STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G576	A. BUILDING 00 B. WING	05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BI-COUNTY SERVICES INC	503 N THIRD ST DECATUR, IN 46733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. Date of Survey: 5/8, 5/9, 5/10 and 5/11/23. Facility Number: 001090 Provider Number: 15G576 Aims Number: 100245540 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 5/19/23.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 2 additional clients (#4 and #5), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Findings include: Observations were conducted on 5/8/23 from 3:55 pm to 6:15 pm and 5/9/23 from 5:54 am to 9:15 am. Clients #1, #2, #3, #4 and #5 were present throughout the observation period. The following environmental issues were noted affecting clients #1, #2, #3, #4 and #5:	W 0104	Third Street Recertification & State Licensure Plan of Correction Survey Event ID KIZG11 May 2023 W104-Governing Body The Governing Body must exercise general policy, budget and operating direction over the facility. BCS failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair.	06/02/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erika Squires	Program Director	06/02/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	1) In the hallway and bathroom on the left side of the house, the flooring was soft and sunk down when walking on it. The wall on the left side of the bathtub had drywall missing measuring 2 inches by 1 inch. The paint on the wall was flaking off on the top of the shower surround. On the wall on the left side of the bathroom on both sides of the light switch measuring 1 and 1/2 inches by 3/4 inches and another area measuring 2 inches by 1/2 inches were missing paint. On 5/8/23 at 4:45 pm the House Manager (HM) stated, "The bathroom floor sinks down. Two people have fallen in the past due to the floor. It is rotten." On 5/9/23 at 6:33 am staff #3 stated, "The floor in the bathroom and hallway has been like that for 8 years. We write it up and nothing happens." 2) In the living room the brown couch had worn spots throughout the couch. 3) In the bathroom off the kitchen, the vent had spots of orange in color on it. The tile on the bottom of the shower had a brown substance in the middle of the floor. The strip between the shower and the sink cabinet had a black substance throughout the metal strip. 4) The wall beside the door in the dining room had an area without paint measuring 2 1/2 inches by 3 1/2 inches. 5) In the backyard on the right side of the house there was a broken fence, cardboard and other wood pieces leaning up against the house. On 5/5/23 at 8:22 am the HM stated, "We put in a work order to have maintenance remove those		A. Corrective Action and Follow-Up (F/U) Specific to all consumers living at 3rd Street group home: 1. The flooring in the hallway outside of the bathroom has been a continued issue. This was cited during a 2020 survey and was attempted to be corrected with the actions described in section 1.a. The issue has continued and the floor is still soft and sunk down. Due to our inability to repair this issue within our own Maintenance Department we have sought out a professional to repair the floor. a. The Maintenance Department completed repairs on the section of flooring by the front hall bathroom which sank when stepped on by bracing added to the flooring, adding new wood on the bottom side of the existing floor and then added two 10-ton jacks under the floor. The repairs were completed on 7/15/20. 2. A sub-contractor from CJ's flooring came to the house on 6/1/23 to provide us with an estimate for the project and a date in which they could complete the repairs. The tentative date for the repairs is the week of 6/5/23. If not, it will be the following week. At a minimum the flooring in the bathroom and in the hallway outside of the bathroom will be replaced with ceramic tile and a water barrier in front of the tub. It is possible once the flooring is up	

