

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 04/03/2014
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: March 31, April 1, 2, and 3, 2014.</p> <p>Facility number: 000688 Provider number: 15G679 AIM number: 100234470</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/11/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, the facility's governing body failed to develop a financial policy which dictated how large purchases with client funds were to be approved which had the potential to impact all clients (#1, #2, #3, #4, #5, #6, #7, #8).</p> <p>Based on record review and interview, the facility's governing body failed to ensure the facility's financial policy was implemented in regards to the right of clients to access and</p>	W000104	<p>The facility's governing body will revise its existing policy-F-50-01 <u>Financial Interests of Individuals Served by LOGAN</u> to ensure that it clearly outlines procedures to be followed for making purchases with client's funds. The revised policy will define large purchases and include the approval process that involves the client and guardian (as appropriate) and the accounting department role in these purchases. The revised policy will include</p>	05/03/2014

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>use their funds to the greatest extent of their abilities for 3 of 4 sampled clients (#1, #3, and #4).</p> <p>Based on record review and interview, the facility's governing body failed to ensure the facility's financial policy was implemented in regards to an accurate accounting of receipts of client finances for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>1) On 3/31/14 between 4:35 PM and 5:57 PM and on 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Client #2's bedroom contained a dresser, hospital bed, and a television belonging to him. All sofas and recliners were in the two living rooms for common use. Throughout the observations, Client #2 was seated in his wheelchair or was in bed. Client #2 did not sit in a recliner or sofa during observations.</p> <p>On 4/2/14 at 1:21 PM, financial records were reviewed for Client #2. Financial record review indicated a "sofa" (which was indicated in the memo portion of the check copy) was purchased with Client #2's funds for the amount of \$853.86 dated on 1/25/14. A receipt for a "HOSP (hospital) BED SEMI ELECTRIC", a "MERIDIAN FOAM MATTRESS", a "ZIPPERED MATT. (mattress) COVER", and a "HOSP (hospital) BEND HAND CRANK" for a total amount of \$2,316.76 dated 12/18/13.</p> <p>On 4/3/14 at 10:47 AM during an interview, the Director of Residential Services (DRS) stated Client #2 needed to "spend down" his funds in order to remain Medicaid eligible. When asked how the purchase of the sofa</p>		<p>specific procedures that identify accounting of receipts for client purchases and finances and the involvement of the accounting department to track each purchase. All departments will work together to obtain, maintain, and pass along receipts for accurate accounting and client funds tracking. The staff accountant will be diligent in obtaining receipts that are missing from designated staff that make purchases using client funds. Designated staff will make every effort to obtain receipts or retrieve missing receipts and deliver them to the staff accountant, as requested and in a timely manner. The staff accountant will continue to be responsible and held accountable to review, audit, and reconcile all client accounts for which the facility is named representative payee.</p> <p>Documented training will be provided to the appropriate and designated staff on the policy revisions to ensure proper implementation.</p> <p>Person Responsible: CFO</p> <p>Clients will be encouraged to access and use their funds to the greatest extent of their abilities. The House Manager/Program Coordinator and QIDP will plan activities and outings for clients #1-8 on a regular basis, in which the clients, with assistance from staff, can take money with</p>	

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	<p>and hospital bed was approved, the DRS stated that "he (Client #2) has the right to purchase items." When asked how Client #2 was able to consent as he is non-verbal, the DRS indicated his guardian gave consent. The DRS indicated the Housemanager (HM) and guardian decided which items Client #2 would most benefit from purchasing. The DRS indicated the QIDP (Qualified Intellectual Disabilities Professional) might have been involved in approving the purchases but he was uncertain. The DRS stated he "believe(s) we have a company policy for large purchases by the company that need approval but perhaps not for individual purchases. There is probably an understanding that the guardian needs to be informed and give consent." When asked whether the facility's accounting department reviewed purchases to ensure client funds were not used to purchase items the facility would be liable to purchase, he stated the accounting department "catches little things here, and there" but stated the accounting departments knowledge of what the facility is liable to purchase under the Medicaid agreement "is a bit fuzzy."</p> <p>On 4/2/14 at 3:12 PM, the facility policy on "Financial Interests of Individuals Served by Logan" (Policy #F-05-01, dated 9/20/11) was reviewed. The policy indicated "It is the policy of LOGAN that these funds or services are managed by the designated staff within the program departments with the written informed consent and approval of the individual or their representative." Review of the policy indicated the facility's governing body failed to develop a policy that indicated how large purchases made with client funds were to be approved for Clients #1, #2, #3, #4, #5, #6, #7, or #8.</p>		<p>them and make purchases. This would include activities such as dances, trips to the Dollar Store, snacks at local fast food restaurants, single item clothing purchases, etc. For any purchase a client makes with their funds, they will be encouraged and assisted to use the item(s) to their full potential and for the purpose of the purchase. On a regular basis, Client #2 will be encouraged and assisted to use the sofa/recliner that was purchased with his funds.</p> <p>Person Responsible: QIDP</p> <p>In the future, LOGAN will review, revise and implement policies that provide general policy, budget and operating direction over the company. The revised financial policy will outline and provide guidance as to how client finances will be managed, monitored and reconciled in effort to promote purchases/purchasing by clients for their use and enjoyment, commensurate with their abilities, utilizing informed consent, and within state and federal guidelines. Review of monthly Cash on Hand ledgers by the House Manager/Program Coordinator, QIDP and Staff Accountant will allow for tracking and checking that the financial policy is followed and clients have the opportunity to use their funds to the greatest extent of their abilities.</p>	

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	<p>2) On 4/2/14 at 1:21 PM, financial records were reviewed for Clients #1, #3, and #4 from 4/2/13 to 2/28/14. Client #1's "Cash on Hand" ledger indicated Client #1's cash on hand remained the same amount of \$11.49 from 5/13 to 2/14. Client #3's "Cash on Hand" ledger indicated Client #3's cash on hand remained the same amount of \$9.62 from 4/13 to 2/14. Client #4's "Cash on Hand" ledger indicated Client #4's cash on hand remained \$10 from 7/13 to 2/14.</p> <p>On 4/2/14 at 3:51 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated she believed staff were hesitant to assist clients in using their "cash on hand" because of an episode of theft last year. The QIDP stated the facility wants to "try to save" money on behalf of the clients so they go to free and/or inexpensive activities like "bowling", "Logan activities", and "parks." The QIDP indicated clothes and larger purchases were done by check. The QIDP indicated she understood how clients could benefit by having access to their own cash on hand for snacks and small purchases.</p> <p>On 4/2/14 at 3:12 PM, the facility policy on "Financial Interests of Individuals Served by Logan" (Policy #F-05-01, dated 9/20/11) was reviewed. The facility's financial policy indicated "The individual receiving services participates in the spending of his or her money to the greatest extent possible."</p> <p>3) On 4/2/14 at 1:21 PM, financial records were reviewed for Client #2. Financial record review indicated a "sofa" (which was indicated in the memo portion of the check copy) was purchased with Client #2's funds</p>		Person Responsible: CFO	

