

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 05/04/2012
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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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W0000	<p>This visit was for the investigation of complaint #IN00107557.</p> <p>Complaint #IN00107557- SUBSTANTIATED: Federal and State deficiencies related to the allegation are cited at W149 and W156.</p> <p>Dates of Survey: May 2 and 3, 2012.</p> <p>Facility number: 000746 Provider number: 15G222 AIM number: 100234830</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 5/10/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility staff neglected to follow their Abuse, Neglect, or Exploitation policy by failing to provide supervision for 1 of 3 sampled clients (client A) who lived in the home and required 24 hour supervision.</p> <p>Findings include:</p> <p>Facility records were reviewed on 5/2/12 at 4:10 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports. The BDDS reports indicated the following:</p> <p>A BDDS report dated 4/22/12 for an incident on 4/21/12 at 4:00 P.M. indicated "[Client A] was dropped off at a community event the March of Dimes Walk on 4/21/12. Staff did not provide supervision to him. As a result, for a period of time [client A] was unsupervised. [Client A] requires 24/7 (twenty-four hours a day seven days a week) supervision. After the walk, [client A] walked to his mother's home." Plan to Resolve: "[Client A] was not harmed. Staff was suspended who dropped him off at the event and did not provide</p>	W0149	<p>LOGAN Community Resources has polices and procedures that prohibit abuse, neglect, and exploitation. The facility works diligently to assure that abuse, neglect and exploitation does not occur to the individuals in this facility. LOGAN continues to provide training to all incoming staff as well as annually and more often as needed, to all staff. This training includes definitions of abuse, neglect and mistreatment, examples, how to prevent such incidents and reporting procedures.</p> <p>Shortly after the incident, both the QMRP and the Program Coordinator spoke with Client A regarding having staff with him at any type of event/activity for his own safety. The Program Coordinator also reviewed with the staff the importance of communicating with management if unsure of a planned or unplanned activity that residents, including Client A, have an interest in</p>	06/03/2012			

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	<p>supervision. An investigation will be completed with response provided in 7 (seven) days."</p> <p>A follow-up BDDS report dated 5/2/12 for the incident on 4/21/12 indicated "...it was substantiated that [client A] was indeed left in the community alone for a significant amount of time. The staff was immediately suspended and then later terminated based on his actions. [Client A] currently lives in a house that requires 24 hour supervision."</p> <p>Facility internal investigation documentation dated 4/22/12 was reviewed on 5/2/12 at 4:45 P.M.. A written statement by Direct Care Staff (DCS) #1 indicated "[DCS #1] was told by (client A) that he had permission from the house coordinator to go to the March of Dimes ...at 9:00 A.M. and that he would call staff after the March was over. Client did not call but his mother's apt. (apartment) is a block away..." DCS #1 reportedly left the group home at the end of his shift at 4:00 P.M. client A had not called the group home. DCS #1 written statement indicated "I (DCS #1) guess I really dropped the ball." A written statement by DCS #2 indicated "... [Client A] on phone with sister on Friday eve ...sister talked to DCS #2 and told DCS #2 [client A] can't be dropped off. He has</p>		<p>attending to ensure that staff will be available to accompany the resident and provide supervision.</p> <p>In the future, all incoming staff will be provided training, in written and verbal format, the definition of providing supervision to residents in effort to prevent neglect. Current staff have been re-trained regarding the definition of providing supervision to residents in effort to prevent neglect. Persons Responsible: Program Coordinator QMRP Director of Group Living</p>				

