

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G416	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 20089 LARK DR SOUTH BEND, IN 46637
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: February 11, 12, 13, and 18, 2014.</p> <p>Facility number: 000930 Provider number: 15G416 AIM number: 100244540</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 3, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 9 medications observed (client #5), to ensure medications were administered per the physician's orders without error.</p> <p>Findings include: On 2/13/14 at 7:20 AM, Client #5's medication</p>	W000369	The DSP who did the medication pass incorrectly received disciplinary action. Further, medication administration training was performed for the staff working at the Lark group home on February 24, 2014. Any staff who missed this training, were trained on an individual basis. To prevent future	03/20/2014

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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W000436	<p>administration was observed. DSP (Direct Support Professional) #1 assisted Client #5 with medication administration. DSP #1 poured Client #5's prescribed "Metamucil Powder" (fiber supplement for constipation) into a cup of water without measuring the powder.</p> <p>On 2/13/14 at 11:50 AM, record review indicated Client #5's physician's order dated 1/1/14 indicated Client #5 had a physician's order to "dissolve one half teaspoon (1.7 GM) (grams) in liquid and drink once daily for constipation."</p> <p>On 2/18/14 at 11:44 AM during an interview, the facility Nurse indicated Client #5's fiber supplement should have been measured by DSP #1. The Nurse indicated the lid of the fiber supplement should have been used to measure the powder as the lid measures exactly 1.7 grams of powder. The Nurse indicated Client #5's fiber supplement was prescribed by his physician and should have been administered as the physician directed without error.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview, and</p>	W000436	<p>occurrences, the QMRP and Program Coordinator will perform scheduled as well as unscheduled visits during the medication administrations times and observe medication passes to ensure that medications are passed without error and to prevent infection from spreading, and contamination of medications. These observations will be documented on the appropriate observation forms. Any issues that arise from the observation by management staff will be addressed with training/discipline, as appropriate.</p> <p>Persons Responsible:</p> <p>Program Coordinator, Program Manager/QIDP, Nurse</p> <p>Client 4 has received glasses and is</p>	03/20/2014	

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	<p>record review, for 2 of 4 sample clients (clients #2 and #4) who had adaptive equipment prescribed, the facility failed to teach and encourage clients #2 and #4 to wear their prescribed eyeglasses.</p> <p>Findings include:</p> <p>1) On 2/11/14 between 4:35 PM and 5:57 PM and on 2/13/14 between 6:29 AM and 7:37 AM, group home observations were conducted. Throughout observations, Client #2 did not wear eyeglasses.</p> <p>On 2/12/14 at 1:12 PM, record review indicated Client #2's record review indicated Client #2 had an eye exam on 11/7/13 which indicated "corrective lenses prescribed but due to minimal need may choose not to wear glasses." Record review indicated Client #2's ISP (Individual Support Plan) dated 10/10/13 indicated no schedule for use of eye wear.</p> <p>On 2/12/14 at 3:13 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #2 did not have eyeglasses and has never had eyeglasses. The QIDP indicated the IDT (Interdisciplinary Team) did not meet to</p>		<p>wearing the glasses during waking hours.</p> <p>The IDT and the parents/guardians of Client 2, do not currently believe that he will wear glasses nor that he would benefit from glasses as evidenced by he does not run into furniture, trip over items, feel for items as if he can not see, watches TV from a normal distance, and further, he does not read or write. Additionally, the current vision exam for Client #2 stated that he had "good ocular health". An addendum to Client 2's ISP will be made at this time reflecting this information. The Support Team for Client 2 will revisit this issue every six months at his team meetings.</p> <p>In the future, at vision exams, the doctor will be asked to clarify the treatment recommendations regarding eye wear prescription and utilization. The vision form will be utilized for all vision exams and if eyeglasses are recommended and the IDT and parents/guardians are in agreement, then eyeglasses will be obtained for the client. If the Support team does not agree with the recommendation, then this will be written into the ISP document with explanation/justification and reviewed at least twice a year.</p> <p>Persons Responsible: Program Coordinator, Program</p>		