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	<p>for the amount of \$853.86 dated on 1/25/14. Record review indicated no receipt for the check #305 out of Client #2's bank account.</p> <p>On 4/2/14 at 1:39 PM during an interview, the accountant for the group home indicated he did not have a receipt for the sofa purchased on 1/25/14 for \$853.86. The accountant stated he "had emailed the housemanager (HM) for a receipt but never got it."</p> <p>On 4/2/14 at 3:51 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the sofa Client #2 purchased was in the living room of the group home.</p> <p>On 4/3/14 at 10:47 AM, during an interview, the Director of Residential Services (DRS) stated he thought "maintenance had the receipt" but usually the "housemanager" turns it into accounting.</p> <p>On 4/2/14 at 3:12 PM, the facility policy on "Financial Interests of Individuals Served by Logan" (Policy #F-05-01, dated 9/20/11) was reviewed. The policy indicated "3. The Staff Accountant is responsible for review, audit and reconciliation of all client accounts for which LOGAN is named as representative payee. Any discrepancies are reported to the Chief Financial Officer, Program Coordinator and Program Manager." The policy indicated "4. The LOGAN Accounting Department has the responsibility to deposit and properly record all funds of individuals served by LOGAN in the collective account; to disperse funds as authorized; to maintain detailed records of all receipts and disbursements; to furnish copies of those records in a format which results in a individual balance for each individual represented."</p>			

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W000140	<p>9-3-1(a) 483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, the facility failed to ensure an accurate accounting of client funds for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>On 4/2/14 at 1:21 PM, financial records were reviewed for Client #2. Financial record review indicated a "sofa" (which was indicated in the memo portion of the check copy) was purchased with Client #2's funds for the amount of \$853.86 dated on 1/25/14. Record review indicated no receipt for the check #305 out of Client #2's bank account.</p> <p>On 4/2/14 at 1:39 PM during an interview, the accountant for the group home indicated he did not have a receipt for the sofa purchased on 1/25/14 for \$853.86. The accountant stated he "had emailed the housemanager (HM) for a receipt but never got it."</p> <p>On 4/2/14 at 3:51 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the sofa Client #2 purchased was in the living room of the group home.</p> <p>On 4/3/14 at 10:47 AM, during an interview, the Director of Residential Services (DRS)</p>	W000140	<p><u>W140</u></p> <p>The facility will diligently implement its procedures to account for and keep documentation for all purchases made with client funds. The departments will work together to obtain, deliver and maintain receipts for all purchases made with client funds. The staff accountant will be diligent in obtaining receipts that are missing from designated staff that make purchases using client funds. Designated staff will make every effort to obtain receipts or retrieve missing receipts and deliver them to the staff accountant, as requested, in a timely manner. The receipt for purchase of the sofa on 1/25/2014 for \$853.86 will be delivered to the staff accountant in order for a full accounting of the funds for Client #2.</p> <p>In the future, if receipts need to be handed off to another department for pick-up and delivery purposes, a copy of the receipt will be made and turned into the staff accountant. Further, when the staff accountant makes a request of a missing receipt,</p>	05/03/2014

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W000210	<p>stated he thought "maintenance had the receipt" but usually the "housemanager" turns it into accounting. The DRS indicated all receipts for purchases made with client funds should be accounted for and documented.</p> <p>9-3-2(a)</p> <p>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.</p> <p>Based on observation, record review, and interview for 1 of 4 sampled clients (Client #3), the facility failed to ensure a speech evaluation was current based on need.</p> <p>Findings include:</p> <p>On 3/31/14 between 4:35 PM and 5:57 PM and on 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Throughout the observations, Client #3 spoke a few words quietly with minimal to no motion of his face and mouth muscles. Client #3 frequently carried a handheld mirror. During an interview on 3/31/14 at 5:10 PM, DSP (direct support professional) #1 indicated Client #3 carried the handheld mirror as it assisted him with peripheral vision (vision outside the center of gaze). During day program (facility owned) observation on 4/2/14 at 12:35 PM, Client #3 spoke the</p>	W000210	<p>the recipient of the request will find the receipt and deliver the receipt, or identify who has the receipt for the staff accountant, or obtain a replacement receipt, in a timely manner.</p> <p>Persons Responsible: Staff Accountant; House Manager/Program Coordinator</p> <p>A speech evaluation will be scheduled for Client #3. Once completed, recommendations will be reviewed, incorporated into the ISP, and staff will be trained (documented training) to implement the recommendations in all program areas. This will include documentation to assess progress/lack of progress in order to revise/reassess/retrain, as appropriate.</p> <p>Prior to a new speech evaluation being scheduled and completed, the 2008 speech evaluation recommendations will be added as an amendment to the current ISP and implemented on a consistent basis. The QIDP will amend the current ISP and provide documented</p>	05/03/2014

