guidelines. It was discovered by the AAQA that the recommendations were not completed by her supervisor until almost 3 months after the fact.</p>	

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			<p>MERT recommendations of a written warning were also made for the staff responsible for not properly Buddy Checking the medications administered during this error. Again, the follow-up to MERT recommendations were not completed in a timely manner. The AAQA provided all staff working at Bollman with training on prevention of medication errors at the next scheduled house meeting on 6/18/14.</p> <p>·On 9/22/14, C2 did not receive her full dose of potassium chloride administering one tab instead of two as prescribed for low levels of potassium at 8 AM med pass. The Buddy Checker caught the error after the window of time. Confusion was caused by medication being packaged differently (blister packs rather than multi dose) due to machine malfunction through Young at Heart pharmacy, however, the error would have been prevented had the staff administering medications followed the 6 rights and triple checks of each medication. Medical On-Call and residential manager were notified of the med error with instructions to continue with next scheduled dose. C2 suffered no adverse effects from the error. BDDS IR submitted and closed at time of submission. MERT recommendations included verbal warning for staff administering medications & training peers at the next house meeting on the 6</p>	

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			<p>rights & triple check process. The Buddy Checker will provide peer training as well on Proper Buddy Check procedure. The meeting/training is scheduled for 10/31/14.</p> <p>Additional corrective action & follow-up for all residential staff working with Bollman consumers:</p> <p>1.All staff working specifically at the group home will receive Medication Administration retraining addressing trends & concerns in the home currently related to medication; medication packaging & labeling; proper medication storage; consequences of errors for consumers in particular, but also for staff; responsibilities of Buddy Checks; importance of communication across all settings; documentation; 6 rights; triple checks and MERT Corrective Action Guidelines review and explanation of Quarterly-Semi-Annual Medication Error Report Card by the RN's on 11/6/14.</p> <p>2.For those DCS staff working at Bollman who have demonstrated through disciplinary action and repeated errors that their employment is in jeopardy, the RN's will provide a Medication Administration Remediation Course (MARC) to designated staff per MERT recommendations. Curriculum will be developed and training specific to needs of those</p>		

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			<p>attending MARC. Competency testing will be individualized per individual need(s). This will be completed by 11/6/14.</p> <p>3.The MERT revised their Medication Administration Guidelines to include very specific Corrective Action Guidelines for personnel action for medication errors. These guidelines address # of errors by individual staff, the reasoning for the corrective action and where an individual staff falls in the continuum. These guidelines apply to the individual administering medications, as well as the Buddy Checker, as their responsibilities are equal. All staff working with the Bollman consumers across all settings will be provided with training on the Corrective Action Guidelines by 11/6/14.</p> <p>4.The agency RN's have developed a Quarterly &/or Semi-Annual Medication Error Report Card which indicates by individual staff any errors, # of errors involved, running total of errors, corrective action and a tally of total house errors compared with the staff's total errors and their responsibility for the % of the Bollman errors. This provides a very visual reminder of concerns related to each staff and their role in being a part of the solution rather than part of the problem. We hope that this will be a motivator. The Report Cards go hand in hand with the MERT Corrective Action Guidelines. All</p>		

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			<p>Bollman staff will meet with the RN's to discuss their Report Card status by 11/6/14.</p> <p>5.All staff working with the Bollman consumers & all residential consumers across all settings will be re-trained on medication administration expectations, the importance of better communication across all settings for med error prevention; an overview of MERT Corrective Action Guidelines, including the Report Card for all residential trainers, management team members, supervisors, and other identified staff. Additional training agenda items will be added as recommended by RN's, MERT, supervisory &/or administrative staff. Training will be completed by 11/6/14.</p> <p>6.The MERT also has identified the importance of any recommendations for disciplinary action needs to have the PAF written & submitted to a MERT administrative team member for review/revision 24 hours prior to supervisor & a MERT member completing the PAF with staff within one week in order for it to be meaningful and clearly understood. Implemented the week of 10/27/14.</p> <p>7.YAH pharmacy has purchased a robot that reads every RX using "machine vision" to check each prescription. It takes a picture of every bag and a computer checks it with 99.999% accuracy prior to leaving the</p>		

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			<p>pharmacy for delivery. This tool from YAH is one of the best in the industry and will provide the best quality of pharmacy services for our consumers.</p> <p>8.BCS had to switch emar providers in the spring of 2014. The accu-flo emar system was started at the WR group home as the trial location to work out any bugs. The Bollman group home is next in line for emar rollout which should occur within the next 6-9 months.</p> <p>9.All RMT members will be trained on items A.3-6 by 10/31/14 Person's Responsible: PD, RA, AAQA, RN's, Medical Caseworker and RMT's. Target Completion Date: 11/6/14</p> <p>B) Corrective Action and Follow-Up specific to BCS practices agency wide to eliminate recurrence of medication error(s):</p> <p>1.The Supported Living Management Team(SLMT) will be trained on items A.3-6 by 11/6/14. The SLMT's will then train their staff at the next staff &/or house meeting. Person's Responsible: PD; RA, AAQA, SLMT's & other supervisory staff. Target Completion Date: 11/6/2014</p>		