STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G620	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PEAK COMMUNITY SERVICES INC	1625 HIGH ST LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. Dates of Survey: 12/6, 12/7, 12/8, 12/12, and 12/13/2022. Facility Number: 001168 Provider Number: 15G620 AIM Number: 100235360 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 12/20/22.	W 0000		
W 0104 Bldg. 00	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 for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the governing body failed to exercise operating direction over the facility to ensure the facility completed maintenance and repair of the group home for clients #1, #2, #3, #4, #5, and #6. Findings include: During observations at the group home on 12/6/2022 from 3:45pm until 5:40pm and on 12/7/2022 from 5:50am until 7:57am, clients #1, #2, #3, #4, #5, and #6 were observed at the group home. During the observation periods, the following maintenance and repairs were identified:	W 0104	Peak Community Services will exercise general policy, budget and operating direction over the facility by completing maintenance and repair of its group homes. Regarding the "gouges" in the dining room table, Peak's maintenance department will install a temporary table and sand and refinish the existing dining room table within 7 weeks. Regarding the Maytag dishwasher, parts have been ordered as of 12/27/22, and Peak is awaiting their arrival and installation. Peak has been given no arrival date for	01/31/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
kim english	director of support and quality assurance	01/06/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	-The wooden eight feet long by three feet wide dining room table had the wood finish worn off exposing the wood grain and gouges into the wood. On 12/6/2022 at 4:00pm, client #2 and DSP (Direct Support Professional) #3 both indicated the dining room table wood finish was worn. At 4:00pm, client #2 stated, "See the ripples" in the wood on the table top. -The facility's dish washer was broken and unable to be used. On 12/6/2022 at 4:00pm, the Assistant Director of Residential Supports (ADRS) stated, "The dish washer has been broken for several months and the parts have been backordered." -The light fixture over the kitchen sink was secured with duct tape. Wires hung down near the sink where running water was collected to wash dishes. -The bathroom towel rack was missing from the wall beside the sink. -The tile floor between the medication room and the laundry area was missing sections of tile that were one foot long by eight inches wide and exposed the wooden floor underneath. At 4:35pm, the ADRS stated, "It (the exposed area of tile) has jagged edges from the missing tile being torn away." -At 4:35pm, the ADRS looked at the damaged tiled floor areas between the hallway and the dining room with the surveyor. The ADRS indicated the area of damaged tile between the hallway and the dining room was four feet long by one inch wide. The ADRS looked at the damaged tiled floor area between the dining room and the living room with the surveyor. The ADRS indicated the area of		the parts. The light fixture over the kitchen sink has been secured by cable ties and there are no exposed wires. The low voltage cabinet light has a shielded cable and no exposed wires. This task has been completed. The bathroom towel rack that had been ripped down by a client has been replaced with hooks for towels to be hung on. This task has been completed. Regarding the two areas of worn flooring, one in the medication room and the laundry area and the other in the hallway and dining room, flooring has been purchased for both of these areas. The completion of installation will be performed by 1/31/23. The client who had removed her closet door has now had it reinstalled. Peak Community Services staff should submit maintenance tickets with Peak's online system Service Engine where tasks will be assigned to maintenance staff and completed within 14 business days barring whether parts have arrived. Some maintenance tasks must be delayed because of delayed parts. If Peak staff have not received communication from the maintenance manager within 14 days, Peak staff submit another maintenance request regarding the issue. Peak staff mark on the	

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	damaged tile between the dining room and the living room was eight feet long by one inch wide. The ADRS stated, "The tiled floor between the hallway and the dining room and the second area between the dining room and the living room had jagged damage to the tiled floors." -Client #3's closet inside her private bedroom was missing a closet door. On 12/6/2022 at 4:00pm, client #3 indicated she did not have a closet door and she was unsure when her door was removed. On 12/12/22 at 8:30am, a review of the facility's undated "Maintenance Open Requests '22 (2022)" was conducted. The document included the following open maintenance and repairs for the group home: "In Progress: Dish Washer 7/26/22, Bathroom Towel Railing 12/3/22, and Floor tile missing 10/19/22." No additional documentation was available for review. On 12/13/2022 at 3:00pm, an interview was conducted with the Director of Supports and Quality Assurance (DSQA), the Assistant Director of Residential Supports (ADRS), and the Registered Nurse (RN). The DSQA indicated there were pending maintenance work yet to be completed for the group home. 9-3-1(a)		ticket whether it is a safety issue and any high priority maintenance tasks become first in line of order. When Peak managers, directors, nurses, and QDDPs complete weekly site inspections, assessments, and observations, they note whether the maintenance tasks have been completed and if not they submit an additional ticket unless communication has been provided as to why the task has not been completed. Peak Community Services managers, QDDPs, directors and nurses will continue to re-submit maintenance tickets for low priority items until they are completed and ensure high priority items are completed as soon as possible.	
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 sampled clients (client #1), the facility failed to	W 0210	Within 30 days of admission, Peak Community Services will	01/06/2023

