STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

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W 0000 Bldg. 00	This visit was for a full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00267443. Complaint #IN00267443 - Substantiated. No deficiencies related to the allegation were cited. Survey Dates: June 3, 4, 5 and 6, 2019. Facility Number: 000678 Provider Number: 15G141 AIM Number: 100234430 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed June 14, 2019 by #15068 and #09182.	W 0000		
W 0126 Bldg. 00	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure the rights of the clients by failing to teach the clients to manage their financial affairs to the extent of their capabilities. Findings include: On 6/3/19 at 2:08 PM, a review of the clients' finances (checking accounts) was conducted for	W 0126	For clients A, B, C, D, E, and F, QIDP completed financial re-assessments to re-assess their financial capabilities. The assessments determined that each individual had varying levels of ability in handling of personal finances. All six re-assessments show that they are unable to manage their finances independently at this time. After	07/06/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	06/06/2019

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	March, April and May 2019. During this timeframe, clients A, B, C, D, E and F did not write out their own checks. The Billing Specialist wrote out and signed each check written. The Billing Specialist wrote out checks for the clients out of their personal accounts in March, April and May 2019 the following amount of times: -Client A: 10 -Client B: 10 -Client C: 10 -Client D: 12 -Client E: 14 -Client F: 11 On 6/4/19 at 10:19 AM, a review of client A's record was conducted. Client A's 3/7/19 Individual Program Plan (IPP) indicated in the Finance section, "...[Client A] is unable to balance a checkbook, write a check or deposit slips without assistance...." The Recommendations section of the IPP indicated, "...[Client A] needs to continue to receive programming designed to increase his money management skills, particularly through routine transactions in the community at stores, restaurants, etc...." The IPP Financial section indicated, "...[Client A] has established a checking account. His spending money will be kept at [name of group home]. He will have no more than $1.00 in his wallet at one time due the possibility of abuse identified herein. He and administrative staff will be the only ones allowed to draw money from his checking account for his needs or wants...." On 6/4/19 at 10:46 AM, a review of client B's record was conducted. Client B's 2/7/19 IPP indicated, "...[Client B] will continue to receive both formal and informal training in all area of		the re-assessment, QIDP has created and implemented new financial goals with various levels so that they become familiar with managing a personal checking account (See attachment 1). As they advance with their capabilities, their goals will be revised to match their capabilities. Per conversation during survey regarding access and signers on their individual checking accounts, PCCS has done some further investigation through Social Security and their financial institution. Results of findings include that the Representative Payee publication from SSA (see attachment 2) states that the beneficiary must never have direct access to the account. Furthermore, contact with the financial institution legal department states that an individual that has a representative payee for Social Security or other federal benefits should not be a signer who can access funds per Federal law (see attachment 3). PCCS recognizes that some of its consumers may have additional funds that are not Federal in nature such as sheltered workshop income or community employment in which all six consumers receive bi-weekly spending money for discretionary purposes. The degree of access an individual's funds is based on their abilities to handle those	