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	items, but they never did it." On 5/9/23 at 11:35 am the maintenance records were reviewed. The bathroom and hallway floor were reported for repair but they were not repaired. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/10/23 at 1:24 pm. The QIDP stated, "The home should be clean, tidy and safe. There have been concerns with the floor stability and how soft the floor is near the bathroom. I have the same concerns with the flooring by the bathroom. After maintenance stated they fixed it, the floor was still soft. I am concerned of safety risk when walking. The cushion of the couch are worn." An interview with the Program Director (PD) was conducted on 5/10/23 at 2:21 pm. The PD stated, "The home should be maintained, and repairs made. There are issues with the flooring in the house and we have been cited before about it. It was 2 years ago. Even after maintenance said they repaired the floor, I still do not think it is as strong as it should be. If there are holes, then the drywall should be repaired and painted." 9-3-1(a)		that the entire hallway's flooring will need to be replaced as well. 3. The drywall on the left side of the tub was repaired on 6/1/23 4. The paint on the wall surrounding the shower will be repaired at the same time as the bathroom flooring 5. The drywall and paint was repaired surrounding the light switch in the bathroom on 6/1/23 6. The couch in the living room is comfortable for consumers 1-3. BCS will continue to monitor the condition of the furniture in the home as well as seek out a new couch for the men in the home that aligns with their sensory needs. Clauser's furniture was contacted as well to notify them of what we are looking for in a couch, so they can provide us with in stock options as well to avoid extended wait times on the purchase of a new couch. 7. The vent in the bathroom of the kitchen was replaced on 6/1/23. 8. The brown substance in the middle of the floor was cleaned up the same day it was observed. 9. The strip between the shower and the sink cabinet was bleached and cleaned on 6/1/23. 10. The wall beside the door in the dining room was repaired and repainted on 6/1/23 11. The trash was removed from the backyard on 5/17/23 12. Residential Management	

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			Team (RMT) members will continue to be responsible for submitting Work Requests to the Maintenance Supervisor and Administrative Assistant (AA) and to F/U with the Residential Administrator (RA) if requests are not completed in a timely manner and/or if a safety concern is identified as a priority & not responded to as a priority. 13. All RMT members will be trained on item #12 by 6/2/23. Person's responsible: Program Director (PD), Residential Administrator (RA), Administrative Assistant (AA), Maintenance Supervisor and Residential Management Team (RMT). Target Completion Date: 6/2/23 B. Corrective Action as it relates to BCS Practices Agency Wide: 1. Supported Living (SL) department has a different process for work requests as many of the waiver consumers rent and/or own their own homes/apartments. SL management staff will take the opportunity to talk with staff and residents of the importance of taking pride and responsibility in their homes. The time line for management teams to speak with their consumers & staff will be at their next scheduled house meetings. Persons responsible: SL	

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			Administrator & SL management teams. TCD: Next scheduled SL house meetings	
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the Qualified Intellectual Disabilities Professional (QIDP) failed to effectively integrate, coordinate, and monitor clients #1, #2 and #3's active treatment programs. Findings include: 1. Client #1's record was reviewed on 5/9/23 at 10:31 am. Client #1's Individual Support Plan (ISP) dated 2/1/23 indicated the following goals: "Making Choices, Emergency Drills, Communication, Washing Hands, Medication, and Money." There was no documentation the QIDP reviewed client #1's goals for progress or lack of progress in March 2023 and April 2023. 2. Client #2's record was reviewed on 5/9/23 at	W 0159	**W159- QIDP** Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. **A) Corrective Action and Follow-up specific to Consumers 1-3:** 1.The QIDP failed to document her review of Client 1's goals for progress or lack of progress in March 2023 & April 2023. Client 1's monthly reports for March 2023 & April 2023 were completed on 5/30/23 2.The QIDP failed to document	06/02/2023