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	<p>words "hi", "bye", and "see you next time" in a quiet tone barely audible with little use of his facial muscles.</p> <p>On 4/3/14 at 3:10 PM, record review indicated Client #3's diagnoses included, but were not limited to, intellectual disabilities, mobidus syndrome (a rare neurological syndrome that primarily affects the facial expression and eye movement), and poland syndrome (underdevelopment of chest muscle). Record review indicated Client #3 had a speech evaluation on 8/8/08 "because of his admission to the group home." The speech evaluation indicated "expressively, his (Client #3) speech is characterized by an echolalia. He is able to echo and then modify a phrase if he does not agree with it. When asked to name pictured objects without a verbal model, his intelligibility dropped to approximately 20% for a new listener, although the staff member was able to pick up and understand more items." The evaluation indicated "[Client #3] presents moderately impaired speech skills with an echolalic response used frequently. Rehabilitation potential is fair. The following are recommendations to be dressed (sic) daily or weekly by the group home." The evaluation indicated the following recommendations: "1. Ask [Client #3] to practice naming pictures, objects, or activities without a verbal model... 2. [Client #3] should be offered choices to communicate... 3. [Client #3] should continue to work on learning his address and phone number...." Client #3's ISP (Individual Support Professional) dated 6/12/13 indicated Client #3 did not include speech evaluation recommendations.</p>		<p>training to staff to implement the speech evaluation recommendations in all program areas, including documentation to assess progress/lack of progress.</p> <p>Person Responsible: QIDP</p> <p>The QIDP will receive documented training regarding all aspects and outcomes of evaluations and the subsequent recommendations that address client deficits and needs. Recommendations will be incorporated into the ISP that includes goal/objective development, data tracking, monthly review, revisions and reassessment, as appropriate.</p> <p>Person Responsible: Director of Residential Services</p> <p>In the future, assessments and reassessments will be scheduled and completed on a timely basis to ensure individuals' current program needs are identified. Assessment outcomes and recommendations will be amended and/or incorporated into the ISP and then reviewed on a regular basis to ensure progress and/or to ensure the timely address of lack of progress.</p> <p>Person Responsible: QIDP</p>	

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W000249	<p>During an interview on 4/3/14 at 1:16 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #3's ISP (Individual Support Plan) did not include the 8/8/08 speech evaluation recommendations. The QIDP stated she thought the speech recommendations were no longer in Client #3's ISP because the "speech evaluation is not current." The QIDP indicated Client #3 needed an updated speech evaluation.</p> <p>9-3-4(a) 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based upon observation, interview, and record review for 1 additional client (Client #6), the facility failed to ensure the Behavior Management Program was implemented as written in regards to the use of bubble wrap as a tactile sensory activity.</p> <p>Findings include:</p> <p>On 3/31/14 between 4:35 PM and 5:57 PM, group home observations were conducted. At 4:35 PM, Client #6 was chewing on a 8" (inch) long by 2" wide strip of bubble wrap (plastic containing air bubbles used for shipping breakable items). Between 5:13 PM and 5:54 PM, dinner was served. At 5:33 PM, Client #6 was done eating his meal and</p>	W000249	<p><u>W249</u></p> <p>The facility will implement Behavior Management Programs on a consistent basis.</p> <p>The QIDP, House Manager/Program Coordinator, and Behavior Consultant will meet to review the Behavior Management Plan and to discuss methods of safe oral sensory stimulation. The use of bubble wrap will be explored in effort to identify if it can be safely incorporated into the plan for tactile stimulation. Additionally, discussion and review will identify training opportunities and techniques that staff will be</p>	05/03/2014

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	<p>was in the living room looking at pictures while chewing on a piece of bubble wrap. At 5:36 PM, Client #6 still had bubble wrap in his mouth while doing activities (game) with staff. At 5:40 PM, Client #6 was walking in the hallway when he dropped the bubble wrap onto the floor. Client #6 picked the bubble wrap back up and stuck it back into his mouth. Client #6 put 2" (inches) to 3" into his mouth and let the rest hang out of his mouth. At 5:46 PM, Client #6 still had the bubble wrap in his mouth while playing with a game. At 5:50 PM, Client #6 took the bubble wrap out of his mouth and left it on the floor in the living room. Client #6 was not redirected to only feel the bubble wrap with his hands as a tactile activity. Client #6 was not trained and/or taught during the observation that bubble wrap was unsafe to have in his mouth.</p> <p>On 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. At 6:12 AM, Client #6 had bubble wrap in his mouth while he was playing with the pieces of a game. The bubble wrap was a new piece in a different size than the piece observed on 3/31/14. At 6:19 AM, Client #6 dropped the piece of bubble wrap on the floor, picked it up, and placed a section back in his mouth. At 6:26 AM, Client #6 continued to chew on the bubble wrap and would pop the bubbles while chewing. At 7:18 AM, prior to breakfast, Client #6 did not have his bubble wrap. Between 7:35 AM and 8:11 AM, breakfast was served. Client #6 was not trained and/or taught during the observation that bubble wrap was unsafe to have in his mouth.</p> <p>On 4/3/14 at 1:35 PM, record review indicated Client #6 had a BSP (Behavior</p>		<p>expected to implement regarding positive interactions with Client #6, and redirection to the use of the many sensory/relaxation activities as outlined in the Behavior Management Plan,</p> <p>Once identified, the training opportunities, techniques, the methods of safe oral sensory stimulation and the use of bubble wrap as a tactile stimulation will be incorporated into the current Behavior Management Program. Documented training will be completed with all staff that implements the Behavior Support Program with Client #6. Training will emphasize all components of the behavior management program including the proactive strategies, redirection strategies, and documentation strategies. Staff will implement the Behavior Management Program on a consistent basis and utilize only the identified safe oral sensory stimulation options.</p> <p>Person Responsible: QIDP</p> <p>In the future, announced and unannounced visits by management staff will include observations in effort to observe and promote staff to implement the Behavior Management Program and other active treatment programming in a consistent manner. On the spot and additional training will be provided</p>	

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	<p>Support Plan) dated 8/15/13 which indicated the target behaviors of physical aggression, self-injurious behavior, and property destruction. Client #6's BSP indicated Client #6's diagnoses included, but were not limited to, intellectual disabilities, attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), and Bipolar disorder. Client #6's BSP indicated "positive replacement behaviors" one of which was "II. Sensory/Relaxation Activities." The "Sensory/Relaxation" included the following:</p> <p>"1. Vestibular activities (balance, knowing where your body is in space) may help meet some of [Client #6]'s needs such as rocking, swinging, dancing...</p> <p>2. Proprioceptive activities (tension, pressure) such as handheld deep pressure massagers, joint compressions, using large muscle groups, weighted vest/blanket...</p> <p>3. Auditory needs can be addressed by but not limited to listening to his favorite music or game shows, videos, having a quiet area that he can go to if noise levels are too loud...</p> <p>4. Tactile (soft touch versus deep touch) items such as Koosh balls (sensory ball), water, clothing (certain types may feel uncomfortable to him), lotion, sand, shaving cream, bubble wrap and laminated pictures etc.</p> <p>5. Olfactory activities such as smelling soothing smells such as vanilla, cocoa...</p> <p>6. Taste spicy items, chips/marshmallows, sweet/sour, cold/hot, etc. [Client #6] has no teeth so you may need to ask his Mom for appropriate items.</p>		<p>to staff, as appropriate.</p> <p>Persons Responsible: QIDP; Director of Residential Services; Director of Quality Assurance.</p>	

