STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G222	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COMMUNITY RESOURCES INC	1602 ORKNEY DR SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	This visit was for a fundamental recertification and state licensure survey. This visit was in conjunction with a post certification revisit to the investigation of complaint #IN00107557 completed on May 4, 2012. Dates of Survey: July 9, 10, 11, and 12, 2012. Facility number: 000746 Provider number: 15G222 AIM number: 100234830 Surveyors: Susan Reichert, Medical Surveyor III-Team Leader Amber Bloss, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/18/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

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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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based upon observation, record review and interview, the governing body failed to exercise operating direction over the facility to maintain the home in good condition and failed to develop a system to monitor and regulate air temperatures in the home for 4 of 4 sampled clients (clients #1, #2, #3, #4) and 3 additional clients (clients #5, #6, and #7). Findings include: During observation at the group home on 7/9/12 from 4:48 PM to 6:50 PM, there was loose carpeting on the second step from the top of the stairs leading to client #1, #2, #3, #4, #5, #6 and #7's bedrooms. The handrail up the steps was loose, and the hinge at the top of client #2 and #4's bedroom was loose and hanging. There was a hole in the wall near client #2's bed measuring 1 and a half feet in diameter. There were no closet doors in client's #3 and #5's room. The thermostat in the living room downstairs registered 78 degrees and was set at 70 degrees and the temperature in the upstairs hallway to the client bedrooms registered 76 degrees. There were in excess of 50 cigarette butts	W0104	The facility is resolving all maintenance and environmental needs including the loose carpeting on the second step from the top of the stairs, the loose handrail up the stairs, the hinge as the top of client #2 and client #4's bedroom doors, the hole in the wall near client #2's bed and replacing the closet doors in client #3 and #5's bedrooms For clients that smoke on the premises, buckets for cigarette butts have been placed both on the front entry way as well as in the backyard. LOGAN makes every effort to maintain the temperature and humidity within a normal comfort range in its homes and facilities. W429 interpretive guidelines define a normal comfort range as 68 degrees to 81 degrees. On the day of the survey and per the summary statement of deficiencies on the 2567, it is noted the temperature was 76 degrees. This is within the normal comfort range as defined by the W429 interpretive guidelines. The previous week when the temperature was reported to	08/11/2012

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	on the front entryway underneath a chair client #1 sat in to smoke. The Program Coordinator was interviewed on 7/9/12 at 5:50 PM and indicated the group home's air conditioning unit did not keep up with the temperature's setting. She indicated there had been requests made to maintenance regarding the air conditioning. She indicated it had been 85 degrees the previous week in the home during a heat wave, and the clients did not cook in the home because of the high temperatures. Clients #1 and 7 were interviewed on 7/9/12 at 5:51 PM and indicated they had slept downstairs where it was cooler during the heat wave. Client #1 was interviewed on 7/9/12 at 6:40 PM and indicated the clients had eaten cold cut sandwiches as it was too hot to cook. He indicated he had requested a receptacle for his cigarette butts. The Director of Group Living was interviewed on 7/10/12 at 1:26 PM and indicated there had been no formal requests to address the air conditioning, the loose carpeting, hand rail or missing hinge.		be 85 degrees, it is noted that this was during a heat wave. The interpretive guidelines allow for brief episodes of unseasonably hot weather. The previous week, there was a brief episode of unseasonably hot weather. As to why there had been no formal requests to address the maintenance issues, the electronic SYSAID was not responding properly at the Orkney home. In the future, when the electronic SYSAID system is not fully operational, maintenance will be made aware of problems by the way of phone, e-mail, or in person in effort to get maintenance issues resolved in a timely manner. In the future when the temperature in the home exceeds the normal comfort range as defined to be within 68-81 degrees, maintenance will be notified and if it is not during a brief episode of unseasonable hot weather, the heating/cooling unit will be checked and adjusted as appropriate. Persons Responsible: Director of Maintenance Program Coordinator QMRP	

