

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 03/01/2013	
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 20089 LARK DR SOUTH BEND, IN 46637			
(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: February 25, 26, 27, 28, and March 1, 2013.</p> <p>Facility number: 000930 Provider number: 15G416 AIM number: 100244540</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 7, 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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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills on the overnight shift for staff (10:00 P.M. to 8:00 A.M.) during the first quarter (January 1st through March 31st) of 2012 and the morning shift for staff (6:00 A.M. to 2:00 P.M.) and afternoon shift for staff (2:00 P.M. to 10:00 P.M.) during the second quarter of 2012 which affected 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients living in the facility (clients #4, #5, and #6.)</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/25/13 at 1:40 P.M. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, and #6 on the overnight shift for staff during the first quarter of 2012 and the morning and afternoon shifts for staff during the second quarter of 2012.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 2/27/13 at 12:11 P.M. QMRP #1 stated the facility was "missing some (evacuation) drills."</p> <p>9-3-7(a)</p>	W000440	<p>During the times that fire drills were conducted, a client of the Lark Group Home was refusing to leave during the fire drills. This was corrected by obtaining a wheel chair which the client agrees to use to evacuate during drills. Additionally ramps were installed off the front and back exits of the house. The client also has a Fire Risk plan and his Behavior Support plan was revised to include his refusals to leave the house. Once these items were put into place, there have not been any other issues with drills not being run appropriately. The Group Living Administrative Assistant will be monitoring all group home drills to ensure that evacuation drills are run at least quarterly for each shift of personnel. The drills will be reviewed monthly and tracked. Persons Responsible:QMRP Group Living Administrative Assistant</p>	03/31/2013			

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary environment to avoid sources of infections by failing to assure a soiled incontinence brief was disposed of properly (bagged prior to disposal) for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 additional clients (clients #4, #5, and #6) living at the group home.</p> <p>Findings include:</p> <p>Client #1 was observed during the 2/27/13 group home observation period from 3:22 P.M. until 5:30 P.M. At 3:46 P.M., client #1 entered the dining room with an unbagged, soiled incontinence brief. Direct care staff #2 instructed client #1 to "put it in the kitchen trash" which client#1 did. Direct care staff #2 did not prompt or assist client #1 to bag the soiled incontinence brief prior to disposing of it. The soiled incontinence brief, which was discarded unbagged into the kitchen trash receptacle, affected the sanitary environment for clients #1, #2, #3, #4, #5, and #6.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on</p>	W000454	Staff were retrained on March 13, 2013 in a house meeting to remind them that soiled incontinence briefs are bagged prior to disposal and that they are disposed of in bathroom trash cans and/or the outside trash receptacle. The QMRP and Lark Program Coordinator will monitor to ensure that staff are disposing of these in a proper manner Persons Responsible:QMRP Program Coordinator	03/31/2013			

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	<p>2/28/13 at 10:28 A.M. QMRP #1 stated, "Staff (direct care staff #2) should have had [client #1] bag the brief before throwing it away."</p> <p>Nurse #1 was interviewed on 2/28/13 at 10:43 A.M. Nurse #1 stated, "The incontinence brief should have been bagged separately if it was going to be thrown away in the kitchen trash."</p> <p>9-3-7(a)</p>				