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 04/03/2014
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W000331	<p>7. Visual stimulation such as looking at lights, fans, numbers...."</p> <p>On 4/3/14 at 1:16 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #6 had a BSP (Behavior Support Plan) which included use of the bubble wrap. The QIDP stated Client #6's BSP indicated Client #6 could use bubble wrap as a "proactive strategy" to calm him down. The QIDP stated Client #6's chewing bubble wrap was considered a "sensory relaxation technique." The QIDP indicated Client #6's BSP was written by a behavior specialist. The QIDP stated Client #6 was admitted to the group home from his home with the habit of chewing inappropriate objects such as bubble wrap and "other equally unsafe" items such as "office supplies." The QIDP indicated staff should be training and teaching appropriate methods of safe oral sensory stimulation.</p> <p>9-3-4(a) 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview, record review, the facility nursing services failed to specifically address/develop a risk plan for 1 of 4 sampled clients (Client #1)'s congestive heart failure (CHF) in regards to physician prescribed fluid restriction, use of oxygen, low sodium diet, weight gain, and the procedure for use of PRN (given as needed) diuretic (Lasix).</p>	W000331	<p>The facility will provide each client with nursing services in accordance to each individual's needs.</p> <p>A risk plan will be developed for Client #1's congestive heart failure. This plan will identify signs/symptoms of Congestive Heart Failure (such as: sudden weight gain from fluid retention, cough, shortness of breath, and chest</p>	05/03/2014

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	<p>Based on observation, interview, and record review, the facility nursing staff failed to continue to monitor and assess a client's skin injury and irritation on his scalp after he was admitted to the group home for 1 of 4 sampled clients (Client #2).</p> <p>Findings include:</p> <p>1) On 3/31/14 between 4:35 PM and 5:57 PM, group home observations were conducted. At 4:35 PM, Client #1 was wearing a nasal cannula (tubing to deliver oxygen to a person through a tubing which splits off into two nostril prongs) attached to a portable (roller) oxygen machine. Between 5:13 PM to 5:54 PM, a dinner consisting of a tuna dish, potatoes au gratin (with cheese sauce), a vegetable, 2% milk, water, and fruit was served. All clients received the same items for dinner without variation. Client #1 was assisted with pouring fluids into his glass without measuring. Client #1 wore his continuous oxygen throughout the observation.</p> <p>On 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Between 7:35 AM and 8:11 AM, breakfast was served. At 7:41 AM, Client #1 asked DSP (Direct Support Professional) #5 to assist him with pouring orange juice. DSP #5 poured Client #1's regular sized drinking cup full of orange juice without measuring. Client #1 wore his continuous oxygen tubing throughout the observation.</p> <p>On 4/1/14 at 1:20 PM, record review indicated Client #1's diagnoses included, but were not limited to, intellectual disabilities, Down's syndrome, systolic murmur, and CHF (congestive heart failure). Client #1's MAR</p>		<p>pains) and how staff should respond if any of these signs/symptoms are present or exhibited by Client #1. This plan will specifically outline the procedures staff will follow regarding prescribed fluid restrictions, the use of the oxygen, the low sodium diet, weight gain, and the use of the PRN prescription of Lasix. The plan will include details of how staff should implement plan and when and how to involve the nurse regarding the use of Lasix and weight gain. The plan will outline what documentation will need to be completed in effort to confirm risk plan steps are being implemented as well as to assess the effectiveness of plan. Documented training will be provided to staff to implement the plan. The plan will be implemented in all program areas.</p> <p>For client #2, a doctor's appointment was scheduled and completed on 4/3/2014 and Client #2 was diagnosed with seborrhea dermatitis and prescribed Selsun Blue shampoo. Staff will use this prescription shampoo as ordered by the doctor. The residential nurse will continue to complete quarterly nursing assessments, more often as needed, that involve full body checks and will include head and scalp checks. Staff will receive additional training that identifies when and how they will notify the residential nurse regarding client</p>	

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	<p>(medication administration record) dated 3/01/14 indicated Client #1 had a physician order for Furosemide (generic for Lasix, diuretic) 20 MG (milligram) PRN (given as needed) dated 3/23/11 to be given "1 tablet orally as directed as needed for lung congestion." Client #1's MAR (medication administration record) indicated a physician order for Guaifenesin (generic for Robitussin) 100 mg/5 ml (milligram per milliliters) dated 6/03/11 to be given "10 ml (milliliters) orally 3 times a day as needed" for chest congestion. Client #1's MAR dated 3/01/14 indicated Client #1 received one dose of Guaifenesin on 3/11/14.</p> <p>Record review indicated Client #1 had an annual physical dated 9/6/13. Client #1's annual physical indicated a prescribed dietary order for "1500 ml (milliliters) fluid restriction" due to CHF (congestive heart failure). Review of Client #1's MAR (medication administration record) indicated no indication Client #1 had a prescribed fluid restriction. Client #1's ISP (Individual Support Plan) dated 3/13/14 indicated no method of tracking fluid intake per day (residential and day program) for Client #1.</p> <p>Client #1's annual physical assessment (dated 9/6/13) indicated Client #1's physician ordered "Continue 3 Liter Nasal Cannula (tubing to deliver oxygen to a person through a tubing which splits off into two nostril prongs) O2 (oxygen)."</p> <p>Client #1's ISP (Individual Support Plan) dated 3/13/14 indicated "a few years ago [Client #1] was diagnosed with CHF and hospice was brought in to treat [Client #1] however he was doing so well that hospice discontinued their services and [Client #1]'s</p>		<p>skin injury/scalp irritation conditions.</p> <p>In effort to manage the care and treatment of seborrhea dermatitis, the residential nurse will develop a risk plan that identifies Client #2's scalp condition, how to treat it, when it is not responding to treatment/showing signs of deterioration, when she should be contacted, and when the doctor should be contacted. Staff will receive documented training on the risk plan</p> <p>Person Responsible: Residential Nurse</p> <p>The residential nurse will receive documented training that reviews and clarifies the completion of full body/skin integrity assessments on a quarterly basis, more often as needed, and risk plan development for individuals that experience medical/health deterioration and in effort to prevent/reduce chronic injury, illness, or decline in health status.</p> <p>Person Responsible: Director of Residential Services.</p> <p>In the future, the residential nurse will complete full body assessments, including the scalp and head area upon admission for new clients, noting any issues and then coordinating the needed medical</p>	

