

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST 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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 02	<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: 01/07/16</p> <p>Facility Number: 001218 Provider Number: 15G641 AIM Number: 100235390</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 32, New Residential Board and Care Occupancies.</p> <p>This one story facility was sprinklered. This facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of six and had a census of six at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K 0000		
------------------------	--	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST 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
K S051 Bldg. 02	<p>Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.4.</p> <p>Quality Review completed 01/12/16 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6. 32.2.3.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 9.6.1.4 requires fire alarm systems to be maintained in accordance with NFPA 72. This deficient practice could affect all clients, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Fire Alarm Inspection reports on 01/07/16 at 2:05 p.m. with the House Manager, the last fire alarm inspection done on 01/20/15 indicated in the comments section the batteries had failed a load test and expired their manufacturer's date code and the control panel multi plex failed. A fire alarm test was conducted at the time of inspection and the alarm worked</p>	K S051	<p>Peak Community Services will ensure battery % of charge and battery age checks are completed and fall within range date. Maintenance has replaced the batteries and will maintain this service. Systemically: Fire Extinguisher and Battery Check Forms have been updated from previous surveys. These forms are to be completed on a monthly basis. Also, this issue will be covered at two group home meetings per year in each Peak Community Service Group Home. It will be documented in the minutes. The Residential Manager in Logansport and the Director of Residential and Day Services in Winamac will monitor the minutes for these trainings. Persons Responsible: Ray Aldridge, Facilities Manager Crystal Doss, House Coordinator John Armstrong, QIDP Heather DeWitt, Residential Manager Stephanie Hoffman, Director of Residential and Day Services, Winamac</p>	02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G641	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016
NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1711 TREEN ST LOGANSPOET, 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	
	properly. Based on interview concurrent with record review of the fire alarm report with the House Manager, it was acknowledged the aforementioned items had not been addressed since the last fire alarm inspection.				