

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/01/2012
NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421		
(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	
W0000	<p>This visit was for an investigation of complaint #IN00102327.</p> <p>Complaint #IN00102327: Substantiated, Federal/State deficiencies related to the allegation(s) are cited at W149, W154, W186 and W189.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: January 31 and February 1, 2012.</p> <p>Facility number: 001165 Provider number: 15G650 AIM number: 100240230</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/8/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client E, the facility failed to implement its policies and procedures to prevent neglect of a client and conduct a thorough investigation.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/31/12 at 2:00 PM. On 1/3/12 at 8:26 AM, client E was assisted to exit the van. Once client E was off the van, she unlocked her brakes to go into the facility-operated day program. Due to snow and ice in the driveway, client E, in her wheelchair, rolled down the hill. Client E hit the left bumper of a parked vehicle. She then rolled into the left back tire of another vehicle. Client E had bruising and swelling on her right hand (ice was applied). At the time of the incident, one staff (did not indicate who) was in the van assisting another client (did not indicate who) out of the van and the other staff (did not indicate who) was in the building. Three staff received performance reviews regarding the incident for not implementing the van unloading protocol. All group home staff</p>	W0149	<p>W 149</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction:</p> <p>Stone Belt has written policies and procedures that prohibit mistreatment, neglect or abuse of a client. The policy and procedures (Attachment # 1) is presented at all orientation trainings and reviewed annually at department inservices.</p> <p>Date of Completion:</p> <p>March 2, 2012</p> <p>Person Responsible:</p> <p>QMRP/Coordinator</p> <p>Plan of Prevention:</p> <p>Stone Belt Director of Group Homes will review all Incident Reports to assure possible client neglect is being reviewed appropriately. Documentation will be kept to assure all such incidents are addressed within 5 working days.</p> <p>All Stone Belt staff working in a group home are trained on the Stone Belt Prevention of Abuse and Neglect/Client Rights and</p>	03/02/2012			

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	<p>were trained on 1/3/12 regarding the following, "Consumers are to never be unloaded and left outside of van without staff until ready to be taken into building." The follow-up BDDS (Bureau of Developmental Disabilities Services) report, dated 1/9/12, indicated the following, "Staff were inside van and there should have been staff outside the van per van unloading procedure." The inquiry did not include documentation the 3 staff were interviewed. The inquiry did not indicate the location of the third staff. The report did not indicate if neglect was substantiated.</p> <p>A review of the facility's abuse and neglect policy, dated 10/08, was conducted on 1/31/12 at 1:53 PM. The policy indicated the following, "All consumers served through programs provided by Stone Belt Arc, Incorporated shall have the following rights: 11. To be free from mental, verbal, sexual and physical abuse... Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma."</p> <p>A review of the Wheelchair Protocol for Unloading and Loading Consumers at</p>		<p>Incident Reporting policy and procedure during orientation training and annually. House staff were retrained. (Attachment # 2)</p> <p>Quality Assurance Monitoring:</p> <p>Stone Belt Director of Group Homes will review all incident reports to assure policy is being followed.</p> <p>The Coordinator and other administrative staff will conduct random visits at the home.</p>		