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	<p>PCP (primary care physician), the group home staff, and nurse has (sic) been able to assist him in managing his CHF." Client #1's ISP indicated he "has participated in bowling, the Best Buddies Program (volunteer friendship program), Special Olympics basketball and track in the past but due to his CHF he is unable to participate in most sports." Client #1's ISP indicated on 4/26/11, he was admitted "to the hospital from the doctors office due to low oxygen." Client #1's ISP indicated 911 (emergency line) was called "due to shortness of breath and red/blue face diagnosed with acute or chronic CHF. During this same year Hospice was called in and then discontinued as [Client #1] was doing so well." The ISP indicated Client #1's "CHF continues to be managed by his PCP (primary care physician), the group home nurse, and the group home staff."</p> <p>Client #1's ISP (Individual Support Plan) dated 3/13/14 indicated Client #1 had a goal "to maintain his weight due to CHF." The goal indicated "[Client #1] will independently weigh himself every morning." The goal sheet dated 3/13/14 indicated "[Client #1] will be weighed daily as recommended by his physician." The methodology indicated the following:</p> <ol style="list-style-type: none"> "1. Get out scale 2. Weigh himself 3. Allow staff to get his weight (staff will document and handle according to doctors instructions located on the MARs) (medication administration records). 4. Put away scale." <p>Review of Client #1's MAR dated 3/1/14 indicated only "WEIGHT ON THE 15TH OF EACH MONTH."</p>		<p>follow up to address the issues. The residential nurse will continue to complete quarterly nursing assessments, more often as needed, that include full body and skin integrity checks.</p> <p>Issues/abnormalities will be identified and will be addressed in a timely manner. Additionally, as client health changes and medical decline occurs the interdisciplinary team, including the residential nurse will develop and implement risk plans, as appropriate. Documented training will be provided to staff to implement the risk plans in an effective manner.</p> <p>Person Responsible: Residential Nurse</p>		

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	<p>On 4/2/14 at 3:03 PM during an interview, the facility Nurse indicated Client #1 only receives his PRN (given as needed) Lasix (diuretic) with nurse approval. The Nurse stated Lasix (generic name Furosemide) was given for "chest congestion". The Nurse stated "yes" Client #1 was also prescribed PRN medications for "cough" and congestion. The Nurse had no further documentation available for review to indicate when staff were to call the nurse to get approval for the PRN Lasix versus giving the PRN Guaifenesin (generic for Robitussin). The Nurse indicated Client #1 was weighed daily for potential sudden weight gain (potential sign and symptom of weight gain due to heart failure) and indicated the HM (housemanager) knew when to call the nurse regarding sudden weight gain. When asked whether all staff knew when to call the nurse regarding sudden weight gain, the Nurse stated she "would assume they know or have a paper at the office." When asked whether staff monitor and measure Client #1's total daily fluid intake to ensure the physician's order of fluid restriction of 1500 cc (fluid ounces), Nurse stated "they've been dealing with this so long, for 5 or 6 years, the [HM] just said they always give him the same amount (of fluid daily)." When asked whether they measure Client #1's fluid intake, the Nurse stated "they always give the same amount." The Nurse indicated she located a fluid intake documentation form for Client #1 from 5/2013 but indicated not all shifts were filled in. The Nurse stated "some days, one meal is documented, some days all three meals, and some days none." No documentation was available for review which indicated documentation of Client #1's fluid intake at day program was being</p>			
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	<p>monitored and measured. The Nurse indicated Client #1 did not have a CHF (congestive heart failure) care plan. The Nurse indicated all the staff had been trained in years past but no current training documents were available for review for sign/symptoms of CHF (sudden weight gain from fluid retention, cough, shortness of breath, chest pains, etc.), diet order (low sodium, 1500cc fluid restriction), or on Client #1's continuous use of oxygen.</p> <p>On 4/3/14 at 11:43 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #1's CHF (congestive heart failure) plans and trainings occurred in 2010. The QIDP indicated the group home had a new HM (housemanager) since the 2010 trainings. The QIDP stated "in hindsight, it should have been reviewed annually." The QIDP stated "it makes sense to have all (the CHF information) in one care plan" for staff.</p> <p>2) On 3/31/14 between 4:35 PM and 5:57 PM, group home observations were conducted. At 4:35 PM, Client #2 was in his hospital bed in his bedroom. At 5:22 PM, Client #2 was seated in his wheelchair in the living room. Client #2 had a large oval shaped area (approximately 4" (inches) long by 2 1/4" wide) on the right posterior (opposite of front) area of the scalp which appeared with spots of red and pink areas with white yellowish dried residue.</p> <p>On 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Client #2's scalp appeared unchanged in appearance from the previous night's observation. During an interview at 7:11 AM, the housemanager (HM) stated Client #2 was admitted to the group home (11/2013) with</p>			

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W000342	<p>"scalp issues." The HM indicated Client #2 had gotten injured at his former group home and his head required staples. The HM stated Client #2 had special "ointment" and "shampoo" to treat Client #2's scalp area.</p> <p>On 4/3/14 at 4:05 PM, record review indicated Client #2 had a physical on 9/24/13 with diagnosis of "Recent Concussion - Post Concussion Synd (syndrome)." The exam indicated Client #2 had "abrasions/contusions R (right) post. (posterior)" of the head. Client #2's ISP (dated 12/3/13) indicated Client #2 moved into the group home on 11/6/13.</p> <p>On 4/2/14 at 3:03 PM during an interview, the facility Nurse stated she didn't "think he has anything" to treat the area on his scalp. The Nurse stated the staff "didn't even call me, I was unaware that he had that." The Nurse reviewed Client #2's current physician's orders and stated he had "no topical, no med (medication)" prescribed for the area on his scalp.</p> <p>9-3-6(a) 483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility's nursing services failed to ensure staff were trained in</p>	W000342	The facility's nursing services will conduct documented training to direct care staff regarding the detection of signs/symptoms involving the diagnosis of illness,	05/03/2014

