STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 000	INITIAL COMMENTS This visit was for a Federal recertification survey and a Focused Infection Control Survey. Facility Number: 005199 Dates of Survey: 4/19-22/2021 Four County Counseling Center was found in compliance with the CMS Focused Infection Control Survey for Acute & Continuing Care.	A 000		
A 168	QA: 05/03/2021 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure the type or technique of restraint used was the least restrictive due to lack of documentation of the type of physical intervention/hold being specified on the physician order and/or in the medical record for 3 of 4 physical interventions reviewed. (Patients #1, 4 and 5) Findings include; 1. Review of facility policy titled "SPECIAL TREATMENT	A 168		5/21/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 168	Continued From page 1	A 168		

PROCEDURES/SECLUSION/RESTRAINT" reviewed/revised 4/20/20 indicated the following: "...II. A. When a client is disturbed and poses a danger to self and/or others, the least restrictive measures shall be tried first to prevent the client from harming himself [/herself]and/or others..."

2. Review of the Crisis Prevention Institute (CPI) "NONVIOLENT CRISIS INTERVENTION with ADVANCED PHYSICAL SKILLS INSTRUCTOR GUIDE" dated 6/2018 provided by A3 (Director of Facilities and Safety) indicated the following: "...Understanding the Risk of Physical Restraints...No physical intervention is free of risks. Physical restraint should only be used as a last resort, with the least amount of restriction when an individual or imminent threat to harm..." The guide indicated the following different types of physical interventions as part of CPI training for adults:
a. Lower-Level Holding in a Seated Position.
b. Medium-Level Holding in a Seated Position.
c. Higher-Level Holding in a Seated Position.
d. Additional Staff - Seated.
e. Lower-Level Holding in a Standing Position.
f. Medium-Level Holding in a Standing Position.
g. High-Level Holding in a Standing Position.
h. Additional Staff - Standing
i. Higher-Level Holding - Standing Position Team Control Position.
j. Floor Transition - Standing to Seated on Floor.
k. Emergency Floor Holding - Supine (Face Up)
l. Floor Transition - Standing to Kneeling.
m. Emergency Floor Holding - Supported Prone.

3. Patient #1 was placed in a physical intervention from 4:20 p.m. to 4:38 p.m. on 4/9/21. The patient had a physician order for a physical intervention, once with a start time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 168	Continued From page 2	A 168		

4:20 p.m. to 4:38 p.m., however failed to document the type of physical intervention that was ordered. The "...PHYSICAL INTERVENTION, RESTRAINT AND SECLUSION FORM" dated 4/9/21 for Patient #1 indicated the following: "...Client yelling, banging head on the wall, tore phone off the wall. Continued to self harm. Orders for hold...Staff held and attempted to deescalate client..." The patient's medical record lacked documentation of the type of physical intervention(s) used, where on the patient's body the patient was held and the number of staff assisting with the physical intervention(s), therefore unable to determine if the physical intervention used was the least restrictive for the patient's behavior.

4. Patient #1 was placed in a physical intervention from 9:04 a.m. to 11:05 a.m. on 4/18/21. The patient had a physician order for a physical intervention, once with a start time of 9:04 a.m. and end time of 11:05 a.m., however failed to document the type of physical intervention that was ordered. The "...PHYSICAL INTERVENTION, RESTRAINT AND SECLUSION FORM" dated 4/18/21 for Patient #1 indicated the following: "...Client was in room, [he/she] was suppose to be going to lay down and staff noticed client taking bandage off [his/her] leg trying to rip out [his/her] stitches. Client placed in a physical intervention...." The patient's medical record lacked documentation of the type of physical intervention(s) used, where on the patient's body the patient was held and the number of staff assisting with the physical intervention(s), therefore unable to determine if the physical intervention used was the least restrictive for the patient's behavior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 168	Continued From page 3 5. Patient #4 was placed in a physical intervention from 1:00 a.m. to 1:10 a.m. on 4/16/21. The patient had a physician order for a physical intervention, once with a start time of 1:00 a.m. and end time of 1:10 a.m., however failed to document the type of physical intervention that was ordered. A linear note dated 4/16/21 indicated the following: "...Client refused 9 PM [p.m.] medication order for Trazodone. RN [Registered Nurse] attempted to administer medication and explain to client rationale for taking medication. Client would not participate in medication education or conversation of any kind. Client looked past writer and refused to respond. Medication administration attempted three times, and [Client] refused each time. Client paced the unit non-stop from beginning of shift (7 PM) [p.m.], to 12:50 AM [a.m.]. Client was not able to express why [he/she] was screaming and was not able to follow suggestion that [he/she] lie down. [Client] experiencing psychosis and extreme agitation. Client was offered PRN Haldol and Ativan to help calm [him/her], but client refused to take medication and was unable to follow redirection. Client placed in physical intervention at 1:00 AM [a.m.] and was administered Haldol 10 mg IM to left deltoid and Ativan 2 mg IM to right deltoid at 1:10 AM [a.m.]. Client physically resisted injections during intervention but was not aggressive and was non-combative immediately following intervention. Client was released from intervention at 1:10 AM [a.m.]..." The patient's medical record lacked documentation of the type of physical intervention(s) used, where on the patient's body the patient was held and the number of staff assisting with the physical intervention(s), therefore unable to determine if the physical intervention used was the least restrictive for the patient's behavior.	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 168	Continued From page 4	A 168		

