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	11/13/2020

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

(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
W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Survey Dates: November 10, 12 and 13, 2020 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 by #15068 on 11/20/20.	W 0000		
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 6 incident reports reviewed affecting client #3, the facility failed to conduct a thorough investigation of an incident of client #3 choking. Findings include: On 11/10/20 at 2:09 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: -On 9/24/20 at 6:20 PM, client #3 was eating dinner when he choked on a piece of meat. The undated Follow-Up on Incident/Investigation indicated, "On 9-24-2020 QIDP (Qualified Intellectual Disabilities Professional) was notified that individual, [client #3] had choked on	W 0154	Residential Director met with the House Manager and QIDP to discuss client #3 chocking incident on 9/24/20. Specifically addressed were the failure to conduct a thorough investigation. Discussed the importance of addressing ALL discrepancies between statements as well as including all details we can provide(in this case, type of meat) even if we need to ask follow-up questions of staff and consumers involved. All investigations must be dated. Residential Director went line by line through the investigation report with QIDP to	12/10/2020

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	11/13/2020

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

(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
	his food while eating dinner on 9-24-2020 at approximately 6:20 pm. DSP (Direct Support Professional), [staff #9] stated to ST (Skills Trainer), [staff #7] that [client #3] was choking. [Staff #7] said that he is still breathing, but his breaths did appear to be raspy. [Client #3] was trying to cough up the food that was stuck in his throat, but was not being successful with his attempt. [Staff #7] then placed her hands on [client #3's] (sic) how you would do the Heimlich. [Staff #7] completed one thrust with slight pressure since [client #3] was still breathing. [Client #3] coughed up a little bit of food up, still appeared to have more food lodged in this throat. [Staff #7] then completed another thrust with slight pressure again; nothing came up with this thrust. [Staff #7] then completed a third thrust with slight pressure. With this last thrust, [client #3] was able to cough up the remaining food that was stuck in his throat. He spit the food out of his mouth into a salad bowl that was on the table. [Client #3] never stopped breathing or lost conscious (sic) during the episode...." The investigation section "where were staff and client(s) located at the time of the incident" section indicated staff #9 was in the dining room at the time of the incident "supervising clients eating." Staff #9 indicated in her statement, "While eating dinner with consumers, I, [staff #9] observed [client #3] having trouble swallowing his food...." Client #2's statement in the investigation indicated, "I was sitting at the dinner table with [client #2]. He was shoveling food in his mouth, and got (sic) too much food in his mouth and started to choke on his food. I hollered for [staff #9] to come over and help. [Staff #9] came over and then yelled for [staff #7] to come in and help... [Staff #7] was getting [client #6's] meds back in the back and [staff #7]		identify what information should be included for each line item. QIDP was directed to re-read the policy on investigation as well as relevant regulations. Additionally, Residential Director explained the importance of conducting a review of the risk plan to determine if an update is needed as well as to determine if the plan had been followed. Training on Thorough Investigations will be provided by the previous QIDP on 12/10/2020 and consulting will be available on an as needed basis. In order to ensure a thorough investigation the QIDP will for the next 90 days, submit all the staff statements along with the Investigation to the Residential Director for review prior to submitting to Quality Assurance Director and Executive Director. The following policies and procedures were reviewed to help the new QIDP's understanding of "thorough investigation": 1. Investigation Protocol 2. Individual Abuse and Neglect 3. Incident Reporting Policy 4. Incident Reporting Admin On-Call Ongoing internal training will continue as well as external training as it becomes available (Covid limits trainings available). Residential Director will be monitoring Investigations.	

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	11/13/2020

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

(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
	was making up [client #6's] water in the kitchen with us...." The investigation section Statement of Discrepancies indicated, "N/A." The investigation was not thorough. The investigation did not indicate what client #3 choked on (steak). The investigation did not include a review of client #3's risk plan for choking. The investigation did not address the discrepancies between staff #7's statement she was in the dining room and client #2's statement indicating staff #7 was in the kitchen at the time of the incident. On 11/12/20 at 10:07 AM, a review of client #3's record was conducted. Client #3's 1/9/20 Health Related Incident Management Plan indicated, "[Client #3] in the past few years has got food lodged in his esophagus and in the past, had to go to the Emergency Room due to food sticking in (his) esophagus. It was discovered that [client #3] was not properly chewing his food before swallowing, or taking drinks as often as needed. In the past, [client #3] had an episode of choking that was significant enough to take emergency action. On 8/23/2018, [client #3] had a swallow evaluation completed at [name of hospital]. Based on the Dysphagia evaluation on 8/23/18 and the radiology report on 7/13/18 (which showed [client #3] having moderate esophageal dysmotility (when contractions in the esophagus become irregular, unsynchronized or absent, the patient is said to have esophageal dysmotility), it was recommended that [client #3] be on a mechanically soft diet with ground meats and thin liquids. It was also recommended... eat at a slow rate of intake. Plan of Action: Staff will monitor [client #3] at			