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	<p>regard to signs and symptoms of CHF (congestive heart failure), how to monitor a physician ordered fluid intake restriction and low sodium diet, when to alert nursing services regarding sudden weight gain due to fluid retention, use of a PRN (as needed) diuretic (Lasix), and use of continue oxygen.</p> <p>Findings include:</p> <p>On 3/31/14 between 4:35 PM and 5:57 PM, group home observations were conducted. At 4:35 PM, Client #1 was wearing a nasal cannula (tubing to deliver oxygen to a person through a tubing which splits off into two nostril prongs) attached to a portable (roller) oxygen machine. Between 5:13 PM to 5:54 PM, a dinner consisting of a tuna dish, potatoes au gratin (with cheese sauce), a vegetable, 2% milk, water, and fruit was served. All clients received the same items for dinner without variation. Client #1 was assisted with pouring fluids into his glass without measuring. Client #1 wore his continuous oxygen throughout the observation.</p> <p>On 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Between 7:35 AM and 8:11 AM, breakfast was served. At 7:41 AM, Client #1 asked DSP (Direct Support Professional) #5 to assist him with pouring orange juice. DSP #5 poured Client #1's regular sized drinking cup full of orange juice without measuring. Client #1 wore his continuous oxygen tubing throughout the observation.</p> <p>On 4/1/14 at 1:20 PM, record review indicated Client #1's diagnoses included, but were not limited to, intellectual disabilities, Down's syndrome, systolic murmur, and CHF</p>		<p>disease, and care to meet the health needs of the clients. The residential nurse will provide initial training and ongoing training to staff regarding the signs and symptoms of congestive heart failure. Training will include, as referenced in W331, but is not limited to; sudden weight gain from fluid retention, chest pains, shortness of breath, cough, use of Lasix, etc. Additionally, training will include the risk plan that has been developed that addresses the monitoring of the physician ordered fluid intake restriction, low sodium diet, alerting nursing services if sudden weight gain due to fluid retention, the use of the PRN diuretic and the continued use of oxygen. Staff will be trained to assist client #1 to measure the fluids when pouring at meal times, consistently document daily fluid intake, record daily weight, follow the low sodium diet order, continuous oxygen use, and conditions in which the residential nurse/physician should be notified. This training will be documented and include staff in all program areas and will be provided on an annual basis, more often as needed. Person Responsible: Residential Nurse The residential nurse will receive documented training that reviews and clarifies the completion of documented training to staff including but not limited to, the detection of</p>				

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	<p>(congestive heart failure). Client #1's MAR (medication administration record) dated 3/01/14 indicated Client #1 had a physician order for Furosemide (generic for Lasix, diuretic) 20 MG (milligram) PRN (given as needed) dated 3/23/11 to be given "1 tablet orally as directed as needed for lung congestion." Client #1's MAR (medication administration record) indicated a physician order for Guaifenesin (generic for Robitussin) 100 mg/5 ml (milligram per milliliters) dated 6/03/11 to be given "10 ml (milliliters) orally 3 times a day as needed" for chest congestion. Client #1's MAR dated 3/01/14 indicated Client #1 received one dose of Guaifenesin on 3/11/14.</p> <p>Record review indicated Client #1 had an annual physical dated 9/6/13. Client #1's annual physical indicated a prescribed dietary order for "1500 ml (milliliters) fluid restriction" due to CHF (congestive heart failure). Review of Client #1's MAR (medication administration record) indicated no indication Client #1 had a prescribed fluid restriction. Client #1's ISP (Individual Support Plan) dated 3/13/14 indicated no method of tracking fluid intake per day (residential and day program) for Client #1.</p> <p>Client #1's annual physical assessment (dated 9/6/13) indicated Client #1's physician ordered "Continue 3 Liter Nasal Cannula (tubing to deliver oxygen to a person through a tubing which splits off into two nostril prongs) O2 (oxygen)."</p> <p>Client #1's ISP (Individual Support Plan) dated 3/13/14 indicated "a few years ago [Client #1] was diagnosed with CHF and hospice was brought in to treat [Client #1] however he was doing so well that hospice</p>		<p>signs/symptoms involving the diagnosis of illness, disease, and care to meet the health needs of the clients. Person Responsible: Director of Residential Services In the future, the interdisciplinary team and the residential nurse will identify the health needs and the changing health needs of the clients and provide training when medical health deteriorates or additional orders for care is added to a client's health/diagnosis. Documented training will be provided to all staff at the time of the changes and subsequent orders and at least annually, more often, as needed. Persons Responsible: Residential Nurse</p>	

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	<p>discontinued their services and [Client #1]'s PCP (primary care physician), the group home staff, and nurse has (sic) been able to assist him in managing his CHF." Client #1's ISP indicated he "has participated in bowling, the Best Buddies Program (volunteer friendship program), Special Olympics basketball and track in the past but due to his CHF he is unable to participate in most sports." Client #1's ISP indicated on 4/26/11, he was admitted "to the hospital from the doctors office due to low oxygen." Client #1's ISP indicated 911 (emergency line) was called "due to shortness of breath and red/blue face diagnosed with acute or chronic CHF. During this same year Hospice was called in an then discontinued as [Client #1] was doing so well." The ISP indicated Client #1's "CHF continues to be managed by his PCP (primary care physician), the group home nurse, and the group home staff."</p> <p>Client #1's ISP (Individual Support Plan) dated 3/13/14 indicated Client #1 had a goal "to maintain his weight due to CHF." The goal indicated "[Client #1] will independently weigh himself every morning." The goal sheet dated 3/13/14 indicated "[Client #1] will be weighed daily as recommended by his physician." The methodology indicated the following:</p> <ol style="list-style-type: none"> "1. Get out scale 2. Weigh himself 3. Allow staff to get his weight (staff will document and handle according to doctors instructions located on the MARs) (medication administration records). 4. Put away scale." <p>Review of Client #1's MAR dated 3/1/14 indicated only "WEIGHT ON THE 15TH OF</p>			