6. Patient #5 was placed in a physical intervention from 2:09 p.m. to 2:11 p.m. on 1/10/21. The patient had a physician order for a physical intervention, once with a start time of 2:09 p.m. and end time of 2:11 p.m., however failed to document the type of physical intervention that was ordered. The "...PHYSICAL INTERVENTION, RESTRAINT AND SECLUSION FORM" dated 1/10/21 for Patient #5 indicated the following: "...[Client] got in the shower with clothes on multiple times standing under very cold water to the point of shivering. [Client] would not change into dry clothes. Staff had to assist [him/her] and [Client] was resistive. [Client] responded to unseen stimuli. On call LIP [Licensed Independent Practitioner] order[ed] Thorazine 100 mg [milligrams] IM [intramuscular], [Client] became resistive [and] placed in physical intervention..." The patient's medical record lacked documentation of the type of physical intervention(s) used, where on the patient's body the patient was held and the number of staff assisting with the physical intervention(s), therefore unable to determine if the physical intervention used was the least restrictive for the patient's behavior.

7. During an interview with A3 on 4/22/21 at 1:41 p.m., he/she verified that the Crisis Prevention Institute (CPI) "NONVIOLENT CRISIS INTERVENTION with ADVANCED PHYSICAL SKILLS INSTRUCTOR GUIDE" dated 6/2018 was the current CPI instructor guide being used at the facility to instruct staff on CPI and that he/she was the current instructor.

8. During an interview with N1 (Director of Nursing) on 4/22/21 at 2:15 p.m., he/she verified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 168	Continued From page 5 the medical record information and the lack of documentation of the type of physical intervention/hold being specified on the physician order and/or in the medical record for Patients #1, 4 and 5. N1 also verified the lack of documentation of the number of staff who held the patient and where on the patient's body the patient was held during the physical intervention(s) for Patients #1, 4 and 5.	A 168		
A 629	THERAPEUTIC DIETS CFR(s): 482.28(b), (b)(1) §482.28(b) Menus must meet the needs of patients. (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital failed to ensure dietary menus met the needs of 11 of 32 patients reviewed. Findings included: 1. Review of policy/procedure titled: "Dietary/Nutrition Screening," policy number "11.2.025l," last revised on "4-20-20," indicated the following: a. The policy/procedure read: "All clients will be evaluated regarding their degree of nutritional risk." b. The "Acute Care Unit Nutrition Screening" form was used to evaluate nutritional risk. The form indicated a risk factor score was calculated based on criteria evaluated during the nutritional screen and the "at" or "not at" nutritional risk box	A 629		5/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 6	A 629		

must be checked by nursing on the "Acute Care Unit Nutrition Screening" form. The policy/procedure further indicated a risk factor score between 3 and 9 was considered moderate risk and the licensed independent practitioner (LIP) determined the need for a dietary consult.

c. The policy/procedure read: "The clinical dietitian is notified of the nutritional status and will assess the client within forty-eight (48) hours of screening..." and "within forty-eight (48) hours of identification of "at nutritional risk" and order from the LIP, the clinical dietician will complete a nutrition assessment and document in the client's record on page 2 of form ACU8919..."