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	The Director of Group Living was interviewed on 7/12/12 at 3:15 PM and indicated there was no system to monitor and address air temperature in the group home. 9-3-1(a)		Director of Group Living August 11, 2012 and On Going Director of Maintenance Program Coordinator QMRP Director of Group Living August 11, 2012 and On Going	

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W0210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on interview and record review for 2 of 4 sampled clients (clients #1 and #4), the agency failed to provide assessments of speech and language development, sensory motor development and physical development, and failed to assess client #1's hearing and behavioral needs within 30 days of admission. Findings include: Client #1's records were reviewed on 7/10/12 at 12:12 PM. The record indicated client #1 had been admitted on 5/18/12. There was no evidence in the record of a speech, occupational therapy, physical therapy, hearing evaluation, or evaluation of client #1's behavioral needs. A psychiatric progress note dated 3/5/12 indicated client #1 was alert and oriented, his thinking was concrete, eye contact fair. "He is quiet which is unusual. His insight and judgement are fair." The note indicated in the plan, "I will continue Ativan 0.5 mg (milligrams) which he thinks is very helpful, it helps him with anxiety..." There was no other evidence	W0210	The speech, occupational and physical therapy evaluations for client #4 were completed on 7/25/12. The facility is waiting for the formal reports to be completed. The speech, occupational and physical therapy evaluations for client #1 are scheduled for 8/8/12. When the reports are received by the agency, any formal recommendations will be addressed through training goals for each individual. The hearing evaluation for client #1 is scheduled for 8/2/12. Once the evaluation is complete any formal recommendations made will be addressed. The behavior support plan for client #1 has been completed and will be sent to the Human Rights Committee for final approval. Once the final approval is received, the staff will trained and the plan will be implemented. The staff continue to track any incidents of behaviors that are to be included in the behavior support plan in effort to continue to identify/assess behavioral needs.In the future, the QMRP will work with the Program Coordinator and all nursing and medical professional staff to ensure that medical	08/11/2012

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	in the record of an assessment of client #1's behavior since 3/5/12. Client #4's record was reviewed on 7/10/12 at 12:20 PM. The record indicated client #4 had been admitted on 5/10/12. There was no evidence in the record of a speech, occupational therapy or physical therapy evaluation. The Qualified Mental Retardation Professional (QMRP) was interviewed on 7/12/12 at 1:03 PM and indicated there was no evidence of a hearing evaluation for client #1, and client #1 had not demonstrated behavioral issues since his admission. The QMRP and Program Coordinator (PC) were interviewed 7/12/12 at 3:20 PM. The PC indicated the evaluations of speech, physical therapy and speech were scheduled for 7/19/12. 9-3-4(a)		appointments/screenings or evaluations are completed within the 30 days of a new admission. Additionally, the QMRP will utilize any historical behavior data to assess behavioral needs within 30 days of a new admission and then develop an individualized behavior support plan.Persons Responsible:QMRP Program Coordinator August 11, 2012 and On Going	

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W0226	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on interview and record review, for 1 of 4 sampled clients (client #1), the facility failed to develop an ISP (Individual Support Plan) within 30 days of admission to the facility. Findings include: Client #1's record was reviewed on 7/10/12 at 12:12 PM. The record indicated client #1 had been admitted on 5/18/12. Client #1's most recent ISP in the record was dated 11/15/11 which had been developed at his previous placement. There were vocational goals to increase money skills and to sustain work after lunch, but no goals for activities of daily living. A comprehensive functional assessment dated June, 2012 (no day listed) indicated client #1 had needs in the area of financial management, laundry, cleaning, leisure activities and medication administration. The record failed to include an updated ISP or goals and objectives to address client #1's needs identified in the comprehensive assessment.	W0226	The ISP for client #1 was completed on 7/12/12. The report was reviewed with client #1 and copies were sent to all pertinent members of the IDT. Goals and objectives for client #1 were implemented on 7/19/12 in the areas of financial management, medication administration, domestic skills including laundry and room cleaning, leisure activities and dressing. The QMRP will monitor goals on a monthly basis and revise them as necessary. In the future the QMRP will make every effort to ensure that goals and objectives are completed and in place within 30 days of admission. Person Responsible:QMRP August 11, 2012 and on-going	08/11/2012