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 04/03/2014
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616
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	<p>EACH MONTH."</p> <p>On 4/2/14 at 3:03 PM during an interview, the facility Nurse indicated Client #1 only receives his PRN (given as needed) Lasix (diuretic) with nurse approval. The Nurse stated Lasix (generic name Furosemide) was given for "chest congestion". The Nurse stated "yes" Client #1 was also prescribed PRN medications for "cough" and congestion. The Nurse had no further documentation available for review to indicate when staff were to call the nurse to get approval for the PRN Lasix versus giving the PRN Guaifenesin (generic for Robitussin). The Nurse indicated Client #1 was weighed daily for potential sudden weight gain (potential sign and symptom of weight gain due to fluid retention) and indicated the HM (housemanager) knew when to call the nurse regarding sudden weight gain. When asked whether all staff knew when to call the nurse regarding sudden weight gain, the Nurse stated she "would assume they know or have a paper at the office." When asked whether staff monitor and measure Client #1's total daily fluid intake to ensure the physician's order of fluid restriction of 1500 cc (fluid ounces), the Nurse stated "they've been dealing with this so long, for 5 or 6 years, the [HM] just said they always give him the same amount (of fluid daily)." When asked whether they measure Client #1's fluid intake, the Nurse stated "they always give the same amount." The Nurse indicated she located a fluid intake documentation form for Client #1 from 5/2013 but indicated not all shifts were filled in. The Nurse stated "some days, one meal is documented, some days all three meals, and some days none." No documentation was available for review which indicated documentation of Client #1's</p>			

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W000382	<p>fluid intake at day program was being monitored and measured. The Nurse indicated Client #1 did not have a CHF (congestive heart failure) care plan. The Nurse indicated all the staff had been trained in years past but no current training documents were available for review for sign/symptoms of CHF (sudden weight gain from fluid retention, cough, shortness of breath, chest pains, etc), diet order (low sodium, 1500cc fluid restriction), or on Client #1's continuous use of oxygen.</p> <p>On 4/3/14 at 11:43 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #1's CHF (congestive heart failure) plans and trainings occurred in 2010. The QIDP indicated group home had a new HM (housemanager) since the 2010 trainings. The QIDP stated "in hindsight, it should have been reviewed annually."</p> <p>9-3-6(a) 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview, the facility failed to ensure medications were kept locked when staff left the medication area for 1 additional client (#7).</p> <p>Findings include:</p> <p>On 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Between 6:35 AM and 7:10 AM, medication administration was observed. At 6:50 AM,</p>	W000382	The facility will keep all drugs locked unless being prepared for administration as prescribed by the physician. Staff will receive documented training regarding the proper preparation and procedure when passing medication that includes staying in the medication room when medication is unlocked. If staff have to leave the medication room for any reason, medication will be locked and the key removed from	05/03/2014

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 04/03/2014	
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616			
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W000440	<p>DSP (Direct Support Professional) #7 assisted Client #7 with medication administration. DSP #7 unlocked the medication closet and left the door slightly open with the key still in the lock. After DSP #7 had assisted Client #7 with the administration of his medications (in pill form), DSP #7 indicated he forgot to bring water into the room. DSP #7 indicated Client #7 had a fiber supplement which needed to be mixed with water. DSP #7 left the medication room for 20 seconds to get water while leaving the medication closet door open with the key still in the door. Client #7 remained in the medication room while DSP #7 left to get the water.</p> <p>On 4/2/14 at 3:03 PM, the facility Nurse was interviewed and stated DSP #7 should have "absolutely not" left the medication room with the medications unlocked. The facility Nurse indicated all staff were trained to never leave medications unlocked while unattended.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the</p>	W000440	<p>the lock and carried by staff or put in a safe place. As part of the training and in effort to ensure competency, the nurse, the QIDP and the House Manager/Program Coordinator will each complete an observation of a medication pass, document the results and follow up and address any concerns and/or issues that did not follow the appropriate medication pass procedures.</p> <p>Persons Responsible: Residential Nurse; QIDP; House Manager/Program Coordinator</p> <p>In the future, announced and unannounced visits to the home will be made by management staff, including the residential nurse, during medication pass times. Observation by management staff and the residential nurse of the medication passes will identify if medication pass protocol is being followed and will be addressed and corrected, as appropriate.</p> <p>Persons Responsible: QIDP; Nurse; Director of Residential Services, Director of Quality Assurance</p> <p>The facility will conduct evacuation drills on a quarterly basis for each shift of personnel. The</p>	05/03/2014			

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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616		
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W000441	<p>facility failed to ensure its third shift evacuation drills were conducted on a quarterly basis for 4 of 4 sampled clients and 4 additional clients (Clients #1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>On 4/1/14 at 1:24 PM, the group home evacuation drills were reviewed from 4/1/13 to 4/1/14 for clients #1, #2, #3, #4, #5, #6, #7, and #8. Record review indicated the following overnight shift (10:00 PM to 6:00 AM) evacuation drills:</p> <p>4/24/13 at 10:58 PM 5/2/13 at 5:00 AM 5/28/13 at 5:00 AM 8/13/13 at 11:00 PM 9/29/13 at 5:20 AM 11/30/13 at 12:00 AM</p> <p>On 4/1/14 at 3:35 PM during an interview, the Administrator indicated the group home had a new housemanager (HM) which might have accounted for the missing overnight shift evacuation drills in the last quarter. The Administrator indicated she understood the importance of evacuation drills occurring every shift for every quarter.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p>		<p>Administrative Assistant will meet with the House Manager/Program Coordinator of the home and review the quarterly schedule for drills for all shifts and the assignment procedure for conducting drills on all shifts for each quarter. Attention will focus on the third shift evacuation drills being completed on a quarterly basis for all clients. This training will be formally documented. A third shift evacuation drill will be completed.</p> <p>In the future, in addition to tracking the evacuation drills that are completed, the Administrative Assistant will speak directly to the House Manager/Program Coordinator prior to the end of the quarter and remind her/him that a 3rd shift evacuation drill must be completed during and prior to the end of the quarter, if one has not been completed for the quarter. Additionally, if an evacuation drill has not been completed for the 1st shift or 2nd shift, the Administrative Assistant will also speak directly and remind the House Manager/Program Coordinator that evacuation drills must be completed on these shifts, too, prior to the end of the quarter.</p> <p>Person Responsible: House Manager/Program Coordinator</p>		

