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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G119 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 10/07/2015 |
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| NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1234 S 50 E WINAMAC, IN 46996 |
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| K 0000 Bldg. 01 | <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 10/07/15</p> <p>Facility Number: 000656 Provider Number: 15G119 AIM Number: 100234050</p> <p>At this Life Safety Code survey, PEAK Community Services Inc was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was not sprinklered. The facility has a fire alarm system with hard wired smoke detection in the basement and common areas of the main floor. Sleeping rooms were equipped with battery powered smoke detectors. The facility has the capacity for 8 and had a census of 8 at the time of this survey.</p> | K 0000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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| K 0130 Bldg. 01 | <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.2.</p> <p>Quality Review on 10/09/15 - DA</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the office was installed on a hanger, bracket, mounted in a cabinet or set on a shelf. LSC 4.5.7 requires whenever any equipment is required for compliance with provisions of the Code, such equipment shall be maintained. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.6 requires fire extinguishers shall be installed on the hangers or in the brackets supplied, mounted in cabinets or set on shelves. NFPA 10, 1-6.7 requires extinguishers installed under conditions where they are subject to dislodgement shall be installed in brackets specifically designed to cope with this problem. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation with the Qualified</p> | K 0130 | October 7, 2015, the fire extinguisher was mounted on the wall by maintenance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Fire extinguishers will be monitored monthly to ensure that the brackets are well maintained and sturdy. How will the corrective action be monitored to ensure the deficient practice will not reoccur? Monthly check chart will be maintained by the House Coordinator/Director/QDDP. | 10/08/2015 |

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| K S017 Bldg. 01 | <p>Intellectual Disability Professional on 10/07/15 at 2:44 p.m., the fire extinguisher in the office was sitting on the floor. Based on interview at the time of observation, the Qualified Intellectual Disability Professional acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is</p> | | | |

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| | <p>no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 clients sleeping rooms provided with a door which would close and latch securely in the door frame. This deficient practice could affect two clients.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Developmental Disability Professional on 10/07/15 at 2:32 p.m. then again at 2:43 p.m., bedroom #4 failed to latch when tested. Then again bedroom #6 failed to</p> | K S017 | <p>Peak Community Services will ensure that all doors in the home are properly adjusted. The doors were properly adjusted by maintenance on 10/7/2015. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. Doors will be monitored monthly to ensure that they will properly close and latch securely in the door frames. How will the corrective action be monitored to ensure the deficient practice will not reoccur? Monthly check chart will be maintained by the House</p> | 10/07/2015 |

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| K S040 Bldg. 01 | <p>latch when tested. Based on interview at the time of each observation, the Qualified Developmental Disability Professional acknowledged each aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors or paths of travel to a means of escape are not less than 28 inches.</p> <p>Exception: Bathroom doors are not less than 24 inches. 33.2.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure the path of travel to a means of escape was not less than 28 inches in one of two exterior exits. This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on observations with the Qualified Intellectual Disability Professional on 10/07/15 at 2:38 p.m., the back patio exit discharge contained a table and four chairs preventing egress. Based on interview at the time of observation, the Qualified Intellectual Disability Professional acknowledged the width of the path of travel to the means of escape was less than 28 inches.</p> | K S040 | <p>coordinator/Director/QDDP.</p> <p>Patio furniture has been moved to allow for proper egress of the required 28 inches. Completed 10/8/2015. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Exit door will be monitored daily to ensure that there is nothing blocking the exits. How will the corrective action be monitored to ensure the deficient practice will not reoccur? Monthly check chart will be maintained by the House Coordinator/Director/QDDP</p> | 10/08/2015 |
| K S046 Bldg. 01 | <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1,</p> | | | |

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| | <p>33.2.5.1 Based on record review and interview, the facility failed to ensure emergency lighting of at least 1½ hour duration was provided in accordance with LSC 7.9 for one of one battery-operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff and patients if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on record review with the Qualified Developmental Disability Professional on 10/07/15 at 3:16 p.m., there was no written record of an annual 90 minute test regarding the battery-operated emergency light available for review. Additionally, the monthly thirty second test for September was not available for review. Based on</p> | K S046 | <p>A 90 minute test of the emergency lighting was conducted and documented. A schedule has been put into place to ensure proper testing the emergency lightening system. Staff have been trained on how to complete the test and how to complete the Fire Extinguisher and Battery check Form. Completed 10/12/2015.How will the corrective action be monitored to ensure the deficient practice will not reoccur?A schedule is in place to ensure proper testing of the emergency lighting system. Staff has been trained on how to complete the test and how to complete the Fire Extinguisher and Battery Check Form.How will the corrective action be monitored to ensure the deficient practice will not reoccur?The Fire Extinguisher and Battery Form will be completed monthly by the staff and monitored by the QDDP.</p> | 10/12/2015 | |

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| K S147 Bldg. 01 | <p>interview at the time of record review, the Qualified Developmental Disability Professional acknowledged the aforementioned conditions.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility failed to provide and to periodically instruct staff of a plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients in the home. Further, NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 edition at 6-5.2.1 says the protection plan should include the following features:</p> | K S147 | <p>Peak will ensure that copies of the fire evacuation plan will be kept in the office as well as in the home. Staff have been instructed in the protection plan located in the home office. Completed 10/23/2015. How will the corrective action be monitored to ensure the deficient practice will not occur? Fire evacuation plans will be kept in the home as well as in the office and will be addressed quarterly during a monthly meeting and monitored</p> | 10/23/2015 |

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| K S150 Bldg. 01 | <p>(a) A description of all available evacuation, escape, and rescue routes and the procedures and techniques needed to evacuate all the residents using the various routes.</p> <p>(b) A fundamental knowledge of fire growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes.</p> <p>This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on record review with the Qualified Developmental Disability Professional on 10/07/15 at 3:30 p.m., there was no copy of a protection plan and there were no records of staff instruction regarding a protection plan located in the home at the time of this visit. Based on interview at the time of record review, the Qualified Developmental Disability Professional acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> | | by the QDDP. | |

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| | <p>Based on interview and observation, the facility failed to ensure 5 of 5 new draperies and curtains were flame resistant. LSC Section 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Method of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects all clients.</p> <p>Findings include:</p> <p>Based on observations with Qualified Developmental Disability Professional on 10/07/15 from 2:18 p.m. to 2:44 p.m., the following was discovered:</p> <ul style="list-style-type: none"> a) Bedroom #1 had curtains b) Bedroom #5 had curtains c) Bedroom #6 had curtains d) Living Room had curtains e) Office had curtains <p>Based on interview, the Qualified Developmental Disability Professional at the time of each observation was unable to provide documentation and acknowledged each aforementioned condition.</p> | K S150 | The curtains in the listed rooms have been removed due to not meeting required standards. The curtains will be replaced with those that meet the standard. Completed 10/8/2015. Only proper draperies will be in home and will be monitored by the Coordinator/QDDP/Director. | 10/08/2015 | | | |