d. The policy/procedure indicated "potential" nutritional risks included: "...refusing to eat (NPO) or only drink for more than 3 days...hypertension...abdominal pain...stomach ulcers...edentulous...diabetes-controlled or uncontrolled...dental problems causing chewing problems...special diet, including need for dietary supplement (i.e. Ensure)..."

d. A "food chart" was to be "maintained on all clients experiencing eating difficulties, after obtaining an order from the physician (example: anorexic, suppressed appetite)..."

e. Intake of meals and snacks was to be documented for patients "requiring observation of daily food intake."

f. The policy/procedure did not require documentation of food intake for all patients, nor did it define the terms or indicate what foods were included/avoided for the following diets" "diet-heart healthy," "diet-finger foods," "diet-soft," and "diet-controlled carb."

2. Review of "Acute Care Unit Nutrition Screening" form read: "Additional Nutrition at Risk Triggers (If any of the boxes are marked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 7	A 629		

below then a Nutrition Consult Needs Completed)...Decrease in food intake...edentulous...teeth and/or dentures causing difficulty eating...refusing to eat (NPO) or only drink for more than 3 days...special diet, including need for dietary supplement (i.e. Ensure)...diabetes controlled, BMI <18.5...hypertension...abdominal/stomach ulcers..."

3. Review of patient records indicated the following:

a. Patient #1 was admitted on 4-16-21 at 12:37 PM. The patient had both a "diet-heart healthy" and "diet-finger foods" ordered on 4-16-21 at 10:55 PM.; and heart healthy (3-2-21; 3-22-21; 3-28-21; and 4-9-21). The patient's "Acute Care Unit Nutrition Screening" form, completed on 4-15-21 did not indicate the patient was on a special diet. The form indicated the patient was "not at nutritional risk." There was no documentation a dietary consult was ordered or performed for the special diet. There was no documentation to indicate the patient received a heart health or finger food diet from 4-15-21 to date of survey, as ordered. There was no documentation of dietary intake or refusal to eat for dinner on 4-9-21; and breakfast, lunch, or dinner on 4-16-21.

b. Patient #3 was admitted on 4-15-21. The patient had a "diet-lactose free" ordered on 4-15-21 at 9:53 PM. The patient's "Physical Examination" form, completed on 4-16-21, indicated the patient had a lactose allergy. The "Acute Care Unit Nutrition Screening" form indicated the patient was "not at nutritional risk." There was no documentation to indicate the patient received a lactose free diet from 4-15-21 to date of survey, as ordered. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 8	A 629		

documentation a dietary consult was ordered or performed for the lactose free special diet.

c. Patient #5 was admitted on 12-24-20. The patient had a finger food diet ordered on 12-24-20. The "Acute Care Unit Nutrition Screening" form, completed on 12-24-20, read: "Unable to assess on 12-24-20 d/t psychosis." The form indicated the patient had a "decrease in food intake" and "refusing to eat (NPO) or only drink for more than 3 days." Psychiatric narrative notes indicated the patient refused to eat on 12-25-20 and 12-26-20. The note indicated the patient ate only applesauce on 12-27-20, when the patient's diet order was for finger foods. The note further indicated the patient refused to eat on 12-28-20. The note indicated she ate a banana to eat on 12-31-20. There was no documentation of food intake or refusal to eat on 12-30-20. A dietitian consult was ordered on 12-24-20. The dietary consult form was completed and was not signed by the person who completed the consult, nor did it indicate the date the consult was completed. It was unable to be determined if the dietary consult was performed within 48 hours of the order. The dietician consult form read: " Nutrition prescription: prostat once a day in cranberry juice..." and indicated the dietitian would follow up with the patient in two days on "Thursday." There was no additional practitioner orders for Pro-Stat, as recommended by the dietitian, nor was there documentation Pro-Stat was offered to the patient. There was no documentation the dietitian provided a follow up consultation with the patient.

d. Patient #24 was admitted on 2-13-21 at 3:25 PM and discharged on 2-16-21 at 11:45 AM. The patient had a regular diet ordered on 2-13-21, upon admission. The "Acute Care Unit Nutrition Screening" form, completed on 2-13-21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 9	A 629		

indicated the patient had an allergy to strawberries and had a "decrease in food intake." There was no documentation a dietary consult was ordered or performed for the decrease in food intake. There was no documentation of food intake or refusal to eat on 2-15-21.