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	<p>Wedgewood protocol, dated 10/6/10, was conducted on 1/31/12 at 3:24 PM. The protocol indicated for client E, "[Client E] will be loaded second into the van. One staff outside putting her onto the lift, with her back facing the opening of the van. Brakes will be locked with staff operating lift from outside. Second staff will be in van waiting for [client E] to come up. Staff operating lift will unlock brakes when lift is up and in place, second staff will pull [client E] in the van using wheelchair handles. Once in van, [client E] will be turned around 180 degrees to face forward. Staff will then secure her wheelchair."</p> <p>An interview with staff #6 was conducted on 2/1/12 at 8:44 AM. Staff #6 indicated she was present, inside the van on the day client E rolled down the driveway at the facility-operated day program. Staff #6 indicated she lowered client E down the lift; there was no staff outside the van to assist client E. Staff #6 indicated she then turned around to assist client A off the van. When staff #6 looked out the window, client E was rolling toward a parked car and hit it. Staff #6 indicated she jumped out of the van and went toward client E. She indicated she stopped client E from hitting a second parked car. Staff #6 indicated the protocol for loading and unloading the</p>			
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	<p>van was not followed. She indicated there was not a staff at the bottom of the lift to assist client E once she made it down the lift. Staff #6 indicated the protocol did not clearly indicate the order and assistance the clients need in order to exit the van and go into the day program.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/31/12 at 3:11 PM. The QMRP indicated the incident would not have occurred if the staff implemented the Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood. The QMRP indicated the protocol for unloading was just the reverse of the instructions for loading the clients. The QMRP indicated the third staff (#8) who was supposed to meet the staff and clients at the day program in her personal vehicle did not do so; she never showed up. The QMRP indicated staff #6 witnessed the incident from inside the van while assisting client A. The second staff (#9) was inside the building. The QMRP indicated the staff failed to implement the protocol.</p> <p>This federal tag relates to Complaint #IN00102327.</p> <p>9-3-2(a)</p>						

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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client E, the facility failed to conduct a thorough investigation in regard to conducting interviews.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/31/12 at 2:00 PM. On 1/3/12 at 8:26 AM, client E was assisted to exit the van. Once client E was off the van, she unlocked her brakes to go into the facility-operated day program. Due to snow and ice in the driveway, client E, in her wheelchair, rolled down the hill. Client E hit the left bumper of a parked vehicle. She then rolled into the left back tire of another vehicle. Client E had bruising and swelling on her right hand (ice was applied). At the time of the incident, one staff (did not indicate who) was in the van assisting another client (did not indicate who) out of the van and the other staff (did not indicate who) was in the building. Three staff received performance reviews regarding the incident for not implementing the van unloading protocol. All group home staff were trained on 1/3/12 regarding the</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly. Stone Belt Investigation Protocol and Procedures will be followed. (Attachment # 3)</p> <p>Date of Completion</p> <p>February 20, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinators and Social Worker reviewed and completed training on Stone Belt investigation procedures. (Attachment # 3a). This included how to conduct proper investigations and who should be interviewed.</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed</p>	02/20/2012			

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	<p>following, "Consumers are to never be unloaded and left outside of van without staff until ready to be taken into building." The follow-up BDDS (Bureau of Developmental Disabilities Services) report, dated 1/9/12, indicated the following, "Staff were inside van and there should have been staff outside the van per van unloading procedure." The inquiry did not include documentation the 3 staff were interviewed. The inquiry did not indicate the location of the third staff. The report did not indicate if neglect was substantiated.</p> <p>A review of the Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood protocol, dated 10/6/10, was conducted on 1/31/12 at 3:24 PM. The protocol indicated for client E, "[Client E] will be loaded second into the van. One staff outside putting her onto the lift, with her back facing the opening of the van. Brakes will be locked with staff operating lift from outside. Second staff will be in van waiting for [client E] to come up. Staff operating lift will unlock brakes when lift is up and in place, second staff will pull [client E] in the van using wheelchair handles. Once in van, [client E] will be turned around 180 degrees to face forward. Staff will then secure her wheelchair."</p>		thoroughly.				

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	<p>An interview with staff #6 was conducted on 2/1/12 at 8:44 AM. Staff #6 indicated she was present, inside the van on the day client E rolled down the driveway at the facility-operated day program. Staff #6 indicated she lowered client E down the lift; there was no staff outside the van to assist client E. Staff #6 indicated she then turned around to assist client A off the van. When staff #6 looked out the window, client E was rolling toward a parked car and hit it. Staff #6 indicated she jumped out of the van and went toward client E. She indicated she stopped client E from hitting a second parked car. Staff #6 indicated the protocol for loading and unloading the van was not followed. She indicated there was not a staff at the bottom of the lift to assist client E once she made it down the lift. Staff #6 indicated the protocol did not clearly indicate the order and assistance the clients need in order to exit the van and go into the day program.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/31/12 at 3:11 PM. The QMRP indicated the incident would not have occurred if the staff implemented the Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood. The QMRP indicated the protocol for unloading was just the reverse of the</p>						