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	money management including making change for small purchases and budgeting for needs rather than wants...." The IPP indicated, "He does not understand the concept of banking, budgeting, or check writing. [Client B] needs assistance with all areas of money management...." On 6/4/19 at 11:09 AM, a review of client C's record was conducted. Client C's 1/10/19 IPP indicated, "...Furthermore, [client C] is unable to make change, understand the cost of an item, or maintain a checkbook...." On 6/5/19 at 3:42 PM, a focused review of client D's record was conducted. Client D's 10/4/18 IPP indicated, "...[Client D] continues to receive training to increase his money management skills. Training areas should include maintaining all steps of a checkbook, weekly and monthly budgeting, comparing prices while shopping, etc...." In the Disposition of Recommendations section, the plan indicated, "...[Client D] will continue to receive training to increase his money management skills. Training areas should include maintaining all steps of a checkbook, weekly and monthly budgeting, comparing prices while shopping, etc...." On 6/5/19 at 3:56 PM, a focused review of client E's record was conducted. Client E's 3/7/19 IPP indicated, "...He needs complete assistance to manage his bank account (making deposits, keeping his checkbook, etc.) because he does not read or write very well... He will also maintain a checking account that will be kept at Putnam County Comprehensive Services, Inc...." On 6/5/19 at 4:00 PM, a focused review of client F's record was conducted. Client F's 3/7/19 IPP indicated, "...He needs assistance to manage his		monies, even if it were too involved opening an additional checking account to keep any federal funds separate from additional income. The representative payee or designated staff member will meet with each client monthly to review their bank statements, answer any questions the client has, and have the client sign their bank statement as outlined in the revised social security payee responsibility policy (see attachment 12 and 14). In order to ensure that the deficient practice does not recur, a banking procedure policy and social security payee responsibilities policy has been revised (see attachment 4 and 12). QIDP will re-assess financial capabilities annually or sooner if the need arises. In order to monitor that corrective actions are taking place, QIDP will monitor new financial goals monthly within the QIDP monthly report and revise goals as needed. The representative payee designee will keep copies of the signed bank statements.	

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	15G141	A. BUILDING 00 B. WING	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

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	bank account (making deposits, keeping his checkbook, etc.)...." The IPP indicated, "...[Client F] continues to participate in programming to increase his money management skills. Training in areas should include all areas of a checkbook, budgeting monthly and weekly expenses...." On 6/4/19 at 11:40 AM, the Qualified Intellectual Disabilities Professional indicated the clients should be signing and/or writing out their own checks. On 6/5/19 at 2:02 PM, the Residential Director (RD) indicated based on a social security audit, if the facility was the representative payee for the clients, the clients could not have direct access to their accounts. The RD indicated the facility was rep payee for clients A, B, C, D, E and F. The RD indicated if the clients had direct access (writing checks) then they would not need a rep payee. On 6/5/19 at 2:22 PM, the Billing Specialist (BS) indicated the clients could not have direct access to their accounts based on a social security audit. The BS indicated the facility was the rep payee for clients A, B, C, D, E and F. The BS indicated the clients have ownership of their accounts but they could not have direct access. The BS indicated since the facility was the rep payee, the facility was indicating the clients did not have the ability to handle their own finances. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 12 of 47	W 0149	After review it was determined that	07/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	incident/investigative reports reviewed affecting clients A, B, C, D and E, the facility failed to implement its policies and procedures to prevent client to client aggression, verbal abuse of client D by a staff and conduct a thorough investigation of a significant medication error. Findings include: On 6/3/19 at 1:51 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 1/17/19 to 3/12/19, client D received the wrong dose of his medication. The 3/12/19 BDDS report indicated, "...[Client D] was receiving the wrong dosage of the medication Celebrex which was originally prescribed on 1/17/2019. After reviewing [client D's] chart, it was determined that [client D] was receiving 200 mg Celebrex instead of 50 mg. After speaking with [name of pharmacy], they admitted fault to this error and noted that they would be filing a report with state regarding their error. No adverse reactions have been reported or observed...." There was no documentation the facility conducted an investigation. On 6/5/19 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there was no formal investigation conducted. The QIDP indicated although the facility investigated the situation to figure out how the medication error occurred, there was no documentation of an investigation. The QIDP indicated an investigation should have been completed. On 6/5/19 at 1:27 PM, the Home Manager (HM) indicated she and the nurse discovered the error.		all six clients (A, B, C D, E, and F) had the potential of being affected. PCCS has now developed a procedure to investigate medication errors and developed a medication error investigation form to ensure that PCCS is thoroughly investigating all medication errors that occur (See attachment 5). This form was implemented on 6/24/2019. Director of Residential Services has retrained QIDP, Residential House Manager, and Skills Trainer on how to properly enter medications in the Medication Administration Record (see attachment 6). On 6/24/2019, a staff in service was held to provide training/retraining to staff members (see attachments 7). At the staff in service, the behavior consultant and Assistant Executive Director completed training with staff members regarding strategies to prevent client-to-client aggression and re-training on behavior support plans specifically on the pro-active strategies. In addition, staff members were retrained on the protection of individual rights and individual abuse/ neglect/mistreatment policy (signed copies by each employee is available upon request) In order to ensure that the deficient practice does not recur, QIDP and Skills trainer will complete random monthly observations. In addition, the staff	

