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| 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 10/07/2014 |
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| NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1111 S OAK ST BLUFFTON, IN 46714 |
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| W000000 | <p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: September 23, 24, 25, 30, October 1, 3 and 7, 2014.</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>Provider Number: 15G469 AIM Number: 100244850 Facility Number: 000983</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/15/14 by Ruth Shackelford, QIDP.</p> | W000000 | <p>OAK Annual Recertification & Licensure Survey Plan of Correction</p> <p>Survey Event ID KLVM11</p> <p>October 2014</p> | |
| W000331 | <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility's nursing services failed for 1 additional client (client #6) to ensure the medication label matched the medication</p> | W000331 | <p>W331-Nursing Services The facility must provide clients with nursing services in accordance with their needs. BCS was found to be deficient in not meeting this standard as</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>administration record (MAR).</p> <p>Findings include:</p> <p>Medication administration was observed at the group home on 9/25/14 at 7:16 AM. Client #6 received 4 capsules of Depakote (seizures) 125 mg (milligrams) from staff #5. The label on the medication indicated client #6 was to receive the Depakote capsules daily at noon.</p> <p>Client #6's September, 2014 MAR was reviewed on 9/25/14 at 7:55 AM. The MAR indicated client #6 was to receive 4 capsules of Depakote 125 mg at 7:00 AM, 12:00 PM and at 9:00 PM.</p> <p>Staff #5 was interviewed on 9/25/14 at 7:55 AM and indicated the labels should match the MAR. She indicated the pharmacy for the group home had recently had a fire and the medications were packaged differently until their system was repaired.</p> <p>The group home nurse was interviewed on 9/25/14 at 10:10 AM and indicated the label on the medication being dispensed should match the MAR.</p> <p>9-3-6(a)</p> | | <p>evidenced by failure to assure the medication label matched the medication administration record (MAR). There was no medication error as a result of the label not matching the MAR, although we clearly understand that it increased the potential of an error occurring had the staff not been well trained on Client#6 medications, needs and plans. BCS uses Young at Heart (YAH) pharmacy. The medications provided for Client #6 during the week of September 22nd was packaged differently, blister packs rather than the usual multi-dose packs, due to a machine malfunction at the pharmacy. Collateral responsibility information from YAH regarding the problem and fixing it will be provided as part of the plan of correction. Although the medications were packaged differently and labeled incorrectly, there were no medication errors and as such the staff did not think to notify the agency RN's or medical On-Call of the packaging labels. The day following the surveyor observation the correct label and packaging were provided for Client #6.</p> <p>A) Corrective Action and Follow-Up Specific to Client #6 (hereafter referred to as C6):</p> <ol style="list-style-type: none"> C6 did not experience any medication error(s) or harm as a result of the deficiency in labeling. YAH provided the correct label and multi-dose packaging | | |

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| | | | <p>on the afternoon of September 30th 2014 after contact with agency RN.</p> <p>3. Tags/labels in very bold colors have been made to attach to any medication packaging (bottles, blister packs, etc) that are different from the usual multi dose packs that staff are used to in order to assure that the staff triple check & refer to the MAR for current/correct physician's orders.</p> <p>4. For C6's protection and that of all our group home residents, the RN's, Medical Caseworker &/or Residential Management Team (RMT) members will be notified immediately when there is a change in labeling that does not match the MAR &/or a packaging change that might lead to the potential for a medication error. All staff working with C6 & other residential group home clients across all setting will be trained on items A.3 & 4 by November 6th 2014. Persons responsible: RN's, Medical Caseworker, OAK RMT, Program Director (PD), Residential Administrator (RA) and Administrative Assistant for Quality Assurance (AAQA). Target completion date: 11/6/14</p> <p>B) Corrective Action as it relates to BCS practices agency wide:</p> <p>1. All staff working with residential consumers across all settings will be trained on prevention of medication errors as it relates to labels matching MAR &/or packaging changes</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.</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were administered without error for 2 of 3 sampled clients (clients #2 and #3) and 2 additional clients (clients #5 and #6).</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/24/14 at 1:02 PM and included the following:</p> | W000368 | <p>that could lead to potential for medication error to contact agency RN's, Medical Caseworker, or RMT immediately. Reference A.3 above.</p> <p>2.RN's will be providing additional training on prevention of medication errors, consequences of errors for consumers as well as staff as part of this POC regarding the W368 tag. Persons responsible: RN's, Medical Caseworker, RMT's, PD, RA & AAQA. 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 four of six 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</p> | 11/06/2014 | |