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	<p>instructions for loading the clients. The QMRP indicated the third staff (#8) who was supposed to meet the staff and clients at the day program in her personal vehicle did not do so; she never showed up. The QMRP indicated staff #6 witnessed the incident from inside the van while assisting client A. The second staff (#9) was inside the building. The QMRP indicated the staff failed to implement the protocol.</p> <p>This federal tag relates to Complaint #IN00102327.</p> <p>9-3-2(a)</p>			

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W0186	<p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (E), the facility failed to deploy staff appropriately to supervise the client while unloading the van.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/31/12 at 2:00 PM. On 1/3/12 at 8:26 AM, client E was assisted to exit the van. Once client E was off the van, she unlocked her brakes to go into the facility-operated day program. Due to snow and ice in the driveway, client E, in her wheelchair, rolled down the hill. Client E hit the left bumper of a parked vehicle. She then rolled into the left back tire of another vehicle. Client E had bruising and swelling on her right hand (ice was applied). At the time of the incident, one staff (did not indicate who) was in the van assisting another client (did not indicate who) out of the van and the other staff (did not indicate who) was in the building. Three staff received</p>	W0186	<p>W186 DIRECT CARE STAFF Plan of Correction: Stone Belt Arc, Inc. will provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Person Responsible: QMRP Coordinator Date of Completion: March 2, 2012 Plan of Prevention: Staff were retrained on Wheelchair Protocol (Attachment # 4 & 4A). A Staff Schedule is prepared by the House Manager and Coordinator to assure sufficient staffing. Quality Assurance Monitoring: QMRP Coordinator will review various loading/unloading to assure staffing is sufficient and the Wheelchair Protocol is being followed.</p>	03/02/2012			

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	<p>performance reviews regarding the incident for not implementing the van unloading protocol. All group home staff were trained on 1/3/12 regarding the following, "Consumers are to never be unloaded and left outside of van without staff until ready to be taken into building." The follow-up BDDS (Bureau of Developmental Disabilities Services) report, dated 1/9/12, indicated the following, "Staff were inside van and there should have been staff outside the van per van unloading procedure." The inquiry did not include documentation the 3 staff were interviewed. The inquiry did not indicate the location of the third staff. The report did not indicate if neglect was substantiated.</p> <p>A review of the Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood protocol, dated 10/6/10, was conducted on 1/31/12 at 3:24 PM. The protocol indicated for client E, "[Client E] will be loaded second into the van. One staff outside putting her onto the lift, with her back facing the opening of the van. Brakes will be locked with staff operating lift from outside. Second staff will be in van waiting for [client E] to come up. Staff operating lift will unlock brakes when lift is up and in place, second staff will pull [client E] in the van using wheelchair handles. Once in van, [client</p>						

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	<p>E] will be turned around 180 degrees to face forward. Staff will then secure her wheelchair."</p> <p>An interview with staff #6 was conducted on 2/1/12 at 8:44 AM. Staff #6 indicated she was present, inside the van on the day client E rolled down the driveway at the facility-operated day program. Staff #6 indicated she lowered client E down the lift; there was no staff outside the van to assist client E. Staff #6 indicated she then turned around to assist client A off the van. When staff #6 looked out the window, client E was rolling toward a parked car and hit it. Staff #6 indicated she jumped out of the van and went toward client E. She indicated she stopped client E from hitting a second parked car. Staff #6 indicated the protocol for loading and unloading the van was not followed. She indicated there was not a staff at the bottom of the lift to assist client E once she made it down the lift. Staff #6 indicated the protocol did not clearly indicate the order and assistance the clients need in order to exit the van and go into the day program.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/31/12 at 3:11 PM. The QMRP indicated the incident would not have occurred if the staff implemented the</p>						

