

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 WOODLAWN AVE LOGANSPORT, IN 46947
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 14, 15, and 16, 2012</p> <p>Facility number: 005550 Provider number: 15G737 AIM number: 200883760</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed August 22, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		
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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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, the governing body failed to exercise operating direction in a manner that resulted in the facility being well maintained for 5 of 5 clients (clients #1, #2, #3, #4, and #5) who lived in the group home.</p> <p>Findings include:</p> <p>On 8-14-12 from 3:15 p.m. until 5:20 p.m. an observation at the home of clients #1, #2, #3, #4, and #5 was conducted. The bathroom in client #1's bedroom had a 10 inch by 2 inch area of drywall missing and 25 black marks on 2 of the bathroom walls. The blinds in client #5's had 2 broken slats. The bathroom flooring had a rip 2 foot long by 1 inch and a hole in the flooring by the drain 3 inches by 3 inches. The desk in the living room had a 4 inch by 3 inch bubbled area on the top. The half wall in the living room had a 3 foot by 1 inch area where the drywall was gone and metal was showing and black marks in a 10 inch by 2 inch area.</p> <p>On 8-15-12 at 11:15 a.m. a review of the facility's maintenance log was conducted.</p>	W0104	<p>W104 – Governing Body Peak Community Services is committed to ensuring the individuals served that the residence is well maintained. The items in the home noted in the survey as needing repair have been repaired or replaced as required to meet the standards of an ICF/DD residence. The residence coordinator will be retrained in the use of the facility maintenance log to ensure that items in need of repair are documented to notify maintenance staff. (09.15.12) Peak Community Services QDDP will observe for items in disrepair or other maintenance items once per month during an observation at the home during the time period of 09.01.12 to 08.31.13. (09.15.12) Completion Date: 09.15.12 Persons Responsible: Michele Luwpas, Residential Coordinator; Stacey Platt, QDDP</p>	09/15/2012			

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	<p>The review did not have any work orders for the listed items above.</p> <p>On 8-15-12 at 11:15 a.m. an interview with the Qualified Mental Retardation Professional indicated there were no maintenance requests for the bathroom walls, flooring, blinds, drywall or for the desk and these items should be fixed.</p> <p>9-3-1(a)</p>			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure program implementation per her Individualized Support Plan (ISP).</p> <p>Findings include:</p> <p>On 8-14-12 from 3:15 p.m. until 5:20 p.m. an observation at the home of client #1 was conducted. At 3:30 p.m. client #1 sat on the floor in her room playing with a baby doll. At 3:55 p.m. client #1 sat on the couch holding her baby doll watching television. At 4:00 p.m. client #1 went to her room and put her shoes on, then came back to the couch to watch television. At 4:15 p.m. client #1 watched television. At 4:30 p.m. client #1 took pictures of herself as she sat on the couch watching television. At 4:45 p.m. direct care staff (DCS) #3 took the tea from the refrigerator, got a cup, filled it with ice, poured the tea into the cup, then took it to client #1 who was sitting on the couch. DCS #3 then took client #1 a paper towel.</p>	W0249	<p>W 249 – Program Implementation Peak Community Services is committed to ensuring the individuals served receive a continuous active treatment program consisting of needed interventions and services... Direct care staff (DCS) # 3 will receive retraining on Client #1's goals as well as the use of prompts to ensure that Client # 1 receives a continuous active treatment program. (09.15.12) DCS in the home will be retrained on the definition of continuous active treatment including the use of prompts and other teaching techniques to ensure that all residents receive a continuous active treatment program. Such training will include the use of role play, question and answer session and direct observation by a Peak Community Services QDDP. (09.15.12) Peak Community Services QDDP will observe staff for the proper administration of a continuous active treatment program once per month during an observation at the home during the time</p>	09/15/2012

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	<p>At 5:00 p.m. client #1 put her shoes on as she sat on the couch watching television. At 5:15 p.m. client #1 sat at the supper table, made her plate, and ate independently.</p> <p>On 8-15-12 at 10:30 a.m. a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 4-11-12 indicated client #1 had the following goals: -complete her share of housekeeping and cleaning chores -complete simple cooking tasks for the evening meal -review her spending money allotment -brush her teeth twice daily -participate in fire drills -punch pill into a cup and repeat the name of the medication -interact appropriately in the community -use the appropriate amount of toilet tissue -chew food, pause between bites -empty trash can</p> <p>On 8-15-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional indicated DCS should implement client #1's ISP goals at times of opportunity and client #1 should be prompted to participate in active treatment activities. The QMRP indicated she could have completed cleaning</p>		<p>period of 09.01.12 to 08.31.13 Completion date: 09.15.12 Person Responsible: Stacey Platt, QDDP</p>				