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	11:03 am. Client #2's ISP dated 6/1/22 indicated the following goals: "Medication, Communication, Money, Community Integration and Improve Health." There was no documentation the QIDP reviewed client #2's goals for progress or lack of progress in March 2023 and April 2023. 3. Client #3's record was reviewed on 5/9/23 at 11:45 am. Client #3's ISP dated 10/1/22 indicated the following goals: "Medication, Handwashing, Safety Drills, Money, Oral Hygiene and Communication." There was no documentation the QIDP reviewed client #3's goals for progress or lack of progress in March 2023 and April 2023. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/10/23 at 1:24 pm. The QIDP stated, "I have not completed monthly reviews for March and April." An interview with the Program Director (PD) was conducted on 5/10/23 at 2:21 pm. The PD stated, "The QIDP does monthly reports. Reports should have been done for March and April." 9-3-3(a)		her review of Client 2's goals for progress or lack of progress in March 2023 & April 2023. Client 1's monthly reports for March 2023 & April 2023 were completed on 5/30/23 3.The QIDP failed to document her review of Client 3's goals for progress or lack of progress in March 2023 & April 2023. Client 1's monthly reports for March 2023 & April 2023 were completed on 5/30/23 Persons Responsible: QIDP & PD TCD: 6/2/23 **B. Corrective Action Agency Wide:** 1. Support Living QIDP's and Residential QIDP's will be trained on the importance and value to a consumer's PC-ISP of completing monthly reviews of their progress. Persons Responsible: QIDP's, Program Director, & Quality Assurance Director TCD: 6/2/23	
W 0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN			

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Bldg. 00	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to develop a Behavior Support Plan (BSP) for client #1 to address his anxiety behaviors and a goal to teach client #1 to use utensils when eating. Findings include: 1. Observations were conducted on 5/8/23 from 3:55 pm to 6:15 pm and 5/9/23 from 5:54 am to 9:15 am. Client #1 was present throughout the observation period. On 5/8/23 at 4:26 pm, client #1 was running down the hallway slamming doors. Client #1 ran into his bedroom. On 5/8/23 at 4:38 pm House Manager (HM), stated "[Client #1] will want his private time in his room and then a lot of times he comes out of his room naked. [Client #1] does not have a Behavior Support Plan to address his anxiety. He beats on himself and then will run through the house and plows into other people. His anxiety is so high. A male stimulator was purchased to help him relieve his anxiety." On 5/9/23 at 6:48 am, client #1 came out of the bathroom naked. Staff #3 went into the bathroom and assisted client #1 with getting dressed. At 6:52 am client #1 was stomping his feet in the hallway and into his room. Client #1 took off his shirt. Staff #3 prompted client #1 to pick out shirt he wanted to wear and assisted him with putting	W 0227	**W227- Individual Program Plan** The individual program plan states the specific objective necessary to meet the client's needs, as identified by the comprehensive assessment. BCS failed to develop a Behavior Support Plan (BSP) for client #1 to address his anxiety behaviors and a goal to teach client #1 to use utensils when eating. **A) Corrective Action and Follow-up specific to Consumer 1:** 1.Consumer 1's behaviors have been discussed extensively over the past year. Most recently before the survey on 3/15/23. During Tommy's annual meeting his reported behaviors were discussed. At the conclusion of the discussion the guardian(s) were asked if they were comfortable with us completing thorough behaviour tracking for a month and then deciding how to proceed in regards to psychotropic medications. The family all agreed to this decision and would wait to be contacted about the next steps at the conclusion of that month. 1.During the month of April	06/02/2023