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	11/13/2020

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

(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
	mealtimes and ensure he is properly chewing his food allowing him to swallow it in a safe manner... Staff will assist in ensuring that [client #3] follows a mechanically soft diet with ground meats and thin liquids. Staff will... prompt him to eat at a slower pace. Staff will continue to prompt [client #3] to take drinks in between bites...." On 11/12/20 at 12:17 PM, the Home Manager indicated based on what she knew of the incident, she thought staff #7 was sitting next to client #3 at the time of the incident. On 11/12/20 at 12:24 PM, the Residential Director (RD) indicated based on what she knew of the incident, she thought staff #7 was right next to client #3 at the time of the incident. The RD indicated the investigation was not thorough. The RD indicated the investigation should have addressed staff #7's location at the time of the incident and why she was not monitoring client #3 at the time. The RD indicated the discrepancy between staff #7's statement and client #2's statement should have been addressed in the investigation. On 11/13/20 at 12:52 PM, the RD indicated the investigation should have included he choked on steak. The RD indicated the investigation should have included a review of his risk plan. 9-3-2(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to	W 0240	Residential Director met with QIDP to discuss the importance of	12/10/2020

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	11/13/2020

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

(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
	update his risk plan for choking following a swallow study. Findings include: On 11/10/20 at 2:09 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: -On 9/24/20 at 6:20 PM, client #3 was eating dinner when he choked on a piece of meat. The undated Follow-Up on Incident/Investigation indicated, "On 9-24-2020 QIDP (Qualified Intellectual Disabilities Professional) was notified that individual, [client #3] had choked on his food while eating dinner on 9-24-2020 at approximately 6:20 pm. DSP (Direct Support Professional), [staff #9] stated to ST (Skills Trainer), [staff #7] that [client #3] was choking. [Staff #7] said that he is still breathing, but his breaths did appear to be raspy. [Client #3] was trying to cough up the food that was stuck in his throat, but was not being successful with his attempt. [Staff #7] then placed her hands on [client #3's] (sic) how you would do the Heimlich. [Staff #7] completed one thrust with slight pressure since [client #3] was still breathing. [Client #3] coughed up a little bit of food up, still appeared to have more food lodged in this throat. [Staff #7] then completed another thrust with slight pressure again; nothing came up with this thrust. [Staff #7] then completed a third thrust with slight pressure. With this last thrust, [client #3] was able to cough up the remaining food that was stuck in his throat. He spit the food out of his mouth into a salad bowl that was on the table. [Client #3] never stopped breathing or lost conscious (sic) during the episode...." A 10/7/20 Physician Continuation Note		completing updates to Risk Management Plans immediately, as soon as the information is available. QIDP did complete a staff training document 10-7-2020 (see attached) with all the relevant information from the swallow evaluation for client 3. This was included in the staff Memo Book for all staff from all shifts to review, sign and date. She did however fail to complete an Addendum to his RMP until 11-17-2020. Staff were provided additional training on the plan on October 9, 2020, November 13, 2020 and December 4, 2020 (see attached). To further ensure client 3's RMP and dinning plan is being implemented properly all staff must send a picture of client 3's plate to RHM prior to serving him. This will continue until RHM feels all staff are able to sufficiently puree his food to the proper consistency. QIDP completed review of all five other consumers RMP and found all plans were current. No one else was affected by this oversight. PCCS is contracting with the previous QIDP to provide ongoing training for the next 6 months.	