e. Patient #25 was admitted on 3-30-21 at 5:00 PM and discharged on 4-1-21 at 10:49 AM. The patient had a "diet-heart healthy" ordered on 3-30-21 at 5:57 PM. The patient's "Acute Care Unit Nutrition Screening" form, completed on 3-30-21, indicated the patient was allergic to fish and shellfish, but did not indicate the patient had "additional nutrition at risk triggers," such as hypertension, and was "not at nutritional risk." A "Nursing Assessment" document, completed on 3-30-21 at 6:29 PM, indicated the patient's blood pressure was 154/102. There was no documentation a dietary consult was ordered or performed for the hypertension. There was no documentation to indicate the patient received a heart healthy diet from 3-30-21 to 4-1-21, as ordered. There was no documentation of food intake or refusal to eat on 3-31-21 and 4-1-21.

f. Patient #26 was admitted on 3-31-21 at 10:15 PM at discharged on 4-15-21 at 8:31 AM. The patient had a "diet-soft" ordered on 3-31-21 at 10:21 PM. The diet was changed to finger foods on 4-12-21 at 2:31 PM. The "Acute Care Unit Nutrition Screening" form, completed on 3-31-21, indicated the patient had allergies to red dye, eggs, and dairy. The form further indicated the patient had hypertension and "abdominal pain/stomach ulcers" and indicated the patient was "not at nutritional risk." There was no documentation a dietary consult was ordered or performed for the patient's food allergies, hypertension, and abdominal pain/ulcers. There was no documentation to indicate the patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 10	A 629		

received a soft diet between 3-31-21 and 4-12-21, nor was there documentation to indicate the patient received finger foods between 4-12-21 and 4-15-21, as ordered.

g. Patient #27 was admitted on 10-29-20 at 8:30 PM and discharged on 11-2-20 at 11:55 AM. The patient had a "diet-controlled carb" ordered on 10-29-20 at 8:30 PM. The "Acute Care Unit Nutrition Screening" form, completed on 10-29-20, indicated the patient had "edentulous...6 teeth on bottom;" "diabetes controlled;" and "hypertension." The form also noted "dietary not indicated." There was no documentation a dietary consult was ordered or performed for the patient's special diet, edentulous, or hypertension. There was no documentation to indicate the patient received a carbohydrate controlled diet between 10-29-20 and 11-2-20, as ordered.

h. Patient #29 was admitted on 4-7-21 at 3:25 PM and discharged on 4-12-21 at 9:02 AM. The patient had a "diet-heart healthy" ordered on 4-7-21 at 6:09 PM. The "Acute Care Unit Nutrition Screening" form, completed on 4-7-21, indicated the patient had hypertension and was "at nutritional risk" and the dietitian was requested on 4-8-21." There was no documentation a dietary consult was ordered or performed for the patient's special diet and nutritional risk. There was no documentation to indicate the patient received a heart healthy diet between 4-7-21 and 4-12-21, as ordered.

i. Patient #30 was admitted on 4-6-21 at 1:45 AM and discharged on 4-9-21 at 11:37 AM. The patient had a "diet-controlled carb" ordered on 4-6-21 at 1:45 AM. The "Acute Care Unit Nutrition Screening" form, completed on 4-6-21 indicated the patient had controlled diabetes and hypertension and indicated the patient was "at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 11	A 629		

nutritional risk." The form indicated a dietary consult was requested on 4-6-21. A dietitian consult was ordered on 4-6-21 at 2:17 PM. There was no documentation a dietary consult was performed for the patient's nutritional risk. There was no documentation of food intake or refusal to eat on 4-2-21; 4-3-21; 4-4-21; or 4-5-21. There was no documentation to indicate the patient received a carbohydrate controlled diet between 4-6-21 and 4-9-21, as ordered.

j. Patient #31 was admitted on 11-23-20 and discharged on 11-30-20. The patient's "Acute Care Unit Nutrition Screening" form, completed on 11-23-20, which read: "Order consult." A dietary consult was performed on 11-25-20. The dietary consult form was completed on 11-25-20 and read: "Nutrition prescription: ensure compact TID w/ jello & milk..." There was no additional practitioner orders for ensure compact three times a day with jello and milk, as recommended by the dietitian, nor was there documentation to indicate ensure compact with jello and milk was offered to the patient three times a day between 11-25-21 and 11-30-20.