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	on a sweatshirt. At 6:53 am client #1 walked into the medication room to take his medications. At 6:58 am client #1 walked out of the medication room. Client #1 did not take his medications. Client #1 was stomping and slamming doors in the hallway. At 7:01 staff #3 brought client #1 back into the medication room. Client #1 was drinking his water. At 7:06 am client #1 walked out of the medication room. Client #1 was stomping in the hallway and jumping up and down. Client #1 went into the bathroom and then into his bedroom. At 7:07 am HM stated ,"Getting client #1 to take his medicine is rough." At 7:09 am client #1 went into the bathroom and came out with no pants on. Staff #3 prompted him to go back into the bathroom and he was assisted in putting on pants. At 7:10 am client #1 walked back into the medication room and immediately walked back out into the hallway stomping his feet and ran out into the backyard. Client #1 ran back into the house and into the bathroom and came out without his pants on. Client #1 ran into his bedroom. At 7:25 am client #1 walked out of his room and back into the bathroom. He came out of the bathroom naked and went into his bedroom. He sat on his bed naked with his bedroom door open. At 7:28 am client #1 shut his bedroom door, opened it up and then stood in the doorway naked. He walked into the hallway. Staff #3 asked client #1 to go back to his bedroom. After asking a couple of times client #1 walked back to his bedroom and slammed the door. At 8:07 am HM went into client #1's bedroom and assisted him in getting dressed. At 8:22 am client #1 came out of his bedroom stomping his feet and ran out into the backyard.		only 1 incidents of anxious behavior was documented. For this reason, no medication intervention was pursued; however, BCS did fail to implement a formal BSP to support Tommy during these times he is feeling anxious. It also should be noted for the behavior described during observations not documentation was provided to the QIDP. **All DSP's working with Tommy will be retrained on the importance of behavior tracking as it relates to BSP development and medication interventions.** 2.During the month of May the PD, QIDP, 2 RN's, and Medical Caseworker were in the home completing medication checks due to reoccurring errors and during that time only one incident of slight anxiety was noted where Tommy was able to calm himself down independently. 3.A formal BSP will be submitted to our Human Right Committee (HRC) for approval on 6/28/23. After approval is received the DSP's working with Tommy will be trained and the plan will be formally implemented. 2.A formal dining goal was developed for Consumer 1 and reads as follows: Tommy will learn to utilize utensils during meals. All staff were trained on this goal and tracking in the home began on 6/1/23. Strategies for the goal	

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	At 8:32 am client #1 ran back into the house, he went into client #5's bedroom and jumped on his bed. He then ran through the kitchen and into the bathroom. At 8:35 am client #1 ran out of the bathroom stomping his feet and ran outside. Client #1 ran back inside and went into his bedroom. Client #1 was not observed taking his medications throughout the observation period. On 5/9/23 at 6:33 am staff #3 stated, "[Client #1] does not have a behavior plan, he should have one. I took him to his primary physician, and he was prescribed anxiety medication. I turned the report from the doctor to nursing staff. Nursing staff presented information to guardians, and it was turned down. He has behaviors 2-3 times a day. He is constantly running out naked or half dressed." Client #1's records were reviewed on 5/9/23 at 10:31 am. Client #1 did not have a BSP to review to address his anxiety and stripping behaviors. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/10/23 at 1:24 pm. The QIDP stated, "[Client #1] does not have a BSP to address his behaviors. Currently there are no plans to address his anxiety or stripping behaviors. There should be plans in place." An interview with the Program Director (PD) was conducted on 5/10/23 at 2:21 pm. The PD stated, "[Client #1] does not have a formal BSP to address his behaviors. I think it would be beneficial for staff to have one. I think structure should be outlined in the BSP." 2. Observations were conducted on 5/8/23 from		include, but are not limited to 1.If during the meal Tommy starts to eat with his fingers rather than utilizing the provided silverware he will be redirected to use the silverware. 2.Staff can provide Tommy hand over hand/physical assistance to pick up his silverware and hold it correctly to use for the meal as needed, weaning assistance when possible. Persons Responsible: QIDP, HM, QAM, and PD TCD: 6/2/23 **B. Corrective Action Agency Wide:** 1. Support Living QIDP's and Residential QIDP's will be trained on goal development & when to seek out behavioral supports. Persons Responsible: QIDP's, Program Director, & Quality Assurance Manager TCD: 6/2/23	