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	11/13/2020

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

(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
	indicated in the Narrative/Recommendations section, "Pt (patient) exhibits mild-mod (moderate) oral pharyngeal dysphagia (with) risk of aspiration (with) all consistencies before/during/after swallow. 2 (degrees) (decreased) strength of swallow (and) poor oral coordination. Pt has a build up of residue in pharynx (a hollow tube that starts behind the nose, goes down the neck, and ends at the top of the trachea and esophagus) after swallow that he does not feel. Recom (recommend): Pureed with 100% supervision for all p.o. (by mouth) intake, nectar thick liquids. Meds to be crushed. Pt may be allowed occasional food that 'melts' easily (i.e. cheese puffs) or easily mashed food (i.e. bananas) (with) staff assisting (controlling bite sizes). No straws!...." A 10/7/20 Staff Memo indicated, "[Client #3] exhibits mild-moderate pharyngeal Dysphagia with risk of aspiration with all consistencies before/during/and after swallow 2-degree decrease in strength of swallow and poor overall coordination. [Client #3] has a building (sic) of residue in pharynx after swallow that he does not feel... Diet: Pureed with 100% supervision for all p.o. (by mouth) intake. Nectar thick liquids. Meds to be crushed. [Client #3] may be allowed occasional food that "melts" easily (i.e. cheese puffs) or easily mashed foods (i.e. bananas) with staff assisting and controlling bite size. [Client #3] is never (to) be left alone while eating. No straws. Thick it for all liquids. Sippy cup, no straws to be used. Small utensils to control bite sizes...." On 11/12/20 at 10:07 AM, a review of client #3's record was conducted. Client #3's 1/9/20 Health Related Incident Management Plan indicated, "[Client #3] in the past few years has			

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	11/13/2020

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

(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
	got (sic) food lodged in his esophagus and in the past, had to go to the Emergency Room due to food sticking in (his) esophagus. It was discovered that [client #3] was not properly chewing his food before swallowing, or taking drinks as often as needed. In the past, [client #3] had an episode of choking that was significant enough to take emergency action. On 8/23/2018, [client #3] had a swallow evaluation completed at [name of hospital]. Based on the Dysphagia evaluation on 8/23/18 and the radiology report on 7/13/18 (which showed [client #3] having moderate esophageal dysmotility (when contractions in the esophagus become irregular, unsynchronized or absent, the patient is said to have esophageal dysmotility), it was recommended that [client #3] be on a mechanically soft diet with ground meats and thin liquids. It was also recommended... eat at a slow rate of intake. Plan of Action: Staff will monitor [client #3] at mealtimes and ensure he is properly chewing his food allowing him to swallow it in a safe manner... Staff will assist in ensuring that [client #3] follows a mechanically soft diet with ground meats and thin liquids. Staff will... prompt him to eat at a slower pace. Staff will continue to prompt [client #3] to take drinks in between bites...." The information from the memo and Physician Continuation Note was not included in a plan for client #3. Client #3's risk plan for choking was not updated after his swallow study on 10/7/20. On 11/12/20 at 10:41 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3's risk plan for choking needed to be updated. On 11/12/20 at 10:43 AM, the Residential			

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	11/13/2020

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

(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
	Director (RD) indicated client #3's plan needed to be revised and updated to include the information from his swallow study. 9-3-4(a)			
W 0365 Bldg. 00	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 2 of 4 clients (#1 and #5) observed to receive their medications from staff #7, the facility failed to ensure staff initialed the clients' Medication Administration Records after the medication was administered. Findings include: On 11/12/20 from 6:42 AM to 9:00 AM, an observation was conducted at the group home. At 6:52 AM, staff #7 prepared client #5's Miralax (constipation). After stirring the Miralax into the water, staff #7 initialed client #5's November 2020 MAR indicating the medication was administered. The medication was not administered. At 6:52 AM, staff #7 prepared client #1's Miralax (constipation). After stirring the Miralax into the water, staff #7 initialed client #1's November 2020 MAR indicating the medication was administered. The medication was not administered. Staff #7 placed both client #1 and #5's cups on the top of the medication cart to be administered later. At 7:29 AM, the Home Manager informed staff #7 that client #5 finished his Miralax. On 11/12/20 at 6:52 AM, a review of client #1 and #5's November 2020 MARs was conducted. Staff #7 initialed the MARs indicating client #1	W 0365	The House Manager immediately trained all staff that were working in the home that the MAR is only to be initialed after administrating the medication. A full staff meeting was held on December 4 where again we reviewed the procedure for initialing the MAR. Staff 7 was given a verbal warning for signing the MAR prior to administering medication. (see attached) We have hired an individual to focus on quality of medication passes in the group homes. The individual hired has a strong professional background in Quality Assurance. This position will provide backup for passing medications when necessary as well completing new hire observations and quarterly observations of a medication passes by each staff. The candidate has been hired and is in the process of completing their training.	12/04/2020