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	The Qualified Mental Retardation Professional (QMRP) was interviewed on 7/10/12 at 12:20 PM. She indicated client #1's 30 day meeting had been held, but the ISP had not been completed yet. The facility's Admissions Policy and Procedures (Adult Programs) was reviewed on 7/12/12 at 1:10 PM. It indicated "the thirty (30) day meeting will result in the development of the individual's first Individual Support Plan, complete with goals and strategies objectives." 9-3-4(a)			

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W0288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to include the use of psychotropic medication in a plan to address client #1's behavior, and failed to develop and implement a plan to address the use of a GPS (global positioning system) monitor for 1 of sampled clients (client #4). Findings include: 1. Client #1's record was reviewed on 7/10/12 at 12:12 PM. Client #1's annual physical and review of medications dated 6/25/12 indicated client #1 received Lorazepam (anxiety) .5 mg (milligrams) daily, Risperdal 4 mg (anti-psychotic) daily, Seroquel 600 mg daily, Depakote ER (extended release) and Benztropine Mesylate (side effects) 2 mg daily. There was no evidence of a plan that included the use of medications to address client #1's behaviors. The Qualified Mental Retardation Professional (QMRP) was interviewed on 7/10/12 at 12:20 PM and indicated client	W0288	The behavior support plan for client #1 has been completed and will be sent to the Human Rights Committee for final approval. This plan contains a complete listing of all psychotropic medications and what they are used for. Once the final approval is received, the staff will trained and the plan will be implemented. Until that time, the staff continue to track any incidents of behaviors included in the behavior support plan. The IDT is in agreement that the GPS monitoring device used by client #4 will be discontinued. This device was used when client #4 lived at home and had times when he was alone in his neighborhood. Now that he is at the group home, 24 hour supervision is provided and he does not access the community independently. Since moving to the group home he has had no incidents of wandering off the premises. The group home staff have been trained on the agency procedure if a client were to wander off the premises. At this time, the IDT does not feel that a formal plan is necessary to address wandering behaviors as client #4 has not had any incidents of wandering since moving into the group home. In	08/11/2012

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	#1's plan to address his behavioral needs including his medications to address behaviors had not been developed yet. 2. Observations were completed at the group home on 7/9/12 from 4:48 PM until 6:50 PM and on 7/10/12 from 6:50 AM until 8:05 AM. Client #4 wore a bracelet with a plastic housing on his wrist during the observations. The group home manager was interviewed on 7/9/12 at 6:06 PM and indicated the bracelet was a GPS monitoring unit client #4 had brought from home when he was admitted to ensure his whereabouts if he were to leave the home without staff knowledge and out of staff eyesight. She indicated client #4 had not had wandering behavior since his admission. Client #4's mother was interviewed on 7/10/12 at 6:10 PM. She indicated client #4 wore the GPS monitoring bracelet in the event he would wander away from home. She indicated he had wandered on at least one occasion while at home and the monitor was worn for his safety in determining his whereabouts. She indicated there was a plan being developed to reduce the need for its use and would also bring client #4's bicycle to the group home once it was determined he		the future, the QMRP will make every effort to ensure that behavior support plans and any other necessary risk plans are in place within 30 days of admission. QMRP August 11, 2012 and on-going	