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	<p>Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood. The QMRP indicated the staff were not following the protocol which led to the staff not being deployed appropriately to supervise the clients. The QMRP indicated the protocol for unloading was just the reverse of the instructions for loading the clients. The QMRP indicated the third staff (#8) who was supposed to meet the staff and clients at the day program in her personal vehicle did not do so; she never showed up. The QMRP indicated staff #6 witnessed the incident from inside the van while assisting client A. The second staff (#9) was inside the building. The QMRP indicated the staff failed to implement the protocol.</p> <p>This federal tag relates to Complaint #IN00102327.</p> <p>9-3-3(a)</p>						

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W0189	<p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (E), the facility failed to provide competency-based training to staff on the protocol for unloading the clients from the van.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/31/12 at 2:00 PM. On 1/3/12 at 8:26 AM, client E was assisted to exit the van. Once client E was off the van, she unlocked her brakes to go into the facility-operated day program. Due to snow and ice in the driveway, client E, in her wheelchair, rolled down the hill. Client E hit the left bumper of a parked vehicle. She then rolled into the left back tire of another vehicle. Client E had bruising and swelling on her right hand (ice was applied). At the time of the incident, one staff (did not indicate who) was in the van assisting another client (did not indicate who) out of the van and the other staff (did not indicate who) was in the building. Three staff received performance reviews regarding the incident for not implementing the van unloading protocol. All group home staff</p>	W0189	<p>W189</p> <p>DIRECT CARE STAFF</p> <p>Plan of Correction:</p> <p>Stone Belt Arc, Inc. will provide each employee with initial and continuing training that enables the employee to perform their duties efficiently, effectively and competently.</p> <p>Person Responsible:</p> <p>QMRP Coordinator</p> <p>Date of Completion:</p> <p>March 2, 2012</p> <p>Plan of Prevention:</p> <p>Staff were retrained on Wheelchair Protocol (Attachment # 4). Staff are observed in their loading/unloading procedures during routine transports to and from the home. Initial training is conducting during the second week of training at a site that requires wheelchair protocol.</p> <p>Quality Assurance Monitoring:</p> <p>QMRP Coordinator will review various loading/unloading to assure staffing is sufficient and</p>	03/02/2012			

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	<p>were trained on 1/3/12 regarding the following, "Consumers are to never be unloaded and left outside of van without staff until ready to be taken into building." The follow-up BDDS (Bureau of Developmental Disabilities Services) report, dated 1/9/12, indicated the following, "Staff were inside van and there should have been staff outside the van per van unloading procedure." The inquiry did not include documentation the 3 staff were interviewed. The inquiry did not indicate the location of the third staff. The report did not indicate if neglect was substantiated.</p> <p>A review of the Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood protocol, dated 10/6/10, was conducted on 1/31/12 at 3:24 PM. The protocol indicated for client E, "[Client E] will be loaded second into the van. One staff outside putting her onto the lift, with her back facing the opening of the van. Brakes will be locked with staff operating lift from outside. Second staff will be in van waiting for [client E] to come up. Staff operating lift will unlock brakes when lift is up and in place, second staff will pull [client E] in the van using wheelchair handles. Once in van, [client E] will be turned around 180 degrees to face forward. Staff will then secure her wheelchair." The protocol did not</p>		the Wheelchair Protocol is being followed.				

