STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BI-COUNTY SERVICES INC	1111 S OAK ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of survey: July 23, 24, 25, 26 and 29, 2013. Surveyor: Kathy J. Wanner, QIDP. Provider number: 15G469 Facility number: 000983 AIM number: 100244850 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/5/13 by Ruth Shackelford, QIDP.	W000000	**OAK Annual Recertification & Licensure Survey Plan of Correction** **Survey Event ID 3V1R11** **August 2013**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000249	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, the facility failed to implement programming (toileting and dining) for 1 of 3 sampled clients (client #1) according to client #1's Individual Support Plan (ISP). Findings include: Observations of the home where client #1 lived were conducted on 7/23/13 from 4:47 P.M. until 6:12 P.M. At 5:18 P.M. client #1 stood up from her chair and indicated she needed to use the restroom. Direct Care Staff (DCS) #3 stated, "It's ok [client #1] you can go to the bathroom." Client #1 walked to the bathroom, pulled her clothes down and sat on the commode. Client #1 did not close the bathroom door for privacy. At 5:20 P.M. client #1 stood up from the commode, did not wipe herself, pulled up her clothes and left the bathroom without washing her hands. DCS #3 did not assist/train client #1 with closing the door for privacy, wiping herself after using the	W000249	**W249-Program Implementation** As soon as the IST has developed a consumer's ISP, each consumer must receive continuous active treatment programming consisting of needed interventions & services in sufficient number & frequency to support the achievement of objectives identified in the ISP. BCS was found to be deficient in not meeting this standard as evidenced by failing to implement programing (toileting & dining) according to Consumer #1's Individual Support Plan (ISP). We will direct the Plan of Correction (POC) focus of corrective action toward assuring that the potential of deficient practice(s) related to not implementing plans as written will not recur. Assuring that staff implement, practice, reinforce	08/28/2013

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	commode or washing her hands. At 5:37 P.M. while client #1 was eating her evening meal she took repeated bites without staff prompting her to take a drink. Client #1 took 12 (twelve) bites rapidly without pausing or drinking. After the twelve bites client #1 took a drink independently. Client #1 then took 8 (eight) bites rapidly without pausing or drinking. Staff did not prompt or encourage client #1 to take drinks between bites. At 5:46 P.M. DCS #2 verbally prompted client #1 from across the table "[Client #1] take small bites." Even though client #1 was utilizing her small maroon spoon, she took one bite of pureed chicken which was the size of two tablespoons. No staff prompting occurred after this large bite. Client #1's record was reviewed on 7/24/13 at 1:55 P.M. Client #1's ISP dated 8/1/12 indicated she had a goal "I want to use the toilet independently." The strategies for the goal indicated "1). Will improve her toileting skills means [client #1], with staff assisting will perform the following tasks: a). get toilet paper, pulling off 5 (five) to 6 (six) pieces of paper...b). spread legs apart and wipe with toilet paper, wiping from front to back. c). drop the toilet paper into the commode. c). flush the toilet. d). wash hands after toileting. 2). Training will occur each		and otherwise carry out strategies and procedures to achieve consumers objectives be they developmental, health, safety, behavioral in nature is the responsibility of the Administrative QA Team, Residential Management Teams (RMT) and the medical department. We will assure that training is provided to staff that allows them to do their jobs competently ***and*** consistently and then monitor & provide competency testing as needed thereafter to assure that plans are being implemented as written. Effective May 2013, the OAK group home had a positive change, providing structure and consistency in leadership [in particular, when a new Residential Management Team (RMT) was put in place. The RMT consists of a QIDP and Residential Manager (RM) with years of experience with BCS. The RMT is providing consistent supports, training, monitoring and setting expectations for the staff at the group home, which has already made a difference in day to day operations of the home and improved quality of life for the ladies living at OAK. **A) Corrective Action and**	