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	3:55 pm to 6:15 pm. Client #1 was present throughout the observation time. At 5:39 pm client #1 was assisted in serving noodles, green beans, and barbeque sauce on his plate. Client #1 used his fingers to pick up green beans and put them in his mouth. Client #1 picked up noodles and put them in his mouth. Staff #1 prompted client #1 to use his silverware. Client #1 picked up his spoon and used his other hand to pick up his food. At 5:45 pm client #1 picked up green beans, dipped them in barbeque sauce and put them in his mouth. At 5:47 pm staff #1 assisted client #1 with getting more shredded chicken and noodles on his plate. Staff #1 prompted client #1 to use his silverware. Client #1 picked up chicken with his fingers and put it in his mouth. At 5:56 pm client #1 used his fingers to pick up green beans and put them in his mouth. Client #1's records were reviewed on 5/9/23 at 10:31 am. Client #1 Individual Support Plan (ISP) dated 2/1/23 did not have a goal to address client using silverware while eating. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/10/23 at 1:24 pm. The QIDP stated, "[Client #1] does not have a goal to address the use of silverware." An interview with the Program Director (PD) was conducted on 5/10/23 at 2:21 pm. The PD stated, "[Client #1] does not have a plan to use silverware. I was not aware it was an issue. He should have a goal in place if he is not using silverware while eating."			

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W 0262 Bldg. 00	9-3-4(a) 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 1 of 3 sampled clients (#1) with restrictive programs, the facility failed to ensure the Human Rights Committee (HRC) reviewed and approved restrictive programs for client #1. Findings include: Observations were conducted on 5/8/23 from 3:55 pm to 6:15 pm and 5/9/23 from 5:54 am to 9:15 am. Clients #1 was present throughout the observation period. Throughout the observations the basement door was locked and unavailable to client #1. 1. Client #1's record was reviewed on 5/9/23 at 10:31 am. Client's Individual Support Plan (ISP) dated 2/1/23 did not include the restriction of having the basement door locked. Client #1 did not have a Behavior Support Plan (BSP) to review. There were no Human Rights Committee (HRC) minutes to review from the time client #1 was admitted to the home on 2/3/21. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/10/23 at 1:24 pm. The QIDP stated, "HRC approval was not received for the basement door	W 0262	**W262- Program Monitoring & Change** The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. BCS failed to ensure the Human Rights Committee (HRC) reviewed and approved restrictive programs for client #1 **A) Corrective Action and Follow-up specific to Consumers 1:** 1.The QIDP failed to ensure HRC approval was received for the locked basement door for Consumer 1. Consumer 1 is the only individual in the home without a BSP, so this was an oversight. HRC approval will be received on 6/28/23. 2.The guardian(s) were aware of this restriction when he moved into the home in 2021. This restriction	06/28/2023

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	15G576	A. BUILDING 00 B. WING	05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BI-COUNTY SERVICES INC	503 N THIRD ST DECATUR, IN 46733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	being locked. It should have been done." An interview with the Program Director (PD) was conducted on 5/10/23 at 2:21 pm. The PD stated, "We missed [client #1] having HRC approval for the basement door being locked." 9-3-4(a)		was also added to the "restrictions" portion of the ISP, so a signature will be received every year from Consumer 1's IST annually. Persons Responsible: QIDP & Program Director TCD: 6/28/23 **B. Corrective Action Agency Wide:** 1. Support Living QIDP's and Residential QIDP's will be retrained on the evaluation and approval process for restrictive interventions. Persons Responsible: QIDP's, Program Director, & Quality Assurance Manager TCD: 6/2/23	

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W 0368 Bldg. 00	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 for 2 of 3 sampled clients (#2 and #3) and 1 additional client (#4), the facility failed to ensure medications were administered as ordered. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) incident reports and investigations were reviewed on 5/8/23 at 1:36 pm. The review indicated the following: 1) A BDDS incident report dated 3/27/23 indicated, "On 3/25/23 [Client #2] received a double dose of Aripiprazole (used to treat schizophrenia) 10 mg (milligrams) at his HS (hour of sleep) medication pass resulting in a medication error due to staff not following Medication Pass Protocol." 2) A BDDS incident report dated 4/11/23 indicated, "On 4/10/23, [client #2] did not receive his prescribed does of 650 mg of Tylenol (used to treat pain) at 7:00 pm due to staff not following the Medication Administration Protocol." 3) A BDDS incident report dated 3/16/23 indicated, "On 3/14/23 and 3/15/23, [client #2] received the wrong medication of Albuterol (used to treat respiratory disease). [Client #2] was prescribed Ipratropium Albuterol (used to treat respiratory disease), but staff administered Albuterol sulfate (used to treat respiratory disease) instead."	W 0368	**W368- Drug Administration** The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. BCS to ensure medications were administered as ordered for Consumers 2-4. **A) Corrective Action and Follow-up specific to Consumers 2-4:** 1.The type of error varied between each medication error; with the main concerns being the length of errors and reoccurring errors. DSP's are to complete triple checks during the medication administration process and then second staff is to complete buddy checks within the medication administration window. These safeguards have not been sufficient for this home, at this time, so increased medication oversight was implemented. 2.For approximately 30 days from the week of May 15th through the week of June 12th medication checks on medications with reoccurring errors as well as new orders were completed Monday through Friday.	06/02/2023