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	The HM indicated the order was sent from the physician to the pharmacy correctly. The pharmacy incorrectly filled the medication as 200 mg instead of 50 mg. The HM indicated the pharmacy accepted responsibility for the error. The HM indicated there should have been an investigation conducted. 2) On 5/21/19 at 8:10 AM, client D kicked client E two times while client E was getting into the van. Client E was not injured. 3) On 5/1/19 at 3:15 PM, client C smacked client A on the buttocks. Client A was not injured. 4) On 4/9/19 at 8:00 AM, client D was verbally abused by staff #12. Prior to the allegation, staff #12 was attempting to get client D out of bed. Staff #4 reported she heard staff #12 say, "You are laying in pee, stop being a lazy a-- and get up." The 4/11/19 Conclusion of the Follow-up on Incident/Investigation indicated, "QIDP/Qualified Intellectual Disabilities Professional completed a thorough investigation into the incident and the outcome of the investigation was substantiated. It was determined that [staff #12] did likely make the statement, as both [staff #4 and client D] had similar statements in what occurred; however, after interviewing staff and clients it was not determined that [staff #12] made the statement in a loud or degrading manner towards [client D]... [Staff #12] was placed on 90 days probation with the parameters being that [staff #12] cannot have any infraction regarding client rights or it will result in termination of employment." 5) On 2/27/19 at 7:26 PM, client C punched client B in the back. Client B was not injured. 6) On 1/28/19 at 3:15 PM, client A grabbed client		member that was involved in the verbal abuse incident with Client D is no longer employed with PCCS. In order to monitor that the corrective actions are taking place, QIDP and the Skills trainer will complete monthly random unannounced staff observations. QIDP will send observations completed to the Director of Residential Services and the skills trainer will send completed observations to QIDP. QIDP will also send all completed medication error investigations and outcomes to the Director of Residential Services for review.	

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	15G141	A. BUILDING 00 B. WING	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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C's hand. Client C screamed for staff. Client A squeezed client C's hand harder. Client A let go when staff approached the clients. Client C's hand had no signs of injury.

7) On 1/24/19 at 2:15 PM at the facility operated workshop, client A hit client C with a piece of paper. Client A, when prompted to stop, grabbed client C around the neck from behind. Client A let go and ran at staff. Client C did not have injuries noted following the incident.

8) On 12/27/18 at 2:45 PM, client D hit a peer on the left side of the face with his lunchbox. The peer's face and neck were red following the incident.

9) On 10/14/18 at 12:45 PM at the facility operated day program, client D playfully poked client B on his cheek. Client B stood up, yelled and slapped client D on his arms. Client D grabbed client B's neck with his left arm and held onto client B with his other arm. Client B had red marks on his neck following the incident. Client D had a scrape on his left wrist.

10) On 9/20/18 and 3:30 PM, client C hit client A on the arm. Client A was not injured.

11) On 8/5/18 at 6:30 PM, client D hit client C on the arm. Client C was not injured.

12) On 7/20/18 at 3:20 PM, client C hit client A on the leg. Client C hit client E on the buttocks. Clients A and E were not injured.