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	time [client #1] uses the bathroom...4). encourage [client #1] to stay in the bathroom until her pants are pulled up. 5). Verbally praise [client #1] for her efforts to improve her toileting skills." Client #1's Nutritional Assessment dated 5/12/13 indicated "...Continue to encourage client to take smaller bites and sip fluids between bites...." Client #1's choking /aspiration risk assessment dated 5/12/13 indicated client #1 was "High risk for choking....encourage client to eat slow and alternate bites of fluid (sic) and sips of fluid. Client may need 1:1 (one to one) assist/cue at meals to control rate of intake and to encourage sips post bite." Client #1's dining plan dated 8/22/12 indicated "...[client #1] will also be encouraged to take sips of her drink between bites using her slow-flow cup." Client #1's ISP indicated she had a history of frequent urinary tract infections and perineal rashes. DCS #1 was interviewed on 7/25/13 at 8:13 A.M. When asked about client #1's bathroom training, DCS #1 stated, "She is pretty much independent. She doesn't like to close the bathroom door, but can do everything else by herself." An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 7/29/13 at 11:40		**Follow-up specific to Consumer #1 (hereafter referred to as C1):** **Restroom Use/Toileting** 1.C1's annual case conference was held on 7/15/13 and her new ISP was implemented on August 1 st 2013. She continues to have a goal for "toileting", which will be revised to include closing the bathroom door for privacy & waiting until she is in the bathroom to pull down & pull up her clothing prior to leaving the bathroom, again for privacy reasons. Revisions to the "Toileting" goal will be completed by 8/21/13 & all staff working with C1 will be trained on revisions by 8/28/13. 2.C1 has a new Restroom Protocol for home & Day Services (DS). This plan was implemented August 1 st 2013 and was developed in order to assist with concerns related to skin breakdown in the groin/perineal areas & as a proactive approach to frequent UTI's. All staff working with C1 was trained on the Restroom Protocols across all settings on 8/1/13 prior to implementing the protocol(s). 3.C1's Skin Care/Breakdown Risk Plan was reviewed on 8/14/13 with recommendations for revisions regarding Baseline Information and Planning/Implementation components. Revisions will be	

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	A.M. When asked if staff should assist client #1 when she uses the restroom, the QIDP stated, "They should be watching to make sure she gets clean. Checking on her to see if she needs assistance. They should have assisted her if she indicated she needed assistance." The QIDP indicated client #1 did have a goal to work on her toileting skills. When asked about client #1 taking bites of food without being prompted to drink, the QIDP stated, "Absolutely she should have been prompted to slow down and take drinks between bites, it is part of her dining plan." 9-3-4(a)		made by 8/21/13 & all staff working with C1 across all settings will be trained prior to implementation no later than 8/28/13. 4.It is the responsibility of the OAK RMT to follow-up/monitor all plans/protocols/agency practices to assure that they are being implemented as written, revise as needed, coordinate with other identified professional staff (RN's, Medical Case Worker, Administrative Team, other supervisory staff) to support Direct Care Staff (DCS) in implementing plans. The RMT &/or other staff identified above ***MUST intervene immediately should they observe that plans are not being implemented as written.*** 5.Although all BCS staff working with residential consumers were retrained on the agency Abuse/Neglect policy in June, it is important that we ***competency test on program plan implementation as part of this POC***. All DCS working with consumers across all settings will be re-trained on understanding that failure to implement plans as written is considered ***negligence*** as per agency standard(s) as well as violation of the Abuse/Neglect/Exploitation and Violation of Individual Rights policy. Personnel Action will be taken with any staff who does not implement plans as written once they have been trained to	

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			competency. This action will be situational in nature and discretionary judgment used in the wide spectrum of addressing neglect from the possibility of retraining, to suspension from working with consumers and/or termination. Team input is a priority in determining personnel action required. Re-training of consequences & the agency A/N policy especially relating to neglect will also be part of the training agenda. Re-training will be completed by 8/28/13. 6.All DCS will be encouraged to ask for clarification, training and any other supports needed for them to feel comfortable in doing their jobs competently and this will also be addressed during POC training by 8/28/13. **Dining Plan** 1.C1 is on a 1500 kcal Puree with thin liquids diet and is reviewed quarterly by Stephanie RD CD. Nutritional Quarterly Review was completed on 7/25/13. Concerns addressed continued weight gain even though some loss should be seen with the 1500 kcal diet. Recommendations made to be included in both Dining and BMI Risk Plans (RP) by 8/21/13. All staff working with C1 across all settings will be trained on revisions prior to being implemented by 8/28/13. 2.C1's Consumer Specific	

