

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2804 CORPUS CHRISTI DR SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 19, 20, 21, 22, and 23, 2013.</p> <p>Facility number: 000770 Provider number: 15G248 AIM number: 100234910</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/3/13 by Ruth Shackelford, QIDP.</p>	W000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G248		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2804 CORPUS CHRISTI DR SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise operating direction over the facility to keep light fixtures and cold air vents in good condition for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, #6, #7, and #8 resided was observed on 8/22/13 from 3:22 P.M. until 5:45 P.M. The plastic covers of the ceiling light fixtures in the kitchen and dining room had dead insects on them. The cold air vent in the living room was dusty with cobwebs on it. A 6 inch by 8 inch section of carpeting on the corner of the living room stair steps was torn.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 8/23/13 at 10:47 A.M.. QIDP #1 indicated house staff needed to submit a work order for the above mentioned areas of the group home to be cleaned and repaired.</p> <p>9-3-1(a)</p>	W000104	<p>On September 5, 2013 the Director of Quality Assurance submitted a electronic "SYSAID" requesting Logan's Maintenance personnel to clean the dead insects out of the light fixtures and to clean the dust and cobwebs from the air vents (in specific the light fixtures in the living and dining room and the air vent in the living room). All staff has been advised to continue to monitor the cleanliness of the homes and to complete maintenance request when things are broken, dirty, and/or not in proper working condition. QMRP and Program Coordinator will make sure that such requests are getting completed (repaired/cleaned) as needed. In the future, all maintenance issues and items not functioning properly and/or in need of repair/cleaning will be reported to the maintenance department verbally and/or by the internal electronic SYSAID system. The Director of Maintenance will receive, evaluate, and address in a timely manner. In addition to notifying maintenance and utilizing SYSAID; during routine visits the Program Manager and Director of Quality Assurance will be observant and notify maintenance of anything that is in need of</p>	09/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2804 CORPUS CHRISTI DR SOUTH BEND, IN 46617
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>repair/cleaning verbally and/or by utilizing the SYSAID system. Program Coordinator and Program Manager will continue to monitor and ensure that light fixtures and cold air vents are in good condition (kept clean of insects, dust, and/or cobwebs). Persons Responsible: Director of Maintenance, Program Manager/QMRP, Program Coordinator, Director of Quality Assurance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2804 CORPUS CHRISTI DR SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to follow up on recommended volunteer work.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/23/13 at 9:07 A.M.. Review of a 6/7/13 "Weekly Therapy Report" indicated a recommendation for "volunteer work." Further review of client #1's record failed to indicate the recommendation for "volunteer work" had been addressed.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 8/23/13 at 10:47 A.M.. QIDP #1 stated a meeting was "being requested" to address client #1's recommendation for volunteer work.</p> <p>9-3-4(a)</p>	W000227	<p>Client #1 was previously volunteering with LOGAN's Community Habilitation program until she was assisted through ADEC, INC in finding community employment with Chuck E Cheese. Per her choice, Client #1 discontinued volunteering through LOGAN's Community Habilitation program when she began working at Chuck E Cheese. Previously, Client #1 had volunteered with her group home staff and housemates at the local Humane Society until they shut down for renovations. On September 9, 2013 Client #1 completed an application in hopes to volunteer at Pet Refuge. The Program Coordinator has also contacted the Humane Society and Reins of Life inquiring about possible volunteer opportunities for Client #1. All places are volunteer choices identified by Client #1. Client #1's employment consultant emailed Client #1's support team to inform everyone that Chuck E Cheese is still interested in Client #1 working but due to the cooler than normal summer, business was slow and unfortunately they had to cut Client #1's hours but according to Client's #1's employment</p>	09/22/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2804 CORPUS CHRISTI DR SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			consultant they may call her back in October. The recommendation by Client#1's therapist was redundant in that Client #1 has always volunteered in some capacity, per her choice. QMRP, Program Coordinator and Client #1 are actively looking for and applying for volunteer opportunities. QMRP will continue to review Client#1's therapist reports and all other reports to address and follow up on recommendation as agreed upon by Client #1 and Client #1's support team. Persons Responsible: Program Manager/QMRP, Program Coordinator		