STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154035	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 0000 Bldg. 00	This visit was for a federal complaint survey. Complaint Number: IN00202932 Substantiated: Deficiency related to the allegation is cited Survey Date: 07-07-2016 Facility Number: 005199 QA: 8/24/16 jlh	A 0000		
A 0701 Bldg. 00	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. Based on interview and observation, the facility created 1 condition which resulted in a hazard to patients. Findings include: 1. In interview, on 07-07-2016 at 11:45 am, employee #A3, Maintenance Technician, indicated upon hearing of a possible issue of a patient toilet leaking after the surveyor arrived, checked all	A 0701	The toilet in bathroom H was replaced by 7-10-16. There is no leaking and it flushes without problem Since then, there has been new floor put down. To continue to monitor, the Facilities Director, Eric Dexter, or his designee will add checking each toilet and flushing to ensure there is no leaking at least monthly, on their safety walk through. This will be documented.	07/10/2016

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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	patient toilets and did find one leaking in patient room H. The employee also indicated the maintenance staff was working to correct the problem. 2. On 07-07-2016 at 2:00 pm in the presence of employees #A1, Vice President Quality/Compliance and #A2, Director of Nursing, the second floor patient care area was toured. It was observed the bathroom door to patient room H had a sign on the locked bathroom door the room should not be used. Staff opened the door to observe the condition of the bathroom and toilet. It was observed there was no water on the floor. It was also observed the covering to the toilet's flush mechanism had been removed and was placed next to the toilet. Attempts were made to flush the toilet, but it was inoperable.			