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	08/10/2021

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: 08/10/21 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 08/17/21	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: 08/10/21 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

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	08/10/2021

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 0.24. Quality Review completed on 08/17/21			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility	K S363	Door #3 will be adjusted so it	09/03/2021

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	failed to ensure 1 of 6 clients sleeping rooms were provided with a door which would self-close and latch securely in the door frame. This deficient practice could affect 1 of 6 clients. Findings include: Based on observation during a tour of the facility with the Director of Supervised Group Living on 09/10/21 at 12:18 p.m., the client sleeping room door identified as sleeping room #3 did not latch into the frame when closed and tested on three separate occasions. Based on interview at the time of the observation, the Director of Supervised Group Living stated that she would have a work order filled-out and the door fixed immediately. During the exit conference with the Director of Supervised Group Living at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.		latches and closes securely in the frame. The Director of Residential Services submitted a maintenance ticket through Peak Community Services online system. The Facilities Services Manager obtained a new latch for the door and will install it. The Residential Manager and Residential Director will monitor all bedroom doors to ensure compliance and that doors are closing and latching securely. Problems with door closures will be immediately reported to the Facilities Manager for repair.	