

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G222	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1602 ORKNEY DR SOUTH BEND, IN 46614
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: July 27, 28, 29, 30, 31, and August 3, 2015.</p> <p>Facility number: 000746 Provider number: 15G222 AIM number: 100234830</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0371 Bldg. 00	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview, the facility failed to ensure an objective was developed to teach medication self-administration skills for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/30/15 at 9:50 A.M. Review of the</p>	W 0371	<p>The QIDP will develop objectives for Client # 2 for medication administration. Once developed, the group home staff will be trained in the implementation of the goal. The goal will be monitored monthly by the QIDP and be revised as necessary. In the future, the QIDP will evaluate the needs of individuals served to determine whether additional objectives should be developed in any area of medication</p>	09/02/2015

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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	<p>client's 8/15 Medication Administration Record indicated the client did not receive any prescribed medication but did indicate the client received over-the-counter medications for headache, colds, and first aid medications for minor cuts and abrasions. A review of his 11/17/14 Individual Program Plan failed to indicate the facility developed and implemented a medication self-administration objective for the client in regards to his over-the-counter medications and first aid medications.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/30/15 at 11:30 A.M. QIDP #1 indicated client #2 did not take any prescribed medications so he (client #2) did not have a medication self-administration objective. QIDP stated, "[Client #2] did occasionally need to take over the counter medications for headache or minor injuries." When asked if the client had a medication self-administration objective that addressed the use of over the counter medications, QIDP #1 stated, "No."</p> <p>9-3-6(a)</p>		<p>administration at time of admission and at least annually, more often as appropriate. When developed, staff will be trained to implement in a timely manner. Additionally, The QIDP will receive additional training from the Director of Quality Assurance regarding goal and program development that addresses training strategies for individuals to self-administer their medications in a successful manner. Persons Responsible: QIDP and Director of Quality Assurance</p>	

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W 0376 Bldg. 00	<p>483.460(k)(8) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician.</p> <p>Based on record review and interview, the facility failed to have evidence of immediately reporting 1 of 1 reviewed medication error to the physician for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/27/15 at 11:49 A.M. A review of incident reports from 2/1/15 to 7/27/15 indicated the following medication error:</p> <p>"Date: 02/14/2015, Name: [Client #1], Narrative: On 2/14/15, On-Call QIDP (Qualified Intellectual Disabilities Professional) received a call from [group home manager] stating that staff person (direct care staff #7) administered medications to [client #1] this morning and gave him his (client #1's) 3mg (milligram) Risperdal (medication for psychosis) which is to be given in the evening instead of his 2mg Risperdal which is given in the morning. Plan to Resolve: On-Call QIDP contacted the On-Call Nurse (nurse #2) and was advised to inform staff to give [client #1]</p>	W 0376	<p>All prescribed medications in the home are to be administered per physician's orders and prescription. Administration errors and adverse drug reactions will be reported in a timely manner to the individual's physician. There is a procedure in place for the group home staff to contact the QIDP on-call when a medication administration error occurs. The QIDP on-call will contact and notify the nurse on-call for further counsel regarding the error. Per LOGAN policy and in the future, the QIDP on-call will inform the primary physician regarding the medication error. Based on the response from the physician, the QIDP on-call will follow and implement any physician's recommendations. The QIDP on-call will document notification of nurse and physician as well as any further instructions given. Person Responsible: QIDP</p>	09/02/2015

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W 0436 Bldg. 00	<p>his 2mg Risperal (sic) this evening. QIDP then notified [group home manager." Further review of the 2/14/15 medication error report failed to indicated the client's physician was immediately notified of the medication error.</p> <p>Client #1's record was reviewed on 7/30/15 at 8:38 A.M. A review of nursing notes from 1/1/15 to 7/30/15 failed to indicate documentation of client #1's physician being notified of the 2/14/15 medication error.</p> <p>Nurse #1 was interviewed on 7/30/15 at 9:21 A.M. When asked if client #1's physician was notified of the 2/14/15 medication error, nurse #1 stated, "No, I have no documentation to show that he was contacted."</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.</p>				

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	<p>Based on observation, record review, and interview, the facility failed to prompt 1 of 3 sampled clients (client #2) to wear his eyeglasses.</p> <p>Findings include:</p> <p>Client #2 was observed during the group home observation period on 7/27/15 from 4:16 P.M. until 6:30 P.M., and on 7/28/15 from 5:49 A.M. until 8:15 A.M. During all observation periods, client #2 did not wear eyeglasses and manager #1 and direct care staff #1, #2, #3, #4 did not prompt or assist client #2 to wear his eyeglasses.</p> <p>Client #2's record was reviewed on 7/30/15 at 9:50 A.M. Review of the client's 4/21/15 indicated the client had "corrective lenses prescribed for constant wear."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/30/15 at 11:30 A.M. QIDP #1 stated, "Staff (direct care staff) should have prompted [client #2] to wear his eyeglasses."</p> <p>9-3-7(a)</p>	W 0436	<p>The QIDP will develop a goal for Client # 2 to wear his glasses. Once developed, the group home staff will receive training to implement the goal successfully. The goal will be monitored monthly by the QIDP and revised as necessary. In the future, the QIDP will evaluate the needs of individuals served at the time of admission, at least annually, or whenever they are prescribed/have an order for adaptive equipment. The QIDP will determine whether additional programming objectives are needed to teach the individual to use their adaptive equipment as prescribed. Additionally, the QIDP will receive additional training from the Director of Quality Assurance that addresses training strategies for individuals to use their prescribed adaptive equipment in a successful manner. Persons Responsible: QIDP and Director of Quality Assurance</p>	09/02/2015