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	<p>to have supervision and staff with him."</p> <p>Client A's Individual Support Plan (ISP) was reviewed on 5/2/12 at 4:16 P.M.. Client A's ISP indicated he was diagnosed with Moderate Mental Retardation. Client A's ISP indicated he had a legal guardian. Staff at client A's home were to provide him access to 24 hour supervision.</p> <p>Client A's guardian was interviewed on 5/3/12 at 3:41 P.M.. Client A's guardian indicated she was aware of the incident. The guardian stated, "[Client A] really snookered all of us." Client A's guardian indicated she did not believe he was in any danger as he "knew the area very well, has lots of friends in the area and one of her neighbors had seen [client A] at the walk-a-thon. He also likes to hang out at the Chocolate Cafe." The guardian did state, "He needs to be supervised, that is why I moved him into the group home last August." Client A's guardian indicated client A had arrived at her home just before dark. She indicated the house manager called her and informed her about [client A] being gone. The guardian indicated she informed the house manager that Client A was present with her at that time.</p> <p>The facility policy Abuse, Neglect, or</p>				

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	<p>Exploitation dated 10/6/08 was reviewed on 5/2/12 at 4:30 P.M. and indicated "Logan prohibits the abuse, neglect, exploitation, mistreatment or the violation of rights of any individual receiving Logan services...Neglect/Mistreatment: Failure to provide necessary care, treatment, or attention to an individual with the intent to cause harm. Failure to provide appropriate care, food, medical care or supervision."</p> <p>An interview with the facility Director of Group Living (DGL) was conducted on 5/4/12 at 9:15 A.M.. The DGL indicated she was aware the facility staff had neglected to provide supervision to [client A] and indicated this was against facility policy. The DGL indicated client A had been unsupervised for possibly 8 (eight) hours from 9:00 A.M. until 5:00-6:00 P.M..</p> <p>This federal tag relates to complaint #IN00107557.</p> <p>9-3-2(a)</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of an investigation of possible neglect to provide supervision for 1 of 3 sampled clients (client A), who lived in the home and required 24 hour supervision, to the Bureau Of Developmental Disabilities Services BDDS office and other officials in accordance with State law within five working days of the incident.</p> <p>Findings include:</p> <p>Facility records were reviewed on 5/2/12 at 4:10 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports. The BDDS reports indicated the following:</p> <p>A BDDS report dated 4/22/12 for an incident on 4/21/12 at 4:00 P.M. indicated "[Client A] was dropped off at a community event the March of Dimes Walk on 4/21/12. Staff did not provide supervision to him. As a result, for a period of time [client A] was unsupervised. [Client A] requires 24/7</p>	W0156	LOGAN Community Resources works diligently to assure that all allegations of abuse, neglect and exploitation to the individuals in this facility are reported immediately to the administrator or other officials in accordance with State law through established procedures. The QMRP made every effort to follow the appropriate protocol for reporting the incident within 24 hours. While the investigation was complete and all appropriate actions had been taken the QMRP failed to report the results within 5 days. The Director of Living has reviewed with the QMRP W156 and the difference in reporting timelines per ISH regulations and BQIS/BDDS regulations. In the future the QMRP will refer to the ISDH regulations as well as agency policy when reporting incidents of abuse neglect or mistreatment. If there is a question regarding reporting timelines, the QMRP will consult with the Director of Group Living for guidance. To prevent future late reporting, the Director of Group Living uses a tracking sheet to monitor incident dates, reporting dates, and follow up dates to ensure timelines will be	06/03/2012			

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	<p>(twenty-four hours a day seven days a week) supervision. After the walk, [client A] walked to his mother's home." Plan to Resolve: "[Client A] was not harmed. Staff was suspended who dropped him off at the event and did not provide supervision. An investigation will be completed with response provided in 7 (seven) days."</p> <p>A follow-up BDDS report dated 5/2/12 for the incident on 4/21/12 indicated "...it was substantiated that [client A] was indeed left in the community alone for a significant amount of time. The staff was immediately suspended and then later terminated based on his actions. [Client A] currently lives in a house that requires 24 hour supervision."</p> <p>An interview with the facility Director of Group Living (DGL) was conducted on 5/4/12 at 9:15 A.M.. The DGL indicated the results of the 4/21/12 incident investigation had not been reported until 5/2/12, which was not within 5 (five) working days of the incident.</p> <p>This federal tag relates to complaint #IN00107557.</p> <p>9-3-2(a)</p>		<p>followed. Persons Responsible:QMRP Director of Group Living</p>				

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