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	complete client #1's assessments within 30 days of admission to the facility. Findings include: Client #1's record was reviewed on 12/9/2022 at 10:10am. Client #1's 7/1/2022 ISP (Individual Support Plan) indicated she was admitted to the facility on 6/24/2022. Client #1's dental assessment was completed on 8/10/2022. Client #1's hearing evaluation with auditory tones was completed on 10/3/2022. Client #1's record did not indicate a completed assessment for her vision. Client #1's dental, hearing, and vision evaluations were not completed within 30 days of admission to the facility. On 12/13/2022 at 3:00pm, an interview was conducted with the Director of Supports and Quality Assurance (DSQA), the Assistant Director of Residential Supports (ADRS), and the Registered Nurse (RN). The DSQA indicated it was the agency's policy to have clients who were new admissions to the group home to be evaluated by a provider within 30 days of admission. The DSQA and the RN both indicated client #1's evaluations were not completed within 30 days of admission to the facility. The DSQA indicated the agency had problems having client #1 evaluated by local providers within 30 days of admission. The DSQA stated, "We scheduled the first available appointment" for client #1 to be evaluated for her vision, hearing, and dental needs. 9-3-4(a)		perform accurate assessments for new clients who are admitted. Peak Community Services admitted client on 6/24/22. She was established with a primary care physician within 3 days of admission. Her annual physical was performed by her primary care physician on 7/11/22 where Peak's annual vision test is performed. Vision is clearly marked as "normal" on the client's annual physical form. Peak fulfilled the vision requirement within 30 days of admission. Peak Community Services will do its best to schedule appointments for auditory examinations and dental visits for new clients within 30 days of admission. Peak Community Services is sometimes at the mercy of providers and/or lack of providers but will continually seek new providers to be able to fulfill the client's dental and auditory examinations within the 30 day window. The Director of Support and Quality Assurance will schedule these appointments to ensure compliance of necessary assessments within 30 days of admission for new clients. Peak's agency registered nurse will request the dates of these appointments for her initial assessment to ensure the appointments have been scheduled. If appointments must	

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			be cancelled due to provider issues, these rescheduled appointments and the reasons why they were rescheduled outside of the 30 day time limit will be noted on the nursing assessment.	
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview for 1 of 12 medications administered during the morning medication administration (client #5), the facility failed to remove medication containers without labels from the pharmacy from client use. Findings include: On 12/7/2022 at 6:35am, DSP (Direct Support Professional) #4 selected then handed client #5 a 8.4 ounce container of Eucerin cream. DSP #4 indicated client #5's medication container had a pharmacy label and the print on the label was unable to be read. DSP #4 indicated the client's name, name of the medication, the amount of medication to be used, and directions for its use was not able to be read. DSP #4 indicated the facility followed Core A/Core B medication administration training and the staff should ensure each container had a pharmacy label which identified the client name, name of medication, amount of medication, and directions for its use. DSP #4 asked client #5 to apply the unlabeled Eucerin cream to her hands and arms and client #5 applied the unlabeled Eucerin cream.	W 0391	Peak Community Services will remove any drug containers with worn, illegible or missing labels for client use. Peak Community Services trains its staff to compare a medication's label and medication administration records to ensure they match before medication administration as per Med Cores A & B. Peak Community Services staff will continue to be trained to read a client's name, the name of the medication, amount of medication, and directions for its use. Any medication not fulfilling these labeling requirements will be removed from the home by nurses, managers, QDDPs, and directors during weekly site inspections and observations. When medications arrive to Peak Community Services, Peak staff notify the client's team by sending a report to Peak Reporting, so Peak staff know exactly where the medication is, how it will be sent	01/06/2023

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	Client #5's record was reviewed on 12/7/2022 at 10:00am. Client #5's 12/2022 MAR (Medication Administration Record) and 11/30/2022 physician's order both indicated "Eucerin Original Healing Cream (for dry skin), apply to body twice a day." On 12/7/2022 at 10:00am, a review of the 2004 "Living in the Community" medication administration training manual, Core A/Core B Lesson 2: Responsibilities in the Area of Medication Administration indicated medication containers should be labeled to identify the client name and directions for use. The policy and procedure indicated medication containers without labels and/or illegible labels should be removed from use. On 12/7/2022 at 10:00am, the facility's 10/2022 policy and procedure for "Medication Administration" indicated each medication should be labeled with the client's name and directions for it's use. On 12/7/2022 at 10:20am, an interview was conducted with the Registered Nurse (RN). The RN indicated each prescribed medication should have a pharmacy label to identify the name of the client, name of the medication, and the directions for the medication use. The RN indicated the facility followed the Core A/Core B medication training for medication administration and the facility's policy and procedure for medication administration. The RN indicated if the medication was not able to be read to compare the medication label to the MAR, the medication should be removed from use and the nurse contacted. The RN indicated she had not been contacted regarding client #5's labeled but not legible Eucerin cream medication. The RN		to the home, and ensure someone is designated to change an administration record if needed and also whether the label is correct. Peak direct support professionals who notice a label that is unable to be read should send a health concern to Peak Reporting and remove the medication from the client's medication basket. Peak's nurses, managers, QDDPs and directors would then ensure the medication is replaced immediately with a label that has the client's name, the name of the medication, the amount of the medication, and the directions for its use. When direct support professionals compare the medication administration record to the label, they should report any discrepancies in a timely manner, so actions will be taken by nurses, managers, directors, and QDDPs.	

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	indicated the facility staff did not follow the training to ensure client #5's medication matched her MAR. The RN stated, "I would consider that to be a medication error. The staff did not follow the proper procedure to administer the medication." 9-3-6(a)			