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			Training (CST) reviewed 8/16/13 with minor changes needed to reflect items listed in RP's listed above in item #7. Revisions will be made by 8/21/13 and training with staff working with C1 across all settings will be completed prior to implementing by 8/28/13. 3.C1's Behavior Support Plan (BSP) includes targeted behavior of "Taking Food & Drink" from others and includes proactive components to assist with redirection. Taking of food & drinks ties in with her weight gain. Her annual BSP will be reviewed for approval by BCS Human Rights Committee on 8/28/13. All staff working with C1 will be trained on her BSP 8/28/13. Person's Responsible: Program Director (PD); RMT; Residential Administrator; AAQA and Medical Department. Target Completion Date: 8/28/13. **B) Corrective Action as it relates to BCS practices agency wide:** 1. DCS working with group home consumers across all settings will be retrained on section A. 5 & 6 listed above in	

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			order to review A/N policy, clarify expectations and consequences and encouragement to ask for help prn by 8/28/13. 2.RMT's, supervisory staff working with SGL consumers across all settings, medical staff and administrative staff will be re-trained on Section A.4-6 above by 8/28/13. 3.RMT's will assure that all SGL DCS are trained on Section A. 5 & 6 by 8/28/13. DS DCS will be trained by the DS Coordinator &/or PD by 8/28/13. 4.Supported Living Management Teams (SLMT) will be retrained on Section A.4-6 above by 8/28/13 and they in turn will provide training to SL DCS at their next scheduled staff meetings. Person's Responsible: PD; RA, AAQA, DS Coordinator and RMT's Target Completion Date: 8/28/13.	

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W000368	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 on record review and interview, the facility failed to assure medication administered to 1 of 3 sampled clients (client #3) was administered according to client #3's physician's orders. Findings include: Facility records were reviewed on 7/23/13 at 2:15 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 7/23/12 and 7/23/13. The BDDS reports indicated the following: -A BDDS report dated 6/10/13 for an incident on 6/9/13 at 7:00 P.M. indicated "On 6/9/13, during a routine medication count, staff discovered [client #3] had been receiving another consumers Albuterol (Chronic Obstructive Pulmonary Disease) .5% 2.5mg/.5ml (point five percent two and one half milligrams/point five milliliter) solution per nebulizer. [Client #3's] order is for .5% 3mg/.5ml solution per nebulizer. All staff involved in this 11 (eleven) day medication error, failed to complete triple checks, the 6 (six) rights of medication	W000368	**W368-Drug Administration** The system for drug administration must assure that all drugs are administered ii compliance with the physician's orders. . BCS did not meet this standard as evidenced by failure to assure that one of six consumer's medications was administered according to her 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 Case Worker is actively involved with DCS in all group homes and provides open communication and supports in providing pertinent changes to consumers' medications and other priority concerns included in consumers MAR/TAR's. Residential Management Teams (RMT) along with the Administrative Team will work closely with the nurses and Medical Case Worker to assist with monitoring of ensuring that staff administers medications/treatments per physician's orders. Although we have several safeguards in place for assuring that	08/28/2013

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	administration, as well as buddy checks, administering medication from the other consumers box of vials of solution." The BDDS report indicated client #3 had received a lower dose of Albuterol then what her physician had ordered for eleven days. The BDDS report indicated all staff involved were retrained and received disciplinary actions per facility policy. The Residential Administrator (RD) was interviewed on 7/25/13 at 1:33 P.M. The RD indicated the staff passing medication to client #3 had not looked at the box of vials. The box had been placed in the wrong area and staff had just not looked. The RD stated, "We rearranged the medication area after the error was found. The error was finally caught when someone actually read the order on the box of Albuterol vials." The RD indicated client #3 had received less Albuterol then what her physician had ordered for her to use. The Qualified Intellectual Developmental Disabilities Professional (QIDP) was interviewed on 7/29/13 at 11:46 A.M. When asked about the medication error for client #3, the QIDP stated "It was inexcusable. I changed the accountability sheet to have staff check prior to and after passing medications. Staff just didn't look at the box to make sure it was [client #3's]		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 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. Our protocols and other safeguards have been reviewed and no revisions were identified for change(s) other than an additional support of "Medical Home Observation(s)" being implemented 8/13. The review did emphasize the importance of our need to aggressively pursue and implement ongoing monitoring & implementing of safeguards with outcome focus on ending recurrence of medication errors. The agency RN's have been working with our pharmacy, Young at Heart (YAH), in pursuing an EMAR system. Progress has been made,	