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	chores, cooked the evening meal, reviewed her money, or emptied a trash can instead of watching television. 9-3-4(a)			

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W0259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #4), who was a new admission to the home, to ensure a comprehensive functional assessment (CFA) was completed.</p> <p>Findings include:</p> <p>On 8-15-12 at 8:35 a.m. a record review for client #4 was conducted. The client roster dated 8-14-12 indicated client #4 was admitted to the home on 12-17-11. The Individual Support Plan dated 12-16-11 did not include a CFA. The review indicated there was no CFA available for review.</p> <p>On 8-15-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional (QMRP) indicated she was not aware the CFA had not been completed. The QMRP indicated the CFA should be completed and reviewed at least yearly.</p> <p>9-3-4(a)</p>	W0259	<p>W259 – Program Monitoring and Change</p> <p>Peak Community Services is committed to ensuring that at on an annual basis the Comprehensive Functional Assessment (CFA) is reviewed by the IDT for relevancy and updated as necessary. Client # 4 has an updated CFS in their file to be used in developing the Individual Support Plan as required in the regulations.</p> <p>Peak Community Services QDDP has done a file check to ascertain that all residents' files contain an updated and current CFA which they do. The QDDP will monitor each residents file on a quarterly basis to make sure that updates occur as necessary to ensure that each resident's ISP is developed using appropriate goals and objectives.</p> <p>Completion date: 09.15.12</p> <p>Person Responsible: Stacey Platt, QDDP</p>	09/15/2012			

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #2) to ensure an annual physical was completed in a timely manner.</p> <p>Findings include:</p> <p>On 8-15-12 at 9:40 a.m. a record review for client #2 was conducted. The review indicated client #2's last annual physical was completed on 5-2-11. There was no current annual physical available for review.</p> <p>On 8-15-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional indicated client #2 did not have a current annual physical for review.</p> <p>9-3-6(a)</p>	W0322	<p>W322 Physician Services</p> <p>Peak Community Services is committed to ensuring that annual physicals are completed in a timely manner. Client # 2's physical was completed on 08.27.12 A file review indicated that other resident's physicals are up to date and were completed within the annual time frame.</p> <p>House coordinator will be retrained on the annual requirements called for in the ICF/DD regulations.</p> <p>Peak Community Services QDDP will monitor the files for annual physician services requirements to document services that need to be completed in a timely manner. A spread sheet will be developed that lists all annually required examinations with the QDDP notifying the house coordinator when they are due.</p> <p>Completion Date: 09.15.12</p> <p>Persons Responsible: Stacey Platt, QDDP; Michelle Luwpas, Residential Coordinator</p>	09/15/2012	

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W0327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #4) to ensure she was free from communicable disease.</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 8-15-12 at 8:35 a.m. Client #4's record did not contain any documentation of a Mantoux test, chest X-ray or any additional documentation to indicate she was free from communicable disease. Client #4 was admitted to the facility on 12-17-11. The Physicians Orders dated 5-15-12 did not indicate client #4 was free of communicable disease.</p> <p>On 8-15-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional indicated client #4 did not have a chest X-ray available for review and one should have been completed upon admission (12-17-11).</p> <p>9-3-6(a)</p>	W0327	<p>W 327 – Physician Services</p> <p>Peak Community Services is committed to ensuring that annual physical examinations that, at a minimum include tuberculosis control are completed in a timely manner. Client # 4's chest x-ray was completed on 08.24.12. File reviews indicated that other resident's TB tests are up to date and were completed within the annual time frame.</p> <p>House coordinator will be retrained on the annual requirements called for in the ICF/DD regulations.</p> <p>Peak Community Services QDDP will monitor the files for annual physician services requirements to document services that need to be completed in a timely manner. A spread sheet will be developed that lists all annually required examinations with the QDDP notifying the house coordinator when they are due.</p>	09/15/2012			

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			<p>Completion Date: 09.15.12</p> <p>Persons Responsible: Stacey Platt, QDDP; Michelle Luwpas, Residential Coordinator</p>	