k. Patient #32 was admitted on 12-15-20 and discharged on 12-21-20. The patient had "diet-soft" and "diet-heart healthy" both ordered on 12-25-20 at 8:00 PM. The patient's "Acute Care Unit Nutrition Screening" form, completed on 12-15-20, indicated a dietary consult was requested on 12-16-20. A dietitian consult was performed on 12-17-20. The dietary consult form was completed on 12-17-20 and read: "Nutrition prescription: Ensure Enlive BID in between meals..." There was no additional practitioner orders for ensure enlive twice a day between meals, as recommended by the dietitian, nor was there documentation to indicate ensure enlive was offered to the patient twice a day between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 629	Continued From page 12 12-17-20 and 12-21-20. There was no documentation to indicate the patient received a heart healthy and soft diet between 12-15-20 and 12-21-20, as ordered. 4. In interview, N#1, Director of Nursing, indicated the following: a. On 4-19-21 at 1:34 PM, N#1 indicated the facility had only one menu and confirmed it was for a regular diet. N#1 further confirmed the menu had not been approved by the current dietitian. N#1 indicated if a patient has a special diet ordered, then their contracted food service agency is notified of the special order and they send the special food for that patient. N#1 confirmed the current dietitian did not approve special diet menus provided by the contracted food service agency. b. On 4-19-21 at 2:15 PM and 4-20-21 at 10:41 AM, N#1 acknowledged the above information regarding patient documentation. c. On 4-20-21 at 11:15, N#1 indicated it is unknown what is meant by a carbohydrate controlled and heart healthy diet. N#1 further indicated fruit is always available as a snack for patients and snacks are not documented a food intake. N#1 acknowledged snacks (including fruit) should be documented as food intake, including for patients on a carbohydrate controlled diet. N#1 confirmed a lactose free diet is considered a "special diet." N#1 also indicated the dietitian recommends various special diets and supplements, but it's the practitioner's responsibility to provide dietary orders for patient diets and supplements.	A 629		
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41	A 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 700	Continued From page 13	A 700		

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.
This CONDITION is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure continuity of egress lighting for 1 of 6 exits (see tag K281), failed to ensure the lighting for 1 of 6 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness (see tag K281), facility failed to ensure 1 of 4 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided with a self-closing device (see tag K321), facility failed to ensure 1 of 4 hazardous areas observed such as Elevator Machine rooms was provided with an entry/exit door which was 3/4 hour fire rated (see tag K321), facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3 (see tag K345), facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3 see tag (see tag K345), facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72 (see tag K345), facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1 see tag K351), facility failed to ensure an automatic sprinkler system provided complete coverage in 1 of 1 Housekeeping rooms (see tag K351), facility failed to maintain the ceiling construction in 1 of 1 Transportation office's in accordance with NFPA 13 (see tag K351), facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 Housekeeping closets (see tag K351), facility failed to ensure 1 of 1 corridors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 700	Continued From page 14 with electrical panels were secured from non-authorized personnel per LSC 19.5.1.1 (see tag K511), facility failed to ensure 1 of 1 electrical junction boxes observed were maintained in a safe operating condition (see tag K511), facility failed to maintain testing of 1 of 1 elevators firefighter recall in accordance with 9.4.6, Elevator Testing (see tag K531), facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip (see tag K531), facility failed to provide a written plan that addressed all components in 1 of 1 written fire plan (see tag K711), facility failed to verify transmission of the fire alarm signal for 3 of the last 4 quarters (see tag K712), facility failed to implement the emergency power system inspection, testing, and maintenance requirements (see tag K918), facility failed to ensure 1 of 2 Staff office doors was provided with only one latching mechanism to release the door and open (see tag 222), facility failed to ensure 1 of 4 power strips observed were not used as a substitute for fixed wiring (see tag K511), facility staff failed to ensure that all personnel on all shifts are trained to perform assigned tasks and were familiar with the use of the facility's fire protection features during fire drills (see tag K712), and the facility failed to ensure 1 of 1 fire alarm control panels (FACP) was maintained in accordance with 9.6.1.3 (see tag K345). The cumulative effect of these systemic problems resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT	A 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 701	Continued From page 15 CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 corridors with electrical panels were secured from non-authorized personnel per LSC 19.5.1.1. LSC 19.5.1.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.2 states electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70 Section 110.27(A) states live parts of electrical equipment over 50 volts or more shall be guarded against accidental contact by approved closures or by any of the following means: (1) by location in a room, vault, or similar enclosure that is accessible only to qualified persons. This deficient practice could affect all at least 9 residents, visitors and staff. Findings include: Based on observation on 04/20/21 at 1:16 p.m. with the Director of Facilities and Safety (DFS) there were two electrical panels installed in the corridor wall on Transportation hall which were not secured against non-authorized personnel. Based on interview during the observation, the DFS confirmed the electrical panels could be opened by anyone and was unaware they needed to be secured against unauthorized access. This was discussed with the DFS and the Director of Compliance during the exit conference. 2. Based on observation, the facility failed to	A 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 701	Continued From page 16	A 701		

