

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  12/02/2014
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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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(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
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: 12/02/2014</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 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 7 at the</p>	K010000		

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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K010130	<p>time of this survey.</p> <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 Dennis Austill, Life Safety Code Specialist on 12/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Based on observation and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals 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. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K010130	A form has been created for 30 day periodic testing performed weekly to assess emergency battery fixtures. Written records of visual inspections and tests shall be kept.	12/31/2014			

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K01S051	<p>Based on review of the Emergency Light Check Form with the qualified developmental disability professional ( QDDP) on 12/02/14 at 12:40 p.m., no entry for testing the battery operated emergency light fixture was documented since 08/02/14. In addition the testing form did not identify the location for each fixture and note whether they passed or failed the test. The QDDP confirmed the record did not note testing for each device, rather a check mark was used to indicate both fixtures were checked. The QDDP acknowledged at the time of record review there was no documentation of testing since August of 2014.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with Section 9.6. LSC 9.6.1.4 requires that all</p>	K01S051	If a defect or malfunction is not corrected at the conclusion of the system inspection, testing or maintenance, the systems owner or designated representative shall	12/31/2014

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K01S147	<p>facilities maintain the fire alarm system in accordance with National Fire Protection Association (NFPA) 72, the National Fire Alarm Code. NFPA 72, at 7.1.1.2, System defects and malfunctions shall be corrected. If a defect or malfunction is not corrected at the conclusion of system inspection, testing or maintenance, the system's owner or designated representative shall be informed of the impairment within 24 hours. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the annual fire alarm inspection report dated 10/24/14 with the qualified developmental disability professional (QDDP) on 12/02/14 at 12:50 p.m., a back up battery for the fire alarm control panel failed the test. The contractor recommended replacing it. The QDDP said the battery had not been replaced yet.</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</p>		be informed of the impairment within 24 hours.A backup battery was replaced for the fire alarm control panel.	

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	<p>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 ensure a plan for protecting 7 of 7 clients in the event of fire. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Evacuation Plan with the qualified developmental disability professional (QDDP) on 12/02/14 at 12:45 p.m., the plan did not include a response to the activation of battery powered smoke detectors located in resident rooms. The plan relied on the activation of the fire alarm for staff response. The QDDP acknowledged at the time of record review, the battery powered smoke detectors were not connected to the fire alarm system. She also confirmed there had been no special training for a response to a battery smoke detector alarm activation.</p>	K01S147	Copies of the fire evacuation plans will be kept at the office as well as in the home. Fire alarm evacuation procedures are practiced regularly and will be evidenced by regular fire drills.	12/31/2014