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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616			
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	<p>The facility must hold evacuation drills under varied conditions.</p> <p>Based on record review and interview, the facility failed to hold evacuation drills during varied times during the overnight shift for 4 of 4 sampled clients and 4 additional clients (#1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>On 4/1/14 at 1:24 PM, the group home evacuation drills were reviewed from 4/1/13 to 4/1/14 for clients #1, #2, #3, #4, #5, #6, #7, and #8. Record review indicated the following overnight shift (10:00 PM to 6:00 AM) evacuation drills:</p> <p>4/24/13 at 10:58 PM 5/2/13 at 5:00 AM 5/28/13 at 5:00 AM 8/13/13 at 11:00 PM 9/29/13 at 5:20 AM 11/30/13 at 12:00 AM</p> <p>On 4/1/14 at 3:35 PM during an interview, the Administrator indicated the facility had identified the need to have overnight shift evacuation drills vary more during the hours of 12:00 AM and 4:00 AM. The Administrator indicated the group home had a new housemanager (HM). The Administrator indicated she understood the importance of evacuation drills occurring at various times of all shifts.</p> <p>9-3-7(a)</p>	W000441	<p>The facility will hold evacuation drills under varied conditions. The Administrative Assistant will meet with the House Manager/Program Coordinator of the home and review the schedule and the assignment procedure for conducting evacuation drills under varied conditions paying particular attention to scheduling the drills and conducting the drills during the hours of 12-4 AM. This training will be formally documented. An evacuation drill will be conducted during the hours of 12-4 AM</p> <p>In the future, in addition to tracking the evacuation drills that are completed, the Administrative Assistant will speak directly to the House Manager/Program Coordinator prior to the end of the quarter and remind her/him that an evacuation drill must be completed during the hours of 12-4 AM prior to the end of the quarter, if one has not been completed during the quarter. Additionally, if evacuation drills are not being conducted under varied conditions and there appears to be a pattern of running evacuation drills at similar times under similar conditions, the Administrative Assistant will directly remind the House Manager/Program Coordinator that the evacuation drill times must be</p>	05/03/2014			

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 04/03/2014
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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed for 8 of 8 clients observed during meal time (clients #1, #2, #3, #4, #5, #6, #7, #8) to encourage clients to function with as much independence as possible in regards to meal clean up.</p> <p>Findings include:</p> <p>On 3/31/14 between 4:35 PM and 5:57 PM, group home observations were conducted. At 5:13 PM, dinner was served. Between 5:13 PM to 5:54 PM, clients #1, #3, #4, #5, #6, #7, #8 were observed to eat their meal with the use of regular silverware and dishes (no adaptive equipment was provided). Clients #1, #3, #4, #5, #6, #7, and #8 were observed to eat their dinner independently after they were assisted as necessary with scooping dinner items onto their plates. At 5:15 PM, DSP (Direct Support Professional) #1 indicated he was providing full assistance to Client #2 because he was unable to grasp his silverware due to contractions in his hands. At 5:27 PM, Client #1 independently got up from the dining room table and walked into the living room. Client #4 did not assist in cleaning up his dinner area or in taking his</p>	W000488	<p>varied and scheduled in a random pattern format.</p> <p>Persons Responsible: House Manager/Program Coordinator</p> <p>The facility will assure that each client eats in a manner consistent with his developmental level. This will include encouraging and training clients to function with as much independence as possible with regards to after meal hygiene and meal clean up.</p> <p>The QIDP will review each individual's assessments, recommendations and program plan to determine if and what adaptive equipment may be beneficial or should be utilized at meal time. The adaptive equipment will be obtained, as appropriate. Staff will receive documented training to consistently use and train client's to use the adaptive equipment, as appropriate.</p> <p>Additionally, staff will receive documented training to assist clients with hygiene care after meals and clean up after each meal. Training will focus on how to identify and assist each client to their greatest</p>	05/03/2014

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	<p>dishes to the kitchen. At 5:27 PM, DSP #2 assisted Client #4 with getting up from the table and walking into the living room by assisting him with his oxygen tank and tubing. DSP #2 wiped Client #1's mouth using a napkin with full assist. DSP #3 wiped Client #1's spot without the assistance of Client #1. DSP #1 assisted Client #8 to a standing position from his chair at the dining room table. Client #8 participated in no clean up of his place setting. DSP #4 took Client #7's fruit bowl to the kitchen without his assistance. DSP #2 took Client #8's fruit bowl to the kitchen without his assistance. The housemanager (HM) assisted Client #7 to the restroom and he did not assist in meal clean up. DSP #2 took Client #3's bowl and silverware to the kitchen without his assistance. At 5:32 PM, DSP #2 took two more bowls and silverware off the table with no client assistance. At 5:33 PM, DSP #3 was sweeping the floor. DSP #4 was rinsing the dishes in the kitchen by herself. At 5:40 PM, clients #1, #3, #4, and #8 were sitting in the living room as Client #5 was still eating his dinner and HM was sweeping the dining area with a broom. At 5:41 PM, DSP #2 was mopping an area in the kitchen with no clients present. At 5:42 PM, staff took Client #5's dishes to the kitchen without his assistance. At 5:46 PM, DSP #2 assisted Client #3 with wiping the entire dining table. At 5:48 PM, DSP #2 assisted Client #5 with vacuuming the dining room rug.</p> <p>On 4/1/14 between 6:12 AM to 8:31 AM, group home observations were conducted. Between 7:35 AM and 8:11 AM, breakfast was served. At 7:43 AM, Client #7 was finished eating breakfast and DSP (Direct Support Professional) #5 picked up his plate and silverware and took them to the kitchen</p>		<p>capability of independence involving meal time activities.</p> <p>Person Responsible: QIDP</p> <p>In the future, announced and unannounced visits at meal times by management staff will include observations to promote staff to encourage and assist clients with independence during mealtime activities in a consistent manner. On the spot and additional training will be provided to staff, as appropriate.</p> <p>Persons Responsible: QIDP; House Manager/Program Coordinator; Director of Residential Services; Director of Quality Assurance.</p>	

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	<p>without his assistance. Client #7 got up from the dining room table and did not assist in cleaning up his dining area. The HM (housemanager) swept the area rug beneath the seat Client #7 had sat in without client assistance. Client #6 finished his breakfast and left the table without prompts to clean up his place setting. Client #4 finished his breakfast and was assisted by DSP #5 in moving his oxygen tank and tubing as he walked to the living room. Client #4 was not prompted to assist in breakfast clean up. Clients #1 and #8 left the dining area without assisting with clean up. At 8:02 AM, DSP #2 was in the kitchen doing dishes without clients present. At 8:11 AM when breakfast observations ended, clients #2, #3, and #5 were still eating.</p> <p>On 4/2/14 at 3:51 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated clients (#1, #2, #3, #4, #5, #6, #7, and #8) should be participating in meal clean-up. The QIDP indicated staff were taught clients should participate in all activities. The QIDP stated "yes, the clients should be helping" with meal clean up.</p> <p>9-3-8(a)</p>			