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	medication. Staff have all been retrained." 9-3-6(a)		although slow. On 8/19/13 the Medical Department will be meeting with YAH & Catalyst Systems Representatives for customizing the Catalyst Systems (oneMAR) for BCS. We hope to have the oneMAR system up and running in the next 60-90 days with specific adaptations for our agency in place. We feel that the *oneMAR* will be a very positive safeguard for administering medications without error. In addition, effective September 16 th 2013, the OAK group home will begin use of multi-dose medication packs. Multi-dose packs have used at one of our other group homes since June 2013 “cycle fill” and have been effective in eliminating errors. ` The citation with corrective action is specific to consumer #3 (C3) which involved an 11 day medication error where C3’s Albuterol solution per nebulizer for diagnosis of Chronic Obstructive Pulmonary Disease (COPD), was administered from another consumers Albuterol of a smaller dosage. The corrective action will address C3, the OAK group home, all residential group homes and practices agency wide. **1.Corrective action & follow-up specific to Consumer# 3 relating to Medication Administration:** **Consumer #3 (C3):** 1. C3’s administration of another consumers Albuterol solution was	

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			discovered during a routine medication count. C3 is prescribed .5% 3 mg/.5ml solution per nebulizer. The other consumers order is for lower dose (.5% 2.5 mg//.5ml solution per nebulizer). C3's PCP was contacted and had no recommendations other than to return to the prescribed order. C3 suffered no ill effects from this error. Four DCS were involved in this eleven day error, all received personnel action including 2 suspensions without pay & 2 written warnings due to failure to complete the 6 Rights of Medication Administration, Triple Checks and Buddy Checks during medication administration. All OAK staff was re-trained on medication administration, following physician's orders and other issues related to medication errors on 6/10/13. The Medication Accountability sheet(s) for the group homed were revised by the QIDP on 6/12/13 to have staff check prior to & after passing medications. 2. The medication administration area at OAK has been rearranged for better organization, however, the storage space and cabinets are small and limited. As a result of a medical department observation the purchase of cabinet &/or containers for storage of overflow routine oral & topical medications is needed to assure that separation of consumer medications is available to avoid	

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			future errors of the type C3 incurred. Containers will be purchased and organization of overflow medications will be completed by 8/28/13. 3. C3 has a medication administration goal that will be revised to address the multi-dose packs which will be implemented at OAK effective 9/16/13 so as to assure that C3 has a goal which is functional for the new process. The goal will be revised by 8/21/13 and training provided to OAK staff prior to goal implementation by 8/28/13. 4. OAK staff was re-trained 6/12/13 on a variety of medication administration components as part of another POC. Further training related to medication errors will be provided to all DCS working with C3 & all OAK consumers by 8/28/13. (*Reference B.1 & 2 below for specifics)* **1.Corrective Action and Follow-Up specific to OAK, all Residential Group Homes and BCS practices agency wide to eliminate recurrence of medication error(s):** 1. **OAK.** The following are actions & training will be completed to assist with prevention of recurrence of medication errors: a. Acquiring new storage cabinet &/or containers to assist with separating & organizing medications including overflow oral & topical medications. b.	

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			Training on & preparation for multi-dose packs for consumers to be completed by 8/28/13 in order to be READY for change in medications & how they are administered effective September cycle fill (9/16/13) . c. All staff working with OAK consumers across all settings will be re-trained & **competency tested** on A/N policy with focus on neglect issues of NOT administering medications as per physician's orders &/or implementing health related plans/protocols as written. Explanation of consequences for neglect and importance of contacting the medical department &/or Medical On-Call when needing clarification &/or additional support/training. Reminder of the importance of following through with RN's directives regarding medications, treatments and plans/protocols as preventative resource for consumers' health & safety. d. Retraining on Six Rights of Medication Administration & Triple Checks. e. Review of the importance of the Buddy Check Procedure. f. Retraining on the importance of communication across all settings as it relates to consumers' health, safety & well-being. **2. Residential & BCS Practices agency wide:** a. All DCS working with residential consumers will be re-trained on items B.1.c-f above. b. Medical Department will be doing regular	