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	<p>discuss the use of eyeglasses for Client #2.</p> <p>On 2/12/14 at 3:31 PM, the facility Nurse was interviewed and stated Client #2 "would not wear them if he had them." The Nurse stated she believed the eyeglasses' prescription was never filled because of Client #2's "level of cooperation." No further documentation was available to show the facility had attempted to train or teach Client #2 to wear his eyeglasses.</p> <p>2) On 2/11/14 between 4:35 PM and 5:57 PM and on 2/13/14 between 6:29 AM and 7:37 AM, group home observations were conducted. Throughout observations, Client #4 did not wear eyeglasses.</p> <p>On 2/12/14 at 12:17 PM, record review indicated Client #4's ISP (Individual Support Plan) dated 12/5/13 indicated no schedule of use for eye wear. Record review indicated Client #4 had an eye exam on 11/13/13. The physician's note indicated "corrective lenses prescribed but due to minimal need may choose not to wear glasses." The record indicated the eye doctor "advised caretaker about adaptation to new specs (glasses) if</p>		Manager/QIDP, Nurse	

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	<p>desires to proceed with filling glasses Rx (prescription)."</p> <p>On 2/12/14 at 3:13 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #4 has never had eyeglasses. The QIDP indicated Client #4's IDT (Interdisciplinary Team) did not meet to discuss Client #4's prescription for glasses. The QIDP indicated they did not have documentation which indicated Client #4's guardian did not want him to wear eyeglasses.</p> <p>On 2/12/14 at 3:31 PM during an interview, the facility's Nurse indicated Client #4 did not have eyeglasses. The Nurse indicated Client #4 was new to the group home. The Nurse stated Client #4 "is more cooperative" and might wear glasses. The Nurse indicated Client #4 may benefit from the use of eyeglasses.</p> <p>9-3-7(a)</p>			

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W000455	<p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based upon observation, record review, and interview, the facility failed to ensure proper infection control procedures were implemented during medication administration for 1 of 7 clients observed during medication administration (Client #5).</p> <p>Findings include:</p> <p>On 2/13/14 at 7:20 AM, Client #5's medication administration was observed. DSP (Direct Support Professional) #1 assisted Client #5 with medication administration. After DSP #1 assisted Client #5 with medication administration, a pill was observed to fall out of a medication bubble pack and onto a notebook. During an interview, DSP #1 indicated the pill was Client #5's Trihexyphenidyl (antiparkinsonian agent) 2 mg. DSP #1 picked up the pill with her bare hands and put it into a medication cup. DSP #1 indicated the pill did not properly fall out of the bubble pack and Client #5 had not received the pill. DSP #1 called Client #5 back into the room. DSP #1 assisted Client #5 in taking the pill. During</p>	W000455	<p>The DSP who did the medication pass incorrectly received disciplinary action. Further, medication administration training was performed for the staff working at the Lark group home on February 24, 2014. Any staff who missed the training, were trained on an individual basis. To prevent future occurrences, the QMRP and Program Coordinator will perform scheduled as well as unscheduled visits during the medication administrations times and observe medication passes to ensure that medications are passed without error. Any issues that arise from the observation by management staff will be addressed with training/discipline, as appropriate.</p> <p>Persons Responsible:</p> <p>Program Coordinator, Program Manager/QIDP, Nurse</p>	03/20/2014			

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	<p>interview, DSP #1 stated "yes" Client #5 had taken the same pill that had fallen out of the bubble pack.</p> <p>On 2/13/14 at 11:50 AM, record review indicated Client #5 had a physician's order dated 1/1/14 for Trihexyphenidyl 2 mg. (milligram) 1 tablet every morning.</p> <p>On 2/18/14 at 11:44 AM during an interview, the facility Nurse indicated DSP #1 should have counted the number of pills in the cup prior to assisting in Client #5's medication administration. The Nurse indicated DSP #1 should not have administered Client #5's Trihexyphenidyl 2 mg. pill once it had fallen out of the bubble pack onto a notebook. The Nurse indicated DSP #1 should have used proper infection control measures and should have placed the dropped pill into a plastic bag for disposal by the Nurse.</p> <p>9-3-7(a)</p>			