ensure 1 of 1 electrical junction boxes observed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 9 residents, staff and visitors.

Findings include:

Based on observation on 04/20/21 at 12:36 p.m. with the Director of Facilities and Safety (DFS), one electrical junction box with exposed electrical wiring and no cover plate was noted in the Electrical Mechanical room in Activities attached to an air handling unit. Based on interview at the time of the observation, the DFS acknowledged the electrical junction box location was not provided with a cover. This finding was reviewed with the DFS and the Director of Compliance during the exit conference.

3. Based on observation and interview, the facility failed to ensure 1 of 4 power strips observed were not used as a substitute for fixed wiring according to 33.2.5.1. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any staff, client or visitor.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 701	Continued From page 17 Based on observation on 04/21/21 at 1:10 p.m. with the Director of Facilities and Safety (DFS), there was a power strip connected to an O2 concentrator in the second story Westside first client's bedroom. Based on interview at the time of observation, the DFS acknowledged the power strip was misused and informed staff this was not allowed. This was discussed with the DFS during the exit conference.	A 701		
A 709	LIFE SAFETY FROM FIRE CFR(s): 482.41(b) Life Safety from Fire This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Director of Facilities and Safety (DFS) on 04/20/21 at 1:35 p.m., the Boiler room on the first floor had several low voltage communication lines attached to the metal sprinkler pipe. Based on interview at the time of observation, the DFS acknowledged there were wires attached to the sprinkler pipe and was unaware this condition existed. 2. Based on observation and interview, the	A 709		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 709	Continued From page 18	A 709		

facility failed to ensure an automatic sprinkler system provided complete coverage in 1 of 1 Housekeeping rooms on the second floor. This deficient practice could affect only staff.

Findings include:

Based on observation on 04/20/21 at 2:01 p.m. with the Director of Facilities and Safety (DFS), the Housekeeping room on the second floor was not provided with sprinkler protection. This was confirmed by the DFS at the time of observation. This was discussed with the DFS and the Director of compliance during the exit conference.

3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Transportation office's in accordance with NFPA 13. NFPA 13, 2010 edition, Section 6.2.7 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff in the Transportation office.

Findings include:

Based on observation on 04/20/21 at 1:25 p.m. with the Director of Facilities and Safety (DFS), an escutcheon was missing around 1 of 2 sprinkler heads in the Transportation office. Based on interview at the time of observation, the DFS acknowledged and confirmed the missing escutcheon. This was discussed with the DFS and the Director of Compliance during the exit conference.

4. Based on observation and interview, the facility failed to ensure the spray pattern for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 709	Continued From page 19	A 709		

sprinkler heads were not obstructed in 1 of 1 Housekeeping closets first floor in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 12 residents, visitors and staff.

Findings include:

Based on observation on 04/20/21 at 1:18 p.m. with the Director of Facilities and Safety (DFS), the Housekeeping closet on the first floor contained several cardboard boxes which were stored on shelves within two to three inches from the deflector on the sprinkler head. Based on interview at the time of observation, the DFS acknowledged the obstructions were less than eighteen inches from the sprinkler head and would convey this to Housekeeping. This was discussed with the DFS and the Director of Compliance during the exit conference.