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| | <p>A report dated 3/2/14 indicated client #2 was not given cetirizine tablet (allergies) 10 mg (milligrams). The report indicated it would be reviewed by the Medication Error Review Team (MERT) and their recommendations would be followed.</p> <p>A report dated 8/25/14 indicated client #2 was not given Topiramate (seizures) 25 mg on 8/23/14. The report indicated the MERT team would review the error and staff would be retrained.</p> <p>A report dated 3/9/14 indicated client #3 received 100 mg of Phenazopyridine (urinary discomfort) at 3:00 PM and 7:00 PM instead of 200 mg.</p> <p>A report dated 5/27/14 indicated client #3 didn't receive a 7:00 AM dose of Septra (antibiotic) 80 mg on 5/26/14 and 5/27/14. The report indicated the MERT would review the error and staff would follow correct medication administration procedures.</p> <p>A report dated 8/23/14 indicated client #3 was not given a 3:00 PM dose of Amoxicillin (antibiotic) 500 mg. The report indicated the error would be reviewed. The report indicated the MERT would review the error and recommendations would be followed.</p> | | <p>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 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. 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 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</p> | | | | |

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| | <p>A report dated 9/6/14 indicated client #3 missed a 2:00 AM feeding of Ensure through her PEG (percutaneous endoscopic gastronomy) feeding tube. The report indicated the error would be reviewed by the MERT. The report indicated staff would be retrained.</p> <p>A report dated 7/28/14 indicated client #5 missed a dose of Ipratropium Albuterol (difficulty in breathing) solution on 7/26/14. The report indicated the MERT would review the error and staff were retrained.</p> <p>A report dated 3/7/14 indicated client #6 received Robafen syrup (cough syrup) instead of Tylenol 350 mg. The report indicated the MERT team would address the error and their recommendations would be followed.</p> <p>A report dated 8/13/14 indicated client #6 did not receive her Nystatin Powder for a rash under her nose or her Tobramycin (antibiotic) solution to her right eye at 7:00 PM. The report indicated the MERT would review the error and their recommendations would be followed.</p> <p>The Program Director and group home nurse was interviewed on 10/3/14 at 3:55 PM and indicated the facility was starting a new protocol for disciplinary action to</p> | | <p>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 OAK 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 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>1. Corrective action & follow-up specific to Consumers #2, 3, 5 & 6 relating to Medication Administration: The following actions and follow-up (F/U) are identified for each of the four consumers that had medication errors due to DCS failure to ensure that medications were administered</p> | | | | |

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| | address medication administration errors as part of the review by the MERT. 9-3-6(a) | | according to physician's orders & without error. In addition, actions & F/U regarding individual employees involved in the medication errors is identified. Consumer #2 (C2): C2 had two medication errors between March 1st – October 7th 2014. ·On 3/1/14, C2 did not receive cetirizine 10 mg. tab at HS for allergies. BDDS Incident Report (IR) was submitted. C2 did not suffer any ill effects due to missed dose. DCS notified Medical On-Call and followed instructions provided by the RN. The MERT recommended a verbal warning through a personnel action form (PAF) with expectations of following doctor's orders & received additional counseling & training on proper med pass/administration procedures by the agency RN. PAF verbal warning given by RM & training completed by RN all completed by 3/28/14. ·On 8/23/14 DCS failed to administer C2's Topiramate 25 mg tab at HS for seizures. On 8/25/14 the medication error was discovered and agency RN & OAK RMT was contacted immediately at time of knowledge, as well as BDDS IR submitted. C2's personal care physician (PCP) was notified of the error. C2 did not experience any adverse reactions due to missed medication dose. A written warning was given to the DCS involved in the missed | | |

