

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G284	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2014
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3031 BENTLEY LN SOUTH BEND, IN 46616
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K020000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 03/03/14</p> <p>Facility Number: 000804 Provider Number: 15G284 AIM Number: 100235020</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Logan Community Resources Inc. was not found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was not sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 7 and had a census of 7 at the time of this</p>	K020000		
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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>survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.28.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/04/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K02S120	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape.</p> <p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of</p>			
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	<p>escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation and interview, the facility failed to maintain a second means of escape in 1 of 4 resident sleeping rooms that was remotely located from the primary exit. This finding could affect clients sleeping in the northwest bedroom.</p> <p>Findings include:</p> <p>During observation in the home on 03/03/14 between 11:15 am and 11:45 am with the maintenance technician, windows in the northwest bedroom could not be opened upon request. The windows were opposite the bedroom door which was the primary escape route into the bedroom corridor. Based on interview with the maintenance technician during the observation, it could not determine how often the windows are checked to ensure they can be opened.</p>	K02S120	The window was repaired on 3/4/2014 and now is fully operational. Maintenance staff use a monthly inspection list when completing walk through inspections of the group homes. Egress checks will be added to the list in effort to prevent any future unusable egress window routes. If the egress window route is found to not be fully operational it will be repaired immediately/in a timely manner. Other LOGAN management personnel also complete monthly and quarterly walk thru inspections and will include egress checks to make sure they are fully operational. Problems will be addressed immediately/in a timely manner. Persons Responsible: Maintenance Staff, Director of Quality Assurance, QIDP/Program Manager, Program Coordinator	04/02/2014			

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K02S147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 7 of 7 clients which is amended, or revised, whenever any resident with unusual needs is admitted to the home. Such instruction is reviewed by the staff at least every two months. This deficient practice could</p>	K02S147	<p>The home has a drill schedule in place that assigns staff, dates, shifts, and times staff are to complete drills. This is an effective form when it is utilized. Unfortunately it was not properly utilized for the 2nd quarter for overnight drills which resulted in a lapse of overnight drills for 5 months. Overnight drills were completed, in the 3rd and 4th quarter as well as the first quarter of 2014. In the future, the Program Coordinator with the assistance of the Administrative Assistant, will review the drills that have been completed on a</p>	04/02/2014
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	affect all clients. Findings include: Based on review of Fire Drill records with the Group Living Administrative Assistant on 03/03/14 at 10:40 am, lapses in staff fire safety training times were more than the two months allowed as evidenced by the lack of any record of fire drills for the overnight shift during the second quarter of 2013. The records reflect a lapse in training for the overnight shift between March 2013 and August 2013. The Administrative Assistant indicated there was no other fire drill documentation or other fire safety staff training documentation available during this time frame.		monthly basis and prior to the quarter ending and will identify any missed drill times/shifts. Staff will be assigned to complete the drill(s) at minimum every two months and prior to the end of the quarter. Persons Responsible: Program Coordinator and Administrative Assistant				
K02S149	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2 Based on record review, observation and interview; the facility failed to provide noncombustible safety type ashtrays in the designated smoking area. This	K02S149	A noncombustible terracotta outdoor ashtray was ordered and has been placed in the designated smoking area. The other containers have been	04/02/2014			

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	<p>finding could affect all residents, staff and visitors to the home.</p> <p>The findings include:</p> <p>During review on 03/03/14 at 10:25 am of the facility's "Smoke Free Environment Policy dated 1/2/1993, the policy indicated each home had a designated area where individuals could choose to smoke. Interview on 03/03/14 during a tour of the home from 11:15 am until 11:45 am with the maintenance technician indicated the smoking area was on the front porch near the front door. Based on observation of the smoking area, there were two plastic coffee containers with plastic lids and a large tin can with no lid sitting on the porch in the smoking area. In the tin can with no lid were discarded smoking materials. Based on interview with the maintenance technician at the time of observation, there was no other safety type receptacle at the home.</p>		<p>removed. In the future, a noncombustible ashtray will be in place in the designated smoking area. Persons Responsible: Maintenance Staff and Program Coordinator</p>		

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K02S152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire and evacuation drills were provided for each shift for 1 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include: Based on a review of Fire Drill records on 03/03/14 at 10:20 am with the Group</p>	K02S152	The home has a drill schedule in place that assigns staff, dates, shifts, and times staff are to complete drills. This is an effective form when it is utilized. Unfortunately it was not properly utilized for the 2nd quarter for overnight drills. Overnight drills where completed, in the 3rd and 4th quarter as well as the first quarter of 2014. In the future, the Program Coordinator with the	04/02/2014	

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	Living Administrative Assistant, documentation of fire drills was not found for the overnight shift during the second quarter (April through June) of 2013. Interview with the Group Living Administrative Assistant at 10:40 am on 03/03/14 indicated fire drill records for that shift during that quarter could not be located.		assistance of the Administrative Assistant, will review the drills that have been completed prior to the quarter ending and will identify any missed drill times/shifts and then assign staff to complete the drill(s) prior to the end of the quarter. Persons Responsible: Program Coordinator and Administrative Assistant	