

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G119	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2013
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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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K010000	<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: 12/12/13</p> <p>Facility Number: 000656 Provider Number: 15G119 AIM Number: 100234050</p> <p>Surveyor: Bridget Brown, LSC Specialist Specialist</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 on all levels including in the corridors, sleeping rooms, and living areas. The facility has the capacity for 8 and had a census of 6 at the time of this survey.</p>	K010000		
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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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	<p>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 0.6.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010130	<p>1. Based on observation and interview, the facility failed to ensure 1 of 2 emergency lighting fixtures operated when tested. LSC 4.6.12.2 requires life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation of the emergency lighting fixtures with the Qualified Mental Retardation Professional (QMRP) on 12/12/13 at 2:10 p.m., bulbs in the dining room fixture failed to light up when tested. A second test produced the same result. The QMRP acknowledged at the time of observation, the fixture was not working.</p> <p>2. Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 2 of 2 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for</p>	K010130	<p>K130Peak Community Services ensures that all emergency lighting fixtures are operable as required by Life Safety Code and that all exits are clear of items that could cause issues with egress.The emergency lighting fixture that failed is not operable.A revised form has been put in place for documenting the testing of the emergency lighting fixtures as required by Life Safety Code. Staff has been trained on the use of the form.The south and northwest exit ramps that were covered by ice and snow are now clear of ice and snow. A new procedure for cleaning ice and snow from exit ramps has been put on place and staff has been trained on the need for all exits to be clear of items that could cause clients to not be able to evacuate in a safe manner.Monitoring: The monitoring of the emergency lighting fixture testing system will be done by the Residential Coordinator through the receipt of the monthly fire extinguisher/emergency light check form. The coordinator will monitor the form to make sure that all applicable testing has been done per regulation.Monitoring: The monitoring of the exit ramps will be done via the monthly supervised group living observations done by the QDDP and the Residential Coordinator.</p>	01/09/2014			

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	<p>not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of facility fire safety inspection and test records with the Qualified Mental Retardation Professional (QMRP) on 12/12/13 at 2:45 p.m., there was no record of a monthly 30 second functional test and an annual 1 1/2 hour test of the two battery powered interior emergency lighting fixtures. The QMRP acknowledged at the time of record review, there was no record of testing the fixtures.</p> <p>3. Based on observation and interview, the facility failed to maintain a clear path of travel for 2 of 3 exits to evacuate clients to an area of refuge. LSC 7.1.6.4 requires walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Qualified</p>		<p>This monitoring will be done on an on-going basis every month starting in January 2014. Persons responsible: Michel Thompson, Residential Coordinator Jan Adair, Residential Manger</p>				

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	Mental Retardation Professional (QMRP) on 12/12/2013 between 2:00 p.m. and 2:50, the south and northwest exit discharge ramps were covered with a layer of ice and snow. The QMRP acknowledged at the time of observations, the surface obstructions could interfere with exiting.			

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K01S018	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 1 of 6 sleeping room doors was not prevented from closing. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation and interview with the Qualified Mental Retardation Professional (QMRP) on 12/12/13 at 2:15 p.m., the northwest sleeping room door failed to self close when items hanging from the door knob caught between the door and door frame leaving a one inch gap. The QMRP acknowledged at the time of observation, the door was prevented from closing.</p>	K01S018	KS018Peak Community Services through the IDT ensures that doors are provided with latches or other mechanisms suitable for keeping the doors closed and that no doors are arranged to prevent the occupant from closing the door. The northwest sleeping door that failed to self close when tested has now been shown to self close. The item that was hanging on the door that prevented the door from self closing has been removed. Staff has been trained on the need for all doors to be free of objects that would prevent it from self closing as required by the life safety code. Monitoring: The monitoring of the self-closing doors will be via the monthly supervised group living observations done by the QDDP and the Residential Coordinator. The observation will be that all doors are free of material that would cause the door not to self close as required	01/09/2014			

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			by Life Safety Code regulations. This monitoring will be done on an on-going basis every month starting in January 2014. Persons responsible: Michel Thompson, Residential Coordinator Jan Adair, Residential Manger		