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	could use it safely at the group home. Client #4's plan was reviewed on 7/10/12 at 12:20 PM. There was no evidence of a plan to address client #4's wandering behavior. The QMRP (Qualified Mental Retardation Professional) was interviewed on 7/10/12 at 1:00 PM and indicated there was not a plan at this time to address the use of the GPS monitor for client #4. 9-3-5(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing services failed for 1 of 4 sampled clients (client #1) to ensure a protocol was developed to provide instructions to staff to address his medical needs in the area of renal failure and reaction to caffeine. Findings include: 1. Client #1's workshop supervisor was interviewed on 7/10/12 at 9:50 AM. When asked if he had concerns about client #1, he indicated he had been informed client #1 had renal failure. He indicated he was unaware of any interventions needed to address client #1's medical condition. Client #1's record was reviewed on 7/10/12 at 12:12 PM. His physical dated 6/25/12 indicated he had chronic renal disease. There was no evidence of a plan to address client #1's renal disease. Client #1's Individualized Support Plan (ISP) dated 11/15/11 indicated client #1 "has a severe reaction (behaviors) when caffeine has been consumed. He is not to have caffeine due this interaction with his medications, but at times [client #1]	W0331	Client #1 currently has a diagnosis of Chronic Kidney Disease stage 3. He is monitored on a regular basis by a nephrologist and has blood work done as necessary. At this time, his condition is stable and does not require any special medical intervention to maintain his health. Included in his ISP dated 7/12/12 are a health care plan for maintaining his condition, a risk plan for his sensitivity to caffeine as well as other information on the importance of daily fluid intake, salt intake limits, and watching for coughing and edema. The group home staff as well client #1's immediate training supervisor and Program Coordinator in the workshop have been trained on this information. In the future, a complete medical review will be done prior to/at the time of admission. This review will assist the IDT to ensure that the appropriate risks plans and/or medical plansare in place at the time of admission. Persons Responsible:QMRP Nurse August 11, 2012 and ongoing	08/11/2012

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	chooses to not follow this and have (sic) caffeine. [Workshop] has caffeine free choices in the vending machines. If the drink is at all questionable, [client #1] can consult with staff...." The group home nurse was interviewed on 7/11/12 at 1:16 PM. She indicated she was unaware of client #1's reaction to caffeine. She indicated client #1 currently was in stage 3 renal disease and staff were to encourage client #1 to limit salt, watch for cough and edema. She indicated staff were to monitor all clients for cough and edema, and no plan was written specifically to address client #1's renal disease. 9-3-6(a)			

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W0352	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed to obtain an annual dental examination for 1 of 4 sampled clients (client #2). Findings include: Client #2's record was reviewed on 7/10/12 at 11:20 AM. Client #2's record indicated the most recent dental examination was dated 6/13/11. The Qualified Mental Retardation Professional was interviewed on 7/10/12 at 1:46 PM. She indicated there was not a more recent dental examination for client #2. 9-3-6(a)	W0352	An appointment for an annual dental exam for client #2 is scheduled for . Once the appointment has been completed, any recommendations, with the assistance of either the nurse or the QMRP, will be implemented if formal goal training in the area of oral hygiene is necessary. In the future, the Program Coordinator and the QMRP will monitor the appointment list that is generated by the nurse to ensure all appointments are completed in a timely fashion. The nurse will ensure that the appointment list is updated monthly or as necessary and given to the appropriate individuals. QMRP Program Coordinator Nurse August 11, 2012 and on-going	08/11/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0455	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 hand washing and infection control procedures were implemented during the administration of medication for 2 of 4 sample clients (clients #1 and #2) and one additional client (client #7). Findings include: Observations were completed on 7/10/12 at the group home from 6:45 AM until 8:04 AM. Medication administration was observed between 7:31 AM and 7:55 AM for clients #1, #2, and #7. Staff #2 did not wash his hands before administering medications or between clients. The Program Coordinator was interviewed on 7/10/12 at 7:57 AM. The Program Coordinator indicated staff #2 should have washed his hands before administering medications for each client as per policy. The procedure "Steps to Passing Meds" (undated) in the Medication Administration Record (MAR) was reviewed on 7/10/12 at 8:00 AM. The	W0455	The posted procedure “Steps for Passing Meds” has been reviewed and revised. The revisions made will continue to ensure that infection control is maintained during the medication administration process. In the future, the QMRP, Nurse and Program Coordinator will continue to ensure that all staff are trained on the appropriate procedures for maintaining infection control when completing medication administration. QMRP Program Coordinator Nurse August 11, 2012 and on-going	08/11/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G222	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/12/2012

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	procedure indicated in Step #1, "Staff must wash hands after each client even if wearing rubber gloves" and Step #7, "When client finishes meds staff must wash hands and then go on to next client." 9-3-7(a)			