STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G620	A. BUILDING -- B. WING	06/09/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 06/09/25 Facility Number: 001168 Provider Number: 15G620 AIM Number: 100235360 At this Emergency Preparedness survey, Peak Community Services Inc was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. At the time of the survey, the census was 6. Quality Review completed on 06/13/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 06/09/25 Facility Number: 001168 Provider Number: 15G620 AIM Number: 100235360 At this Life Safety Code survey, Peak Community Services Inc was found not in compliance with Requirements for Participation in Medicaid, 42	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brad Williams	Quality Director	06/24/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G620	A. BUILDING 01 B. WING	06/09/2025

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

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	CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story facility was not sprinkled. The facility has a fire alarm system with smoke detection in the corridors common living areas, and hard-wired smoke detectors in client sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the time of this survey. 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 0.42. Quality Review completed on 06/13/25			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 33.2.3.4.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices	K S345	All fire alarm visual inspections will be conducted and documented as required. Completed inspection documentation will be sent to the Director of Residential Services and Senior Director of Human Resources to ensure compliance and administrative oversight. All completed documentation will be maintained at the 1416 Woodlawn location as well as the 1625 High St. location. See attached Semi-Annual Fire Alarm and Signaling Inspection.	06/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G620	A. BUILDING 01 B. WING	06/09/2025

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

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	This deficient practice could affect all clients and staff in the home. Findings include: Based record review with the Senior Director of Human Resources (SDHR) on 06/09/25 at 9:25 a.m., documentation could not be provided regarding a visual semi-annual fire alarm system inspection. Based on interview on 06/09/25 at 9:27 a.m., the SDHR agreed that the documentation of a visual semi-annually inspection of the fire-alarm system was not available for review at the time of this survey adding that she would bring this deficiency to the attention of the Maintenance Director.			