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	11/13/2020

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

(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
	and #5's constipation medications were administered prior to the medications being administered. On 11/12/20 at 11:30 AM, the Home Manager indicated the staff should initial the MAR after the medication was administered, not before. On 11/12/20 at 11:30 AM, the Residential Director indicated the staff should initial the MAR after the medication was administered, not before. 9-3-6(a)			
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 2 of 4 clients (#1 and #5) observed to receive their medications from staff #7, the facility failed to ensure staff secured the clients' medications at all times. Findings include: On 11/12/20 from 6:42 AM to 9:00 AM, an observation was conducted at the group home. At 6:52 AM, staff #7 prepared client #1, #3 and #5's Miralax (constipation) drinks. Staff #7 placed the cups on the top of the medication cart to be administered later. At 7:02 AM, staff #7 left the medication room and left the three drinks with Miralax unattended on the top of the medication cart. The three cups with Miralax remained out and accessible to all clients until 7:32 AM.	W 0382	Medications should NEVER be left unattended. Staff number 7 was given a verbal warning to never leave any medication unsecured for any length of time. In the event Staff 7 repeats this mistake she will receive a written warning and lose her quarterly bonus. (see attached) We have hired an individual to focus on quality of medication passes in the group homes. The individual hired has a strong professional background in Quality Assurance. This position will provide backup for passing medications when necessary as well completing new hire observations and quarterly	12/04/2020

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	11/13/2020

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

(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
	On 11/12/20 at 11:30 AM, the Home Manager indicated the staff should not leave medications out and unsecured for any length of time. On 11/12/20 at 11:30 AM, the Residential Director indicated the staff should not leave medications out and unsecured for any length of time. 9-3-6(a)		observations of a medication passes by each staff. House Managers and Nurses may also complete quarterly observations.	
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure staff implemented client #3's diet as ordered. Findings include: On 11/12/20 from 6:42 AM to 9:00 AM, an observation was conducted at the group home. At 8:10 AM, client #3 was eating his breakfast including a muffin. The muffin was finely chopped and dry. There was no moisture to the muffin. At 8:10 AM after the surveyor asked the Home Manager about client #3's muffin, the Home Manager asked staff #5 to add yogurt to client #3's muffin. The Home Manager told staff #5 client #3's muffin needed to be pureed. The Home Manager stated to staff #5 regarding client #3's food, "was mechanical soft." At 8:13 AM, staff #5 served client #3 a hard boiled egg. Client #3's hard boiled egg was finely chopped and dry. There was no moisture added to client #3's egg. At 8:38 AM after the surveyor asked the Qualified Intellectual Disabilities Professional (QIDP) about client #3's egg, the	W 0474	On 11-12-2020 The House Manager sent out a Memo which staff have signed reminding them of Client 3's pureed diet plan. Client 3's entire diet plan was reviewed in great detail at the full staff meeting on 12-4-2020 as well. (see attached) Currently staff are sending a picture to the House Manager prior to each meal until House Manger feels that all staff are obtaining the appropriate consistency for client 3's purred diet.Furthermore all the diet plans for each consumer were reviewed and staff have gone through retraining. The House Manager will continue to monitor implementation of all diet plans.	12/04/2020

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	11/13/2020

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

(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
	QIDP stated to staff #3 that client #3's "eggs are too dry." At 8:39 AM, the QIDP put ketchup on client #3's egg. On 11/12/20 at 10:07 AM, a review of client #3's record was conducted. A 10/7/20 Physician Continuation Note indicated in the Narrative/Recommendations section, "Pt (patient) exhibits mild-mod (moderate) oral pharyngeal dysphagia (with) risk of aspiration (with) all consistencies before/during/after swallow. 2 (degrees) (decreased) strength of swallow (and) poor oral coordination. Pt has a build up of residue in pharynx (a hollow tube that starts behind the nose, goes down the neck, and ends at the top of the trachea and esophagus) after swallow that he does not feel. Recom (recommend): Pureed with 100% supervision for all p.o. (by mouth) intake, nectar thick liquids. Meds to be crushed. Pt may be allowed occasional food that 'melts' easily (i.e. cheese puffs) or easily mashed food (i.e. bananas) (with) staff assisting (controlling bite sizes). No straws!...." On 11/12/20 at 8:10 AM, the Home Manager indicated client #3's muffin needed to be moistened. The Home Manager indicated client #3's diet included pureed food. On 11/12/20 at 8:36 AM, the QIDP stated client #3's eggs were "a little dry." The QIDP indicated client #3 was on a pureed diet. On 11/12/20 at 10:44 AM, the Residential Director (RD) indicated the staff needed to be retrained on client #3's pureed diet and what puree was. The RD indicated the staff failed to implement client #3's diet order.			

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	11/13/2020

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

(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
	On 11/12/20 at 10:44 AM, the QIDP indicated client #3's food during breakfast was not pureed. The QIDP indicated the staff failed to implement client #3's diet order. On 11/12/20 at 10:44 AM, the Home Manager (HM) indicated client #3's food during breakfast was not pureed. The QIDP indicated the staff failed to implement client #3's diet order. 9-3-8(a)			