

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G679		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/18/2013	
NAME OF PROVIDER OR SUPPLIER  LOGAN COMMUNITY RESOURCES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616			
(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			
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 11, 12, 13, 14, 15, and 18, 2013</p> <p>Facility number: 000688 Provider number: 15G679 AIM number: 100234470</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 18, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000					

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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W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed to assure privacy when escorting 1 of 4 sampled clients (client #3) who required privacy.</p> <p>Findings include:</p> <p>Client #3 was observed at the group home on 3/12/13 from 6:16 A.M. until 8:00 A.M.</p> <p>At 6:28 A.M., client #3 was escorted by direct care staff #5 from the bathroom to his bedroom while the client was nude. Direct care staff #5 did not prompt or assist client #3 in putting on a robe or an outer garment to assure privacy while going to the client's bedroom.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 3/15/13 at 9:42 A.M. QMRP #1 indicated direct care staff #5 should have directed or assisted client #3 to put on a robe or outer garment to assure privacy for himself.</p> <p>9-3-2(a)</p>	W000130	QMRP will continue to review with clients and staff Logan's Policy P-3-01 "Rights of Persons Served" which outlines expectations for providing and protecting privacy during personal care. QMRP will facilitate a mandatory staff training (routine monthly house meeting) on April 17, 2013, at which time all Walnut Staff will be retrained on ensuring the rights of all clients in regards to privacy during treatment and care of personal needs (in specific ensuring privacy by covering clients when escorting them to and from the bathroom). Staff will be reminded that we must provide privacy when individuals are in or traveling between their bedrooms, bathrooms, when passing medications, etc. A Memo has been placed in the communication log reminding staff to ensure that client privacy is maintained. Staff reminders will continue to be posted in the communication log and all staff is required to read and initial or sign the communication log at the beginning of their shift. Staff trainings will continue as a part of routine house meetings/required trainings and topics such as maintaining client rights	04/17/2013	

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			<p>will periodically be discussed. QMRP and Program Coordinator will monitor this privacy practice through monthly observations of the home.</p> <p>Persons Responsible: QMRP/Program Manager Program Coordinator</p>	

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure a medication was locked except when it was being prepared for administration for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>Direct care staff #7 was observed passing medications to client #4 during the 3/12/13 observation period from 6:16 A.M. until 8:00 A.M. At 7:51 A.M., direct care staff #7 called client #4 to the medication room and prepared the client's medications for administration and placed them into a medication cup. Direct care staff #7 left the medication room for 20 seconds to get a cup of water for client #4. During this time, the client's medications were openly accessible to client #4 who was waiting to take his medications.</p> <p>Nurse #1 was interviewed on 3/13/13 at 3:31 P.M. Nurse #1 indicated direct care staff should have had all medications locked when staff were not in the medication room.</p> <p>9-3-6(a)</p>	W000382	<p>QMRP will facilitate staff training on April 17, 2013, at which time staff will be retrained on how to properly complete a medication pass including making sure that all medication are locked except when being prepared for administration. Staff #7 was retrained that client #4 and all other clients should never be left alone when medications are not locked away. A Memo has been placed in the communication log reminding staff of the proper procedures when administering medications (see attachment). QMRP and/or Nurse and/or Program Coordinator will observe medication passes periodically to ensure that medication are administered properly.</p> <p>Persons Responsible: Nurse QMRP/Program Manager Program Coordinator</p>	04/17/2013			

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