STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G448	A. BUILDING -- B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LOGAN COMMUNITY RESOURCES INC	907 COTTAGE GROVE SOUTH BEND, IN 46628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/12/22 Facility Number: 000962 Provider Number: 15G448 AIM Number: 100249360 At this Emergency Preparedness survey, Logan Community Resources Inc was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 7 beds are certified for Medicaid. At the time of the survey, the census was 7. Quality Review completed on 12/12/22	E 0000		
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/12/22 Facility Number: 000962 Provider Number: 15G448 AIM Number: 100249360 At this Life Safety Code survey, Logan	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl Groves	Director of Group Living	12/29/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	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 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This two story building with a partial basement was determined to be fully sprinklered. The facility has a monitored fire alarm system with hardwire smoke detection in corridors, in client sleeping rooms and all living areas. Heat detection was provided in the attic space. The facility has a capacity of 7 and had a census of 7 at the time of this survey. 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 0.65. Quality Review completed on 12/12/22			
K S222 Bldg. 02	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors			

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	only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 5 exterior exit doors were provided with only one latching mechanism to release the door and open. LSC 33.2.2.5.7 refers to LSC 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: Based on observation during a tour of the facility with Maintenance Director on 12/12/22 at 10:53 a.m., the exit door leading to the back of the facility were equipped with two latching devices, a regular door handle with a turn lock and a separate deadbolt lock. Based on interview at the time of observation, the Maintenance Director	K S222	In order to meet this citation now and in the future Maintenance will remove the deadbolt on this door that was cited. Maintenance will inspect doors for all homes to ensure deadbolts, if any, are removed. This deadbolt has been removed (refer to picture that is uploaded in this survey). (Maintenance responsible)	12/24/2022

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	agreed the entrance/exit door contained a deadbolt lock in addition to the lock on the door handle. The finding was reviewed with the Director of Group Living during the exit conference.			
K S345 Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 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, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 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. This deficient practice could affect all occupants. Findings include:	K S345	In order to meet this citation now and in the future, the maintenance department will work with Koorsen Fire and Security to ensure all inspections, including the inspection of the fire alarm system in accordance with 9.6.1.3. To be in compliance with NFPA 72, 14.4.5.3.1 the sensitivity test will be completed every alternate year. For this citation the inspection was actually completed on 4/27/21 and attached to this survey. LOGAN Maintenance will review records on a quarterly to ensure all necessary requirement	12/31/2022

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	Based on record review from with the Director of Group Living and Maintenance Director at 10:31 a.m. on 12/12/22, documentation titled "Sensitivity and Detection Inspection Report" stated that the last smoke detector sensitivity test was done on 03/20/2019. No other documentation could be provided to determine if a smoke detector sensitivity test was done in 2021. Based on interview at the time of record review, the Maintenance Director stated they were unaware if the contracted entity had conducted a smoke detector sensitivity test for the fire alarm system. Findings were discussed with the Director of Group Living at exit conference.		inspections are completed in a timely fashion. (Director of Maintenance and Koorsen Fire and Security responsible) ADDENDUM-Attached is an updated report from Koorsen fire systems where the battery was fixed in December 2021. Upon every inspection completed by Koorsen the LOGAN maintenance will review report and have any deficiencies, including batteries, fixed within 30 days. (maintenance department responsible)	
K S712 Bldg. 02	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation			

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	drills, including accidents and take corrective action; and e. 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. 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. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 4 of 12 shifts. This deficient practice affects all staff and clients. Findings include: Based on records review with the Director of Group Living and Maintenance Director on 12/12/22 at 10:27 a.m., the following shifts were missing fire drills: a) There was no documentation for a first and third shift fire drill in the second quarter of 2022 b) There was no documentation for a first and third shift fire drill in the third quarter of 2022 Based on interview at the time of record review, the Director of Group Living stated documentation of the fire drills could not be located. Findings were discussed with the Director of Group Living at exit conference.	K S712	In order to correct this citation and ensure the citation does not occur in the future, the facility will conduct evacuation drills on a quarterly basis for each shift of personnel. There is a schedule of drills for this home, and all other homes in place and the House Lead will assign drills to be run on specific days, specific shifts and specific times to meet LSC guidelines. The drill completion is tracked by the Case Coordinator and reviewed by the Director of Group Living each month. In the future, the Case Coordinator will review monthly reports and send reminders to the House Lead of drill times for completion. If the drill date is missed, the staff will make up the drill as soon as possible to stay in appropriate guidelines. The Director of Group Living will address this issue at the monthly Program Manager/House Lead meeting and complete a staff development record on this requirement.	12/24/2022

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			This will be ongoing each month. (DSP, House Lead, Program Manager, Administrative Assistant, Case Coordinator and Director of Group Living responsible)	