5. Based on observation, record review and interview, the facility failed to maintain testing of 1 of 1 elevators firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 709	Continued From page 20	A 709		

premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, visitors and staff.

Findings include:

Based on observation on 04/20/21 at 1:10 p.m. with the Director of Facilities and Safety (DFS), the elevator had a key access fire department recall feature. Based on record review with the DFS there was no documentation of a monthly firefighter recall test for the past year. Based on interview with the DFS, when asked during record review it was indicated there was no documentation for the monthly firefighter recall testing for the elevator in the facility. This was discussed with the DFS and the Director of Compliance during the exit conference.

6. Based on observation, interview, and record review; the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. The elevator equipment room was located in the basement and could affect any resident using the elevator as well as visitors and staff.

Findings include:

Based on observation and interview on 04/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 709	Continued From page 21 at 1:32 p.m. with the Director of Facilities and Safety (DFS), the elevator equipment room located on the first floor was provided with a quick response sprinkler head and smoke detector protection, however a shunt trip could not be located. The DFS acknowledged she did not know what a shunt trip is and did not know where one may be located. Based on the Sprinkler Inspection and Test Report record review at 12:15 p.m. with the DFS, there was no mention of a shunt trip installation in the elevator machine room. This was discussed with the DFS and the Director of Compliance during the exit conference.	A 709		
A 714	FIRE CONTROL PLANS CFR(s): 482.41(b)(5) (5) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities. This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plan. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation	A 714		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 714	Continued From page 22 (9) Extinguishment of fire Section 18.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on record review on 04/20/20 at 12:05 p.m. with the Director of Facilities and Safety (DFS), the Fire Safety plan did not address a. types of fire extinguishers throughout the facility, b. how to evacuate a smoke compartment to another smoke compartment behind a set of smoke/fire doors, c. extinguishment of fire or d. isolation of fire. Based on interview at the time of record review with the DFS and the Director of Compliance during the exit conference it was agreed the Fire Safety policy did not identify items a through d. 2. Based on record review and interview, the facility failed to verify transmission of the fire alarm signal for 3 of the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff and visitors.	A 714		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 714	Continued From page 23 Findings include: Based on review of Monthly Fire Drill Reports on 04/20/21 at 12:13 p.m., with the Director of Facilities and Safety (DFS) there was no documentation for the transmission of the fire alarm signal the following quarter: a. First quarter 2021, Night shift 1/28/21 b. Fourth quarter 2020, Night shift 12/17/20 c. Third quarter 2020, Night shift 09/28/20 Based on an interview with the DFS at the time of record review, it was stated the transmission signal of the fire alarm to the monitoring station had not been documented for the last 3 of 4 quarters. This was discussed with the DFS and the Director of Compliance during the exit conference. 3. Based on record review and interview, facility staff failed to ensure that all personnel on all shifts are trained to perform assigned tasks and were familiar with the use of the facility's fire protection features during fire drills conducted for 2 of the last 4 quarters over the past year. This deficient practice could affect all clients. Findings include: Based on record review of Emergency Evacuation Drill Reports on 04/20/21 at 12:03 p.m. with the Director of Facilities and Safety (DFS) the fire drill reports indicated the following drills had not been done: a. All shifts for the second quarter 2020. b. All shifts for the third quarter 2020. Based on an interview with the DFS at the time of record review, it was acknowledged previously mentioned shifts of the past year had not been	A 714		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 714	Continued From page 24 done. In addition, the DFS could not produce documentation of staff participating in an orientation training program related to the current fire plan. The training will instruct all employees on their current duties, life safety procedures and the fire protection devices in their assigned area. This was discussed with the DFS during the exit conference.	A 714		
A 715	REGULAR FIRE AND SAFETY INSPECTIONS CFR(s): 482.41(b)(6) (6) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies. This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Facilities and Safety (DFS) on 04/20/21, the fire alarm annual report dated 03/11/21 in the comments section regarding the elevator stated: "This device will shut down the elevator will reset when system is reset, does not recall the elevator, the elevator stops where it's at until its reset." Based on interview at the time of record review it was acknowledged by the DFS the statement on the fire alarm annual report must be	A 715		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 715	Continued From page 25	A 715		

valid. This was discussed with the DFS and the Director of Compliance during the exit conference.