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| | | | <p>medication, as well as failure to complete two Buddy Checks on the date of the error(s), which would have prevented the medication error(s) if they had been completed. Training with DCS involved in the error included proper procedures for medication administration provided by the Residential Manager(RM) and the Medication Mentor (MAM) for OAK. Staff was also encouraged to ask for additional assistance &/or training when unsure of medication or treatment orders. All disciplinary action & training completed by 9/28/14. Consumer#3 (C3): C3 had four medication errors between March 1stand October 7th at the time of the survey exit. She had an additional error on October 11th following the exit interview.</p> <p>·On 3/8/14, staff failed to administer C3's full dose of Phenazopyridine at 3 pm & 7 pm medication times, administering just 100 mg rather than 200 mg per physician's order. The error was discovered on the morning of 8/9/14 & Medical & RMT On-Call were notified at time of knowledge, as well as a BDDS IR submitted. C3's PCP was notified and her recommendations included an order for a urine analysis to assure that C3 did not have a UTI (C3 did not have a UTI) and also instructed the agency RN to change the medication order for</p> | | |

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| | | | <p>Phenazopyridine 200 mg back to prn status. C3 suffered no ill effects from the reduced medication dosage. The MERT recommended that the DCS administering medications receive a written warning from her supervisor, retraining on completing Injury/Illness (I/I) Reports, tracking, pill counts along with proper medication administration procedures by a MAM. Other expectations identified in the PAF included administering medications per physician's orders and to seek guidance with any questions regarding medication administration. Two additional staff who were responsible for Buddy Checks at the 3 pm & 7 pm med passes received verbal warnings for their lack of follow through with checking the MAR's to assure accuracy, thus also being responsible for C3's medications not being administered as prescribed. All PAF's & retraining was completed by 3/31/14.</p> <p>·On May 26th & 27th 2014, C3 did not receive her 7 am dose of Septra 80 mg. At the time that the error was discovered on 5/27/14 at 5 pm the Medical & RMT On-Call staff were notified & a BDDS IR was submitted. This medication had been "on hold" due to other antibiotics being prescribed. C3 was to have restarted the Septra 80 mg medication with the 7 am dose on</p> | |

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| | | | <p>5/26/14. The medication was restarted at 7 am on 5/28/14. C3 had no adverse reactions as a result of the med errors. Her PCP was contacted & had no other directives other than to restart the medication on 5/28/14 at 7 am. MERT recommended a systematic protocol for tracking C3's antibiotics including start/stop dates/times for specific antibiotics. OAK staff, Medical department team, RMT & AAQA participated in developing the protocol at a house meeting on 6/13/14. All staff were trained on the protocol by 7/11/14.</p> <p>·On 8/23/14, DCS failed to administer C3's 3 pm dose of Amoxicillin 500 mg by mouth. Medical On-Call & RM were notified and a BDDS IR submitted. DCS administered her HS dose as ordered and extended the administration of the medication by one day/one dose. C3 did not suffer any ill effects from the missed dose of antibiotic. No other PCP recommendations. MERT recommendations included staff administering medications received a one day suspension without pay and staff responsible for Buddy Checks received a written warning.</p> <p>·On 9/6/14, C3 did not receive her 2 am feeding of 120 ml of Ensure through her PEG tube, but she did receive the 2 am flush of 90 cc's of water. At 5 am that date it was noticed that she did</p> | | |

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| | | | <p>not get the 2 am feeding & medical on-call was notified immediately. Since the 120 ml Ensure feeding & flush of 90 cc's of water is ordered every four hours, the discovery at 5 am made it too close to the next feeding so instructions were given to continue with the next scheduled normal flush & feeding scheduled/ordered. C3 did continue her feedings/flushing's as scheduled. She was monitored and suffered no ill effects. A BDDS IR was submitted. Her physician recommended that she continue to sit at the table as tolerated & eat pureed meals as tolerated along with her feeding/flushing schedule. Staff responsible for the missed feeding was pulled from 3rd shift as it is typically an unsupervised shift and from feeding C3 until able to demonstrate competency per RN's & RMT by completing training with the OAK MAM including the PEG tube feeding process & correct documentation. Staff also received a verbal warning.</p> <p>·On 10/11/14 (following survey exit interview), C3 failed to receive Nitrofurantion 100 mg at 7 pm. Two staff were working at the time of the error, one of which was a regular OAK staff & the other was a "relief" who does not work regularly in the home. The relief staff rather than the regular OAK staff was administering medications at 7 pm med pass &</p> | |