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			group home observations with specific format of priorities they have identified as stumbling blocks for assuring administering medications without error. Medical Home Observations implemented 8/12/13. c. Home Observations will be completed by RMT's & Administrative Team on a regular basis with attention to medication administration and implementing plans/protocols consistently and as written. d. The implementation of the Medication Administration Mentor (MAM) system effective 11/12 has been an excellent "on the job" support for DCS in providing assistance with administration of medications/treatments/protocols/ plans in maintaining required documentation within the scope of the agency policy & State mandated medication administration course "Living in the Community". We believe that this mentoring system will be successful in preventing recurrence of medication errors & assuring implementation of health related plans & protocols, including those designed by dieticians, physical & occupational therapists, etc. This practice will continue. e. BCS Medication Administration Guidelines has been reviewed no recommendations for revisions. This practice will continue. f. The Medication Error Review Team (MERT) Guidelines were reviewed and revisions made	

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			6/13. Staff were trained on those revisions 6/12/13. · In addition, members of the MERT will be assessing & looking at new & better ways of identifying trends in a timelier manner in order to intervene & prevent recurrence. · The AAQA maintains an Employee Medication Error Record which is a tool that the MERT can refer to in identifying trends & concerns needing addressed. g. The agency RN's have developed a Medication Error Remediation Class that was designed to support, re-train and clarify issues leading to recurrence of errors. This additional support system has been appreciated by management teams, as well as DCS participating in the course. This practice will continue. h. A Group Home Medication Tracking System with specific responsibilities for 3 rd shift staff has been developed with daily, weekly & monthly "duties" which will assist with a variety of tasks such as checking for expired medications, proper labeling, ordering and monitoring of transcribing of orders. All residential 3 rd shift staff was trained on the tracking system monitoring of "duties" to assist with recurring issues that can be prevented on 6/12/13. i. Agency RN's &/or Medical Caseworker complete a Proper Medication Pass Observation at least monthly in each group home. This	

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			observation allows for staff administering medications to clarify concerns with medical staff, while at the same time RN's can make recommendations related to any concerns identified during med pass and/or provide encouragement for staff doing an excellent job with following the 6 rights, etc. This practice will be continued. j. The Buddy Check Procedures was reviewed with no identified revisions and will continue as a priority support/safeguard. k. A Checklist for Transcribing Orders has been developed and implemented 5/13. This tool to assure correct transcribing of orders also includes a staff to Buddy Check as an additional safeguard. All residential staff was re-trained on the Checklist for Transcribing Orders on 6/12/13. l. A procedure for transporting &/or transferring of any consumer medications that might be "shared" across settings (group home & DS or workshops) was identified as a need to assist with preventing errors. The procedure was implemented and staff trained across all settings on 6/12/13. m. The RMT's and other supervisory staff involved with residential consumers across all settings will be retrained on: · The A/N policy with focus on neglect issues tied in with recurrence of medication errors and failure to implement health related protocols & plans as	

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			written. · RMT responsibility to intervene immediately when needed to respond, investigate and correct situations with potential of consumer neglect. Our role is to prevent recurrence of problems/trends. · RMT's and all supervisors are encouraged to utilize the Human Resources Competency Evaluation tool. · Re-training will also include the 6 rights, Triple Check & using the Buddy Check system as a prevention tool. · RMT's will be responsible for training their staff on agenda items identified throughout this POC by 8/28/13. n. BCS Human Rights Committee (HRC) which meets every other month is an excellent resource for providing direction & guidance related to residential consumer's medications, monitoring of drug interactions, as well as addressing concerns about errors. The HRC is made up of an attorney, pharmacist, retired physician, social worker, physical therapist, pastor and residential consumer. Their mission is to advocate for BCS consumers individual rights are not violated and that they are free from abuse, neglect & exploitation o. Supported Living Management Teams (SLMT) will be re-trained on items listed in section C.2.c/e-g/i-m by 8/28/13. It will be the responsibility of the SLMT to assure that their staff is trained on these identified issues at the	

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			next scheduled staff meetings. Person's Responsible: PD; OAK RMT; RN's & Medical Caseworker: Administrative Team and SLMT & other supervisory staff. Target Completion Date: 8/28/13	