2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on review of Brenneco's Fire Alarm Systems "Initiating & Supervisory Device Tests & Inspections" documentation dated 03/11/21 with the with the Director of Facilities and safety (DFS) during record review on 04/20/21 it was stated in the device specs: Johnson controls duct detector model # 760 sensitivity test was not available. Based on interview at the time of record review, the DFS acknowledged the statement made in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 715	Continued From page 26 the device specs section must be correct. This was discussed with the DFS and the Director of Compliance during the exit conference 3. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review on 04/20/21 at 12:00 p.m. with the Director of Facilities and Safety (DFS), no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the DFS acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review.	A 715		
A 720	STANDARD: BUILDING SAFETY CFR(s): 482.41(c)	A 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 720	Continued From page 27 (c) Standard: Building safety. Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 6 exits. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect clients, staff and visitors. Finding include: Based on observation on 04/20/21 at 1:05 p.m. with the Director of Facilities and Safety (DFS), the exit discharge out of 100 hall did not have any outside lighting for illumination of the public way.	A 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 720	Continued From page 28	A 720		

Based on interview at the time of observation, the DFS confirmed there was no lighting devices illuminating the public way for 100 hall. This finding was reviewed with the DFS and the Director of Compliance during the exit conference.

2. Based on observation and interview, the facility failed to ensure the lighting for 1 of 6 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect 9 residents who reside on the Old Hall.

Findings include:

Based on observation on 04/20/21 at 1:08 p.m. with the Director of Facilities and Safety (DFS), the exit discharge outside the IT exit there is only a one bulb fixture available to illuminate the outside path to a public way. Based on interview at the time of observation, the DFS confirmed there was only a single bulb fixture available for the IT exit discharge. This finding was reviewed with the DFS and the Director of Compliance during the exit conference.

3. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 720	Continued From page 29	A 720		

and visitors.

Findings include:

Based on review of generator Weekly and Monthly Load Test Log on 04/20/21 at 11:50 a.m., with the Director of Facilities and Safety (DFS) there was no documentation of monthly load testing done for the past twelve months. In addition, the last generator annual load bank test for diesel emergency power systems available for review was dated 05/06/19. Based on interview at the time of record review, the DFS acknowledged the load bank was past due and stated maintenance present before her did not keep records of weekly inspections or monthly load for the past year. This was discussed with the DFS and the Director of Compliance during the exit conference.

4. Based on observation and interview, the facility failed to ensure 1 of 2 Staff office doors was provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 720	Continued From page 30 Based on observations on 04/21/21 during the tour between at 1:10 p.m. to 2:00 p.m. with the Director of Facilities and Safety (DFS), the four exit doors in the building were equipped with a deadbolt requiring more than one motion to open the door when in the locked position. This was acknowledged by the DFS at the time of observations discussed with the DFS during the exit conference.	A 720		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 4 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided with a self-closing device. This deficient practice could affect staff on first floor. Findings include: Based on observation on 04/20/21 at 1:10 p.m. with the Director of Facilities and Safety (DFS), there were twenty six cardboard boxes stored in the "Mancave" on first floor next to the front reception area and there was no self closing device on the corridor door. Based on interview at the time of observation with the DFS it was acknowledged the corridor door to the Mancave was not provided with a self closing device on the corridor door. It was further acknowledged the area was over 50 square feet. This was discussed with the DFS and the Director of	A 724		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR COUNTY COUNSELING CENTER	1015 MICHIGAN AVE LOGANSPORT, IN 46947

(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
A 724	Continued From page 31 Compliance during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 4 hazardous areas observed such as Elevator Machine rooms was provided with an entry/exit door which was 3/4 hour fire rated. This deficient practice could affect all occupants in the facility. Findings include: Based on observation on 04/20/21 at 1:32 p.m. with the Director of Facilities and Safety (DFS), the entry/exit door to the Elevator Machine room was missing a fire rated label and could not be identified as having the 3/4 hour fire rating. Based on interview at the time of observation with the DFS it was acknowledged the Elevator Machine room door did not have a label to indicate it's fire rating and had to be considered a non-rated door. This was discussed with the DFS and the Director of Compliance during the exit conference.	A 724		