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	<p>indicate the instructions to staff on the order to unload the clients. The protocol did not indicate the unloading of the clients was the reverse of loading the clients. The protocol did not address when the ambulatory clients should be unloaded.</p> <p>An interview with staff #6 was conducted on 2/1/12 at 8:44 AM. Staff #6 indicated she was present, inside the van on the day client E rolled down the driveway at the facility-operated day program. Staff #6 indicated she lowered client E down the lift; there was no staff outside the van to assist client E. Staff #6 indicated she then turned around to assist client A off the van. When staff #6 looked out the window, client E was rolling toward a parked car and hit it. Staff #6 indicated she jumped out of the van and went toward client E. She indicated she stopped client E from hitting a second parked car. Staff #6 indicated the protocol for loading and unloading the van was not followed. She indicated there was not a staff at the bottom of the lift to assist client E once she made it down the lift. Staff #6 indicated the protocol did not clearly indicate the order and assistance the clients need in order to exit the van and go into the day program.</p> <p>An interview with the Qualified Mental</p>			
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	<p>Retardation Professional (QMRP) was conducted on 1/31/12 at 3:11 PM. The QMRP indicated the incident would not have occurred if the staff implemented the Wheelchair Protocol for Unloading and Loading Consumers at Wedgewood. The QMRP indicated the protocol for unloading was just the reverse of the instructions for loading the clients. The QMRP indicated the third staff (#8) who was supposed to meet the staff and clients at the day program in her personal vehicle did not do so; she never showed up. The QMRP indicated staff #6 witnessed the incident from inside the van while assisting client A. The second staff (#9) was inside the building. The QMRP indicated the staff failed to implement the protocol.</p> <p>This federal tag relates to Complaint #IN00102327.</p> <p>9-3-3(a)</p>				

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W0368	<p>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 3 of 6 clients living in the group home (A, B and F), the facility failed to administer the clients' medications as ordered.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/31/12 at 2:00 PM.</p> <p>Client A: -On 9/29/11 at 7a, staff #10 failed to administer Artane (Dystonia) during the morning med pass. The Medication Error Report (MER) indicated she missed the dose. -On 1/3/12 at 8:30 PM and 1/4/12 at 7:00 AM, the group home staff failed to ensure Docusate Sodium (laxative) was in the home to administer. Client A did not receive the Docusate Sodium.</p> <p>Client B: -On 8/1/11 at 7:00 AM, staff #8 signed off as having administered Kloron lotion (dermatitis) on the Medication Administration Record (MAR). The medication was discontinued on 11/30/11 and was not in the home to administer. -On 9/28/11 at bedtime, staff #10 administered 2 tabs of Risperidone</p>	W0368	<p>W368</p> <p>DRUG ADMINISTRATION</p> <p>Plan of Correction</p> <p>Stone Belt will have a system of drug administration that assures all drugs are administered in compliance with physicians orders.</p> <p>Date of Completion</p> <p>March 2, 2012</p> <p>Responsible Person</p> <p>QMRP Coordinator</p> <p>Plan of Prevention</p> <p>Stone Belt Medication Error Protocol will be followed as written. (Attachment # 5) This includes retraining and disciplinary action as necessary. Medication Administration is review annually by SGL staff.</p> <p>Quality Assurance Monitoring</p> <p>The Coordinator and SGL Director of Group Homes will review all medication errors to assure protocol is being followed</p>	03/02/2012			

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	<p>(Depression) instead of 1 tab. -On 11/8/11 at 6:45 AM, staff #8 administered Simvastatin (hyperlipidemia). The medication was ordered for bedtime. -On 12/9/11 at 7:05 PM, staff #1 failed to administer Cryselle (low dose estrogen). The medication was not administered.</p> <p>Client F: -On 8/19/11 at 7:00 AM, staff #10 administered 2 tabs of Depakote (seizures) instead of 1 tab, as ordered.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/31/12 at 2:51 PM. The QMRP indicated the staff failed to do 3 point checks with the medications prior to administering the medications. The QMRP indicated staff were not paying attention to the orders which led to the errors.</p> <p>An interview with the nurse was conducted on 1/31/12 at 4:57 PM. The nurse indicated the staff were not implementing the 3 point checks (MAR against the Medication Information Sheet, MAR against the pill pack, and then the pill pack upon dispensing the medication) leading to the errors. The nurse indicated the number of medication errors was a known issue. She indicated staff had</p>						

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	been trained. Staff have been disciplined. 9-3-6(a)			
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