On 6/4/19 at 10:05 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she spoke to the staff about client to client aggression and how to prevent it on a monthly basis. The

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	15G141	A. BUILDING 00 B. WING	06/06/2019

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	QIDP indicated the staff should prevent client to client aggression. The QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. On 6/4/19 at 10:05 AM, the Residential Manager (RM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The RM indicated the facility had a policy and procedure prohibiting abuse of the clients. On 6/4/19 at 10:06 AM, the Home Manager (HM) stated the staff needed to be "more vigilant." The HM indicated the staff needed additional training on preventing client to client aggression by the behavior specialist. The HM indicated the staff discussed client to client aggression at their monthly meetings. On 6/3/19 at 1:19 PM, a review was conducted of the facility's January 2006 Individual Abuse and Neglect/Mistreatment Policy. The policy indicated the following, "PCCS (Putnam County Comprehensive Services) shall prohibit any form of mistreatment, neglect or abuse, including physical, verbal, mental or sexual abuse. Any form of abuse, including but not limited to humiliation, harassment and threats of punishment or deprivation will not be tolerated." The policy indicated, "Any reports of such mistreatments, abuse or neglect shall be thoroughly investigated by the Investigation Committee, reviewed by the Executive Director and reported to the Human Rights Committee." The policy indicated, "Physical abuse includes, but not limited to, any physical motion or action, i.e., slapping, punching, kicking, pinching, by which intentional bodily harm or trauma occurs. It include the use of corporal punishment as well as the use of any restrictive, intrusive procedure to			

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	15G141	A. BUILDING 00 B. WING	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

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	control challenging behaviors for purpose of punishment. Physical abuse also occurs when too much intentional force is used during restraint procedures." The January 2006 Abuse and Neglect policy indicated, "To insure that battery, neglect or exploitation of clients by staff members, other clientele or others will not be tolerated, all alleged incidents will be immediately and thoroughly investigated...." 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 47 incident reports reviewed affecting client D, the facility failed to conduct a thorough investigation of client D's medication errors. Findings include: On 6/3/19 at 1:51 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/17/19 to 3/12/19, client D received the wrong dose of his medication. The 3/12/19 BDDS report indicated, "...[Client D] was receiving the wrong dosage of the medication Celebrex (non-steroidal anti-inflammatory) which was originally prescribed on 1/17/2019. After reviewing [client D's] chart, it was determined that [client D] was receiving 200 mg Celebrex instead of 50 mg. After speaking with [name of pharmacy], they admitted fault to this error and noted that they would be filing a report with state regarding their error. No adverse reactions have been reported or observed...."	W 0154	For client D, PCCS had investigated the alleged violation; however, it was not documented. PCCS has developed a procedure to investigate medication errors and developed a medication error investigation form to ensure that PCCS is thoroughly investigating all medication errors that occur (See attachment 5). This form was implemented on 6/24/2019. Director of Residential Services has retrained QIDP, Residential House Manager, and Skills Trainer on how to properly enter medications in the Medication Administration Record (see attachment 6). All other clients within the home had a medication audit completed comparing all doctors orders to the medication administration record to ensure all orders match and no other deficiency were	07/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

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	There was no documentation the facility conducted an investigation. On 6/5/19 at 1:27 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there was no formal investigation conducted. The QIDP indicated although the facility investigated the situation to figure out how the medication error occurred, there was no documentation of an investigation. The QIDP indicated an investigation should have been completed. On 6/5/19 at 1:27 PM, the Home Manager (HM) indicated she and the nurse discovered the error. The HM indicated the order was sent from the physician to the pharmacy correctly. The pharmacy incorrectly filled the medication as 200 mg instead of 50 mg. The HM indicated the pharmacy accepted responsibility for the error. The HM indicated there should have been an investigation conducted. 9-3-2(a)		located (See attachment 11). In order to ensure that the deficient practice does not recur, only the director of residential services, QIDP, Residential House manager, PCCS nurse, or Skills trainer will only be allowed to enter new medications into the Medication Administration Record. In order to monitor that corrective actions are taking place, QIDP will send completed investigations with outcomes to Director or Residential Services. Once the new medication is entered into the mediation administration record, a copy of the doctors order and medication administration record will be scanned to the PCCS nurse for review.	
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 5 of 6 clients (A, B, C, D and E), the facility failed to ensure staff administered the clients' medications as ordered. Findings include: On 6/3/19 at 1:51 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:	W 0368	After review it was determined that all six clients (A, B, C D, E, and F) had the potential of being affected. On 6/13/2019, staff members completed medication pass training with PCCS nurse, reviewing all procedures to administer medications without error (see attachment 8). In addition, Residential house manager has completed	07/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

