

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G448	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 BRENTWOOD COURT SOUTH BEND, IN46628
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K0000	<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: 10/07/11</p> <p>Facility Number: 000962 Provider Number: 15G448 AIM Number: 100249360</p> <p>Surveyor: Robert Booher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Logan Community Resources Inc. was found not 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 two story facility with a basement was not sprinklered. The facility has a monitored fire alarm system with smoke detection on all levels including the sleeping rooms, corridors and common living areas. The facility has a capacity of 7 and had a census of 7 at the time of this survey.</p>	K0000		
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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>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 0.68.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/11/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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KS017	<p>The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety,</p>			

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	<p>sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 clients slept in a room provided with a door which would close and latch securely in the door frame. This deficient practice could affect one client housed in the living room on the first floor.</p> <p>Findings include:</p> <p>Based on observation at 2:20 p.m. on 10/07/11 with the Director of Group Living, a single bed was set up in a corner of the living room. The living room did not have a door to separate it from the kitchen dining area. Based on interview at the time of observation, the Director of Group Living was aware of the situation and had been trying to get permission to move the client to another house where climbing and descending stairs would not be required since the client was no longer able to do this.</p>	KS017	<p>Every effort is being made to move the client to another home. The Division of Disabilities and Rehabilitative Services requires that the following steps/tasks be completed prior to approving the move for this client to another home:</p> <p><u>1.A completed and signed 450B form from the doctor-completed and signed 10/3/2011. Received on 10/5/2011 and immediately faxed to designated service coordinator at the local BDDS office.</u></p> <p><u>2.A completed Developmental Disability Profile from the designated service coordinator form the local BDDS office-completed on 10/19/2011. On this date we explained the urgency in receiving approval for the move to another home for this client to the local BDDS service coordinator.</u></p> <p><u>3.Level of Care approval from a BDDS Level of Care Consultant-we are awaiting this and have submitted a formal written request and contacted BDDS Central Office staff requesting a rush on this</u></p>	11/07/2011	

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KS147	<p>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 failed to ensure the plan for protecting all persons in the event of a fire was reviewed at least every two months so staff could assist 7 of 7 clients during a</p>	KS147	<p>approval. Every effort is being made to receive approval for the client to transfer to an more appropriate home by November 6, 2011.</p> <p>In the future, we will continue to work with the local and central office BDDS coordinators to expedite and receive approvals for clients to transfer to other homes or facilities as their needs dictate.</p> <p>Persons responsible: QMRP Director of Group Living</p> <p>A successfully conducted fire drill will be completed on the 3 rd shift the week of 10/24/2011.</p> <p>In the future, fire drills will continue to be conducted on a</p>	11/06/2011	

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	<p>fire emergency. This deficient practice could affect all 7 clients living in the facility.</p> <p>Findings include:</p> <p>Based on review of the Logan Community Living New Drill Report forms at 1:23 p.m., a fire drill had not been conducted on the third shift (10:00 p.m. to 6:00 a.m.) since 06/29/11. When the Director of Group Living was asked about the missing fire drill at 1:53 p.m. on 10/07/11, she checked for other fire drill documentation and said according to their tracking chart, a third shift drill had not been conducted since 06/29/11. When asked about other fire safety training during the last two months since it had been over three months since a fire drill had been conducted, she said there were no other records of training available for review.</p>		<p>regularly scheduled monthly and quarterly basis for 1 st , 2 nd , 3 rd and weekend shifts and turned in for review in a timely manner. As the Group Living Administrative Assistant tracks these drill, if she sees that there are drills missing or are not turned in, she will contact and follow up with designated staff/Program Coordinator to ensure drills are completed and turned in; in a timely manner.</p> <p>Persons Responsible: Group Living Administrative Assistant Program Coordinator Director of Group Living</p>		

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KS152	<p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(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 -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(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 drills were conducted quarterly on each shift for one shift during 1 of 4 completed quarters. This deficient practice could affect all 7 of the clients living in this facility.</p> <p>Findings include:</p> <p>Based on review of the Logan Community Living New Drill Report forms at 1:23 p.m., a fire drill had not been conducted</p>	KS152	<p>A successfully conducted fire drill will be completed on the 3 rd shift the week of 10/24/2011.</p> <p>In the future, fire drills will continue to be conducted on a regularly scheduled monthly and quarterly basis for 1 st , 2 nd , 3 rd and weekend shifts and turned in for review in a timely manner. As the Group Living Administrative Assistant tracks theses drill, if she sees that there are drills missing or are not turned in, she will contact and</p>	11/06/2011	

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	on the third shift (10:00 p.m. to 6:00 a.m.) since 06/29/11. When the Director of Group Living was asked about the missing fire drill at 1:53 p.m. on 10/07/11, she checked for other fire drill documentation and said according to their tracking chart, a third shift drill had not been conducted since 06/29/11.		follow up with designated staff/Program Coordinator to ensure drills are completed and turned in; in a timely manner. Persons Responsible: Group Living Administrative Assistant Program Coordinator		