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| | | | <p>failed to administer the medication which was in a bottle clearly labeled & on the MAR. The regular staff who was responsible for Buddy Checks & did not check the medications administered nor documented in the MAR as per guidelines. In addition the regular staff should have been completing the medication pass and not the relief staff who is not as familiar with the consumers' medications & increased the potential of med errors as demonstrated in this incident. C3's PCP was contacted at the time of knowledge of the med error and recommended that the medication be given at time of next dose and then given until completion of the script as ordered. C3 was monitored for 48 hours with no adverse reactions indicated. Regular staff to receive an unpaid suspension, retraining & competency testing with medical department staff, MAM, and RMT. All training & disciplinary action will be completed by 11/6/14.</p> <p>Consumer#5 (C5): C5 had one medication error from March 1st through October 7th 2014.</p> <p>On 5/26/14, C5 did not receive her dose of Ipratropium/Solution Albuteral at 1 pm as ordered. Medical & RMT on-call were notified at the time DCS realized they had missed her 1 pm dose and it was close to the next scheduled dose. Staff was instructed by Medical On-Call to</p> | | |

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| | | | <p>skip the 1 pm dose & move forward with the next dose as per scheduled order. C5 was monitored and suffered no ill effects from the missed dose. PCP was notified & had no recommendations or concerns at the time. Staff assigned to medication passes received a verbal warning, provided a peer presentation at the August house meeting on the benefits of nebulizer treatments. Also re-training on ensuring medications are given as per physician's orders are properly completed prior, during &/or after outings. All staff working at OAK were re-trained on the Six Rights of medication administration and planning outings around consumers medication orders/needs on 8/15/14.</p> <p>Consumer#6 (C6): C6 had two medication errors from March 1st through October 7th 2014</p> <ul style="list-style-type: none"> On 3/6/14, C6 was to be given Robafen DM 10 ml syrup PRN for a sore throat and received Tylenol 350 mg syrup instead. Although both medications are prescribed for C6 prn, the Robafen is prescribed for coughs, sinus drainage and sore throats, while the Tylenol is prescribed for pain & fever. At time of knowledge on 3/7/14, medical department was notified and a med error form was completed. BDDS IR was submitted on 3/9/14. Due to the fact that this was a prescribed medication for | | |

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| | | | <p>C6 & that the Tylenol was of no harm to her, C6's PCP was not notified. She suffered no ill effects as a result of taking Tylenol instead of Robafen DM. C6 offered no further complaints. Triple checks of the medication label & MAR would have prevented this error. Also better communication between all settings involved in C6's life would have helped in preventing this error as well. The Day Services staff who administered the wrong medication received a verbal warning from her supervisor per MERT recommendations. All personnel action was completed by 3/12/14.</p> <p>·On 8/13/14, C6 did not receive her dose of Nystatin powder for a rash or Tobramycin solution to her right eye at 7 pm medication pass. This was a new order for both medications & the information had been clearly communicated by agency RN to both staff administering the medications as well as the Buddy Checker. The error was discovered the following day, at which time medical was contacted & a BDDS IR was submitted. Although C6 did not suffer any ill effects from the missed topical medications she would have been more comfortable had the orders been followed. In addition, these were new orders which staff failed to enter the new orders on the MAR per instructions from RN's, the</p> | | |

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| | | | <p>medications were not locked up properly & Buddy Checks were not completed as per guidelines. MERT recommendations included a written warning for staff administering medications, noting that any further error(s) would result in an unpaid suspension. The staff person also was responsible for providing a presentation for her peers at the next house meeting covering the importance of antibiotics being given as ordered and dangers of missing a dose. Training occurred at August house meeting and disciplinary action was completed on 9/10/14.</p> <p>Additional corrective action & follow-up for all ladies living at OAK:</p> <p>1. All Oak 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 11/3/14.</p> <p>2. For those DCS staff working</p> | |

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| | | | <p>at OAK 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 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 OAK ladies 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</p> | |

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| | | | <p>errors and their responsibility for the % of the homes 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 OAK 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 OAK ladies & 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 theimportance of any recommendations for disciplinary action needs to have the PAFwritten & submitted to a MERT administrative team member forreview/revision 24 hours prior to supervisor & a MERT member completing the PAF with staff within one week in</p> | | |

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| | | | <p>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 thatreads 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 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 OAK group home is 3rdin line for emar rollout which should occur within the next 6-12 months.</p> <p>9.All RMT members will be trained onitems 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>1. 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,</p> | | |

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| | | | SLMT's & other supervisory staff. Target Completion Date: 11/6/2014 | | |