(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
	1) On 5/28/19, 5/29/19 and 5/30/19 at 12:00 PM, client D did not receive Tobramycin (antibiotic) 0.3% eye drops. 2) On 5/20/19 at 3:52 PM, staff found a Metformin (diabetes) 850 milligram (mg) tablet in the top of the medication cart belonging to client B. The 5/21/19 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...It is unknown when this medication error occurred as it is unknown how long the medication had been in the medication cart...." 3) On 5/9/19 and 5/10/19 at 8:00 AM, client A did not receive two Invega (antipsychotic) 6 mg tablets as ordered. Client A received one tab each day. 4) On 4/9/19 at 8:00 AM, client E did not receive Nabumetone (anti-inflammatory) 500 mg. 5) On 4/6/19 at 8:00 AM, client B did not receive Metformin (diabetes). 6) On 3/19/19 at 8:00 AM, client B did not receive Sertraline (depression) 50 mg. 7) On 3/16/19 at 9:23 AM, the BDDS report indicated, "...an extra pill (Fenofibrate 54 mg/cholesterol) belonging to individual, [client B], was accidentally popped out of the medication card and had unable to be located. It is unknown whether [client B] received an extra dose of this medication...." 8) On 1/17/19 to 3/12/19, client D received the wrong dose of his medication. The 3/12/19 BDDS report indicated, "...[Client D] was receiving the wrong dosage of the medication Celebrex (pain) which was originally prescribed on 1/17/2019.		medication pass observations with all staff members that are trained to administer medications to ensure proper procedures are being followed (see attachment 9). Director of Residential Services has retrained QIDP, Residential House Manager, and Skills Trainer on how to properly enter medications in the Medication Administration Record (see attachment 6). In order to ensure that deficient practice does not recur, Residential House Manager will complete quarterly medication pass observations with each staff member trained to administer medications to ensure that proper medication pass procedures are being followed. In addition, only the director of residential services, QIDP, Residential House manager, PCCS nurse, or Skills trainer will only be allowed to enter new medications into the Medication Administration Record. In order to monitor that the corrective actions are taking place, Residential House Manager will send quarterly medication pass observations to QIDP and DRS for review. Once the new medication is entered into the mediation administration record, a copy of the doctors order and medication administration record will be faxed to the PCCS nurse for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	06/06/2019

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PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

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	After reviewing [client D's] chart, it was determined that [client D] was receiving 200 mg Celebrex instead of 50 mg. After speaking with [name of pharmacy], they admitted fault to this error and noted that they would be filing a report with state regarding their error. No adverse reactions have been reported or observed...." 9) On 3/8/19, 3/15/19 and 3/22/19 at 8:00 AM, client C did not receive one of the two capsules of Vitamin D3 (supplement) he was prescribed. On 6/4/19 at 9:48 AM, the Qualified Intellectual Disabilities Professional indicated the clients' medications should be administered as ordered. On 6/4/19 at 9:48 AM, the Residential Director indicated the clients' medications should be administered as ordered. On 6/4/19 at 9:15 AM, the Registered Nurse (RN) stated "Med errors are an issue." The RN indicated the clients' medications should be administered as ordered. The RN indicated the staff was retrained and she and another nurse were conducting drop in visits to ensure staff was administering the clients' medications as ordered. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 3 non-sampled clients (D), the facility failed to ensure staff administered client D's medication for GERD (gastroesophageal reflux	W 0369	For client D, PCCS has implemented the use of timers during medication pass to ensure compliance that medications are	07/06/2019