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W0352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure she had a dental exam at least annually.</p> <p>Findings include:</p> <p>On 8-15-12 at 10:30 a.m., a record review for client #1 was conducted. The review indicated client #1's last dental exam was on 5-26-09.</p> <p>On 8-15-12 at 11:10 a.m., an interview with the House Manager indicated client #1 did not have a current dental exam available for review due to her having to go to a dentist out of town.</p> <p>9-3-6(a)</p>	W0352	<p>W352 – Comprehensive Dental Diagnostic Service Peak Community Services is committed to ensuring that annual dental examinations are completed in a timely manner. Client # 1' dental examination is scheduled for September 5, 2012. File reviews indicated that other resident's dental examinations are up to date and were completed within the annual time frame. House coordinator will be retrained on the annual requirements called for in the ICF/DD regulations. Peak Community Services QDDP will monitor the files for annual dental services requirements to document services that need to be completed in a timely manner. A spread sheet will be developed that lists all annually required examinations with the QDDP notifying the house coordinator when they are due. Completion Date: 09.15.12 Persons Responsible: Stacey Platt, QDDP; Michelle Luwpas, Residential Coordinator</p>	09/15/2012	

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #4), to ensure she wore her eyeglasses as prescribed.</p> <p>Findings include:</p> <p>On 8-14-12 from 3:15 p.m. until 5:20 p.m. an observation at the home of client #4 was conducted. At 4:30 p.m. direct care staff (DCS) #3 prompted client #4 to read the receipt and put the numbers from the receipt into the calculator. Client #4 indicated she could not see the numbers, so DCS #3 read the numbers to client #4. DCS #3 prompted client #4 to write the name of the place the receipt was received from. Client #4 indicated she could not read the print on the receipt then DCS #3 spelled each letter as client #4 wrote it down. DCS #3 did not prompt client #4 to use her glasses so she could read the receipt.</p> <p>On 8-15-12 at 8:35 a.m. a record review for client #4 was conducted. Her vision exam dated 12-22-11 indicated client #4</p>	W0436	<p>W436 – Space and Equipment</p> <p>Peak Community Services is committed to ensuring that residents are furnished, maintained in good repair, and are taught to make informed choices about the use of prescribed devices that are identified by the IDT as needed.</p> <p>Direct Care Staff #3 and other DCS will be retrained in the use of prompts and other techniques to use when a client does not wear or use their prescribed assistive device such as eye glasses. Such training will include the use of role play, question and answer session and direct observation by a Peak Community Services QDDP.</p> <p>Peak Community Services QDDP will observe staff for the use of appropriate prompts and other techniques in the event that a client chooses not to use their prescribed assistive device. This observation will occur once per month at the home during the time period of 09.01.12 to 08.31.13. (09.15.12)</p>	09/15/2012			

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	<p>was to wear glasses and new glasses were recommended.</p> <p>On 8-15-12 at 11:00 a.m. an interview with the Qualified Mental Retardation Professional indicated client #4 should be wearing her glasses to assist her with seeing and reading.</p> <p>9-3-7(a)</p>		<p>Completion Date: 09.15.12</p> <p>Persons Responsible: Stacey Platt, QDDP; Michelle Luwpas, Residential Coordinator</p>	

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing body</p> <p>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>The state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 5 clients (client #3) who lived in the home, to ensure her falls with injury were reported to the Bureau of Developmental Disabilities Services (BDDS) in accordance with State Law.</p> <p>Findings include:</p> <p>On 8-15-12 at 9:00 a.m. a record review for client #3 was conducted. The review indicated client #3 fell which resulted with an injury on 8-12-12 while at a birthday party with her sister. The Health Concern Case Note dated 8-12-12 indicated client #3 had a bruise on her left</p>	W9999	<p>W9999 – Final Observations</p> <p>Peak Community Services is committed to ensuring that incidents that are required to be reported to the State of Indiana are reported within the time frame called for in the regulations. This includes incidents such as client # 3's fall with injury.</p> <p>Staff will be retrained on the Bureau of Developmental Disabilities Services Incident Reporting requirements. Such training will include the use of role play, question and answer session and direct observation by a Peak Community Services QDDP.</p> <p>Completion Date: 09.15.12</p> <p>Persons Responsible: Rick Phelps, Director of Residential Services.</p>	09/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 WOODLAWN AVE LOGANSPORT, IN 46947
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	<p>buttock and another bruise on her leg just below it.</p> <p>On 8-15-12 at 10:00 a.m. an interview with the Qualified Mental Retardation Professional indicated she had not filed a BDDS report for the fall with injury and there were no BDDS reports to review for client #2's fall with injury for the 8-12-12 incident at the birthday party.</p> <p>9-3-1(b)</p>			