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	4) A BDDS incident report dated 3/26/23 indicated, "On 3/25/23 Staff did not give [client #2] his 5 pm medication pass of Metformin (used to treat diabetes) 500 mg and Ventolin HFA (hydrofluoroalkane, different type of propellant spray) (used to treat respiratory disease) resulting in a medication error due to staff not following Medication Pass Protocol." 5) A BDDS incident report dated 11/18/22 indicated, "On 11/14/22 and 11/16/22, [client #3] received .5 mg of Haldol (used to treat mental disorder) when he was not supposed to." 6) A BDDS incident report dated 12/16/22 indicated, "On 11/29/22 through 12/15/22, [client #4] received 12.5 mg of Lisinopril (used to treat hypertension), when the medication was supposed to be discontinued to 11/29/22, this was due to issues getting the proper paperwork and clarification from the Doctor (sic)." 7) A BDDS incident report dated 1/27/23 indicated, "On 1/26/23, [client #4] received an extra dose of his prescribed medication of 20 mg Protonix (used to reduce acid in your stomach), resulting in a double dose." An interview with the Registered Nurse (RN) was conducted on 5/10/23 at 12:57 pm. The RN stated, "Medications should be administered according to the physician's orders. It has been a constant struggle to prevent medication errors in this home." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/10/23 at 1:24 pm. The QIDP stated, "Staff should follow physician's orders. We did a medication administration course retraining for all		3.On Thursday 5/18/23 the QIDP cleaned out Consumer 4's medication box due to the excessive amount of medications in there that made it difficult to pull medications out individually administration. He now has two boxes for accommodate his large amount of medications. On this same date all of the excessive overflow and expired medications were removed from the home in an effort to prevent future errors as well. 4.The Medication Error Review Team (MERT) & Internal Sentinel Event Review Team (ISERT) now has a set time to meet each week on Tuesday at 10 am to meet. The teams will also meet as needed when there is an increase in incidents or those of a more serious nature. A set time is in an effort to not let the "day to day" issues take precedence over ensuring the quality of our services. 5.On 3/7/23 a Medication Administration Remediation Course (MARC) was completed with the staff who work in the Third Street Home as well as the managers when the trend of medication errors was first recognized. The course focused on what the home was struggling with as opposed to the entire Core A & B curriculum. 6.Unfortunately, the errors continued and our efforts for	

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	staff in this home to try and prevent future errors." An interview with the Program Director (PD) was conducted on 5/10/23 at 2:21 pm. The PD stated, "Medications should be administered according to the physician's orders. A mini medication class was completed for this home due to the medication errors." 9-3-6(a)		prevention have changed. On May 11th 3 DSP's along with the House Manager received suspensions related to a medication error. The additional oversight in the home, specifically related to medications, will continue until a decrease in errors is noted. Persons Responsible: QIDP, Residential RN's, Medical Caseworker, Program Director, and HM. TCD: 6/2/23 **B. Corrective Action Agency Wide:** 1. SLMT members and Supported Living Assistant Managers will complete 2 medication administration pass watches per month at each 24-hour location Persons Responsible: QIDP's, HM's, SLAM, & SL Administrator TCD: 6/2/23	