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	disease) as ordered. Findings include: On 6/3/19 from 6:18 AM to 8:29 AM, an observation was conducted at the group home. At 7:28 AM, client D received Omeprazole for GERD. The label indicated to administer the medication "30 minutes prior to breakfast." At 7:41 AM, client D started eating his breakfast. None of the staff (#7, #10 and #11) prompted client D to wait 30 minutes before eating breakfast. On 6/3/19 at 7:30 AM, a review of the medication packaging was conducted. The label on the packaging indicated to administer the medication 30 minutes before a meal. Client D's June 2019 Medication Administration Record indicated client D was to wait 30 minutes before eating breakfast. On 6/4/19 at 9:57 AM, the Home Manager indicated the staff should follow the order and encourage client D to wait 30 minutes before eating. 9-3-6(a)		administered as ordered. Staff members were trained on the use of timers during medication passes on 6/24/2019 (see attachment 7). Timers were implemented on 6/24/2019. All other client's within the home have had medication audits completed and timers have also been implemented with those additional clients that have doctors orders for a time lapse between a medication being administered and a task being completed (i.e. eating, drinking, sitting up). In order to ensure that the deficient practice does not recur, QIDP and skills trainer will be completing random monthly observations within the group home. In addition, RHM will be completing quarterly medication pass observations. In order to monitor that the corrective actions are taking place, QIDP will send monthly observations to DRS for review. Skills trainer will send monthly observations to QIDP for review. RHM will send completed medication pass observations to QIDP and DRS for review.	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 6 of 6 clients living in the group home (A, B, C, D, E and	W 0382	For clients A, B, C, D, E, and F, PCCS nurse completed a	07/06/2019

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	F), the facility failed to ensure client C's medication was locked up except when being prepared for administration. Findings include: On 6/3/19 from 6:18 AM to 8:29 AM, an observation was conducted at the group home. At 7:05 AM after client C received his medication from staff #7, staff #7 left the Levothyroxine (hormone) medication package on the table unsecured. Staff #7 left the medication area. Client C remained in the medication area. Staff #7 returned to the medication area at 7:13 AM and locked the medication in the medication cart. This affected clients A, B, C, D, E and F. On 6/3/19 at 7:13 AM, staff #7 stated the medication should be locked "at all times." On 6/4/19 at 9:48 AM, the Residential Director indicated the clients' medications should be secured at all times. On 6/4/19 at 9:48 AM, the Qualified Intellectual Disabilities Professional indicated the clients' medications should be secured at all times. 9-3-6(a)		medication pass retraining with all staff members that included securing of all medications when not being prepared for administration (see attachment 8). The staff member that failed to ensure Client C's medication was secured when not being prepared for administration received a written reprimand for the incident (see attachment 10). In order to ensure that the deficient practice does not recur, QIDP and skills trainer will be completing random monthly observations within the group home. In addition, RHM will be completing quarterly medication pass observations. In order to monitor that the corrective actions are taking place, QIDP will send monthly observations to DRS for review. Skills trainer will send monthly observations to QIDP for review. RHM will send completed medication pass observations to QIDP and DRS for review.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include:	W 0440	For clients A, B, C, D, E, and F, there were six overnight drills completed at the group home; however, they were out of the 90-day window for compliance. A 2019/2020 fire drill schedule has	07/06/2019

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	On 6/3/19 at 4:27 PM, a review of the facility's evacuation drills was conducted and indicated the following: -During the night shift (12:00 AM to 8:00 AM), there were no evacuation drills conducted from 7/14/18 to 12/17/18 and 12/19/18 to 4/25/19. This affected clients A, B, C, D, E and F. On 6/3/19 at 4:35 PM, the Home Manager indicated the facility should conduct quarterly evacuation drills. On 6/4/19 at 10:11 AM, the Residential Director indicated there should be one drill per shift per quarter. On 6/4/19 at 10:11 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated there should be one drill per shift per quarter. 9-3-7(a)		been created to provide a guideline to ensure compliance with fire drills (see attachment 13). Once a fire drill is completed, the fire drill will be reviewed by the residential house manager or designee and then scanned to the assistant executive director within 24 hours after completion of the fire drill. Staff members were retrained on completion of fire drills and proper documentation of a fire drill during a staff meeting on 6/24/2019 (see attachment 7). Management and skills trainer were retrained on the frequency of completion of drills on 6/27/2019 (see attachment 6).	