

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
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NAME OF PROVIDER OR SUPPLIER PUTNAM COUNTY COMPREHENSIVE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 BLOOMINGTON GREENCASTLE, IN 46135
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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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: December 2, 3, 4, 5, 8, 9, 2014</p> <p>Provider Number: 15G274 Aims Number: 100234880 Facility Number: 000794</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 12/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed for 1 of 3 sample clients (client #3) to ensure client #3 had an annual dental visit.</p> <p>Findings include:</p> <p>The record of client #3 was reviewed on 12/8/14 at 10:44a.m. Client #3's most</p>	W000352	Client #3's dental exam was completed on December 15, 2014(see document entitled "Client #3's Dental Appointment Form"). The facility's Residential House Manager has reviewed all 5 other client's files and has found no other consumer that is deficient per the state standard. The Residential House Manager, in unison with the Residential	12/15/2014

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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	<p>recent documented dental visit was on 10/3/13.</p> <p>Staff #1 was interviewed on 12/8/14 at 11:18a.m. Staff #1 indicated client #3 had not had a dental exam since the 10/3/13 exam. Staff #1 indicated client #3 was past due for her annual dental exam.</p> <p>9-3-6(a)</p>		<p>Nurse, will perform quarterlyreviews of all consumer medical files to discuss future dental appointments, aswell as routine medical appointments and specialist appointments that willhappen or should be scheduled within the following quarter.</p>		