

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G421	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2012
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711
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W0000	<p>This visit was for the investigation of complaint #IN00118988.</p> <p>This visit was in conjunction with the post-certification revisit survey to the investigation of complaint #IN00117254 completed on 10/19/12.</p> <p>Complaint #IN00118988 Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149 and W153.</p> <p>Unrelated Deficiency cited.</p> <p>Dates of Survey: 11/29, 11/30 and 12/13/12</p> <p>Facility Number: 000935 AIMS Number: 100235180 Provider Number: 15G421</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/19/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure the client's rights were promoted and protected in regard to the client's guardianship. The facility failed to aggressively advocate for client A's rights and/or to assist the client's guardian to understand his right as an individual, and/or to seek outside assistance to ensure the client's rights were not being violated by the guardian without due process.</p> <p>Findings include:</p> <p>Interview with client A on 11/29/12 at 5:10 PM indicated the client was upset with his guardian. Client A started crying and shaking as he was trying to speak. Client A cried while stating "Please help me." Client A indicated he liked living at the group home. Client A indicated he did not want to go back and live with his sister/guardian. Client A indicated he needed people to help him stay at the group home as the client's sister was trying to take him out of the group home. Client A indicated his sister/guardian did</p>	W0125	<p>W125: Protection of Clients Rights</p> <ul style="list-style-type: none"> - The facility will hold an IDT meeting on 1/11/13 with the local BDDS department and Client A's guardian in which the facility will review the rights of Client A with the guardian which are protected by ResCare policy. At this meeting the team will introduce the use of the Human Right's Committee to review any restrictions requested of the guardian to ensure that the guardian is not impeding on the basic human rights of Client A. - The ResCare Bill of Rights will be reviewed with Client A's guardian. - The ResCare Bill of Rights will be reviewed with Client A. - The ResCare Grievance Policy will be reviewed with Client A. - Staff will be retrained on the following related to ResCare policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, Elder Law, & Chain of Command. - Staff will be trained on reporting any potential 	01/12/2013	

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	not allow the client to go on activities in the community. Client A indicated he wanted to go out to eat with the other clients and go shopping. Client A indicated he was not allowed to have any money to spend. Client A indicated he wanted to be able to buy things like the other clients. Client A indicated he was not allowed to go to the zoo and the circus when the other clients went. Client A started crying more and shaking saying "I really wanted to go to the circus." Client A stated "She (sister) does not want me to go out this house." Client A indicated he was not allowed to get a library card and was not allowed to attend church anymore. Client A indicated he liked going to church. Client A stated his sister stopped him from attending when she found out the client was going to a "black church." Client A indicated his workshop caseworker had been trying to help him with his sister, but his sister would not listen. Client A indicated the group home manager did not want him to leave the group home and was trying to help him all she could. Client A indicated he wanted to get away from his sister. Client A indicated he did not know why his sister would not let him do anything at the group home. Client A indicated he liked working at the workshop and was concerned he would not be able to attend. Client A indicated he did not want to call		restrictions mentioned by Client A and/or requested by Client A's Guardian through the Chain of Command. - The Program Coordinator and Operations Manager will be trained on ensuring that all potential restrictions are reported to ResCare Administration. - The Program Director has already met with Client A's guardian on 12/21/12 to address concerns about Client A's rights being violated. This meeting addressed the following in which the guardian agreed: Client A will be allowed to attend church, Client A will be allowed to attend outings with the group home with approval, Client A will receive \$5 weekly for spending, Client A will continue working at Kotter, & Client A will be allowed access to the library. Person Responsible: Program Coordinator & Operations Manager		

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	<p>his sister every Saturday and Sunday at 7:00 PM. Client A indicated he wanted to go to bed early sometimes. Client A indicated his sister would call the group home and cuss the staff.</p> <p>Client A's record was reviewed on 11/30/12 at 1:25 PM. Client A's 5/11/12 Individual Support Plan (ISP) indicated client A's sister was the client's guardian. The ISP indicated client A was admitted to the group home in April 2012. Client A's 5/11/12 ISP indicated client A's diagnosis included, but was not limited to, Mild Mental Retardation.</p> <p>Client A's Documentation of Phone Contact forms from 6/12 to 11/12 indicated the group home manager contacted/phoned client A's guardian on a weekly basis (Friday) to inform the client's guardian of what had occurred with the client. The phone contact sheets indicated the following (not all inclusive):</p> <p>-6/15/12 "Weekly call to guardian. 1. He doing well at [name of workshop] (sic). 2. I want all documentation on [client A] faxed to me. 3. Is [client A] masturbating on your walls yet (sic) 4. Do not give him the box of items she (the guardian) sent."</p> <p>-6/22/12 "Weekly talk with guardian 1.</p>				

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	<p>No problems. 2. She wants him to do his math game 1x (time) daily on weekends. 3. She wants him to call her at 7pm Sat & Sun (Saturday and Sunday)."</p> <p>-7/20/12 "Called guardian told her [client A] was fine. She stated he was smart to her on the phone and she didn't want him to go to work for a couple of days next week."</p> <p>-11/5/12 "Purpose of Call: Clarification of Church Attendance Spoke with [name of guardian]-Guardian/Sister for [client A] to get clarification on what church preference that she wanted for [client A] in order for him to attend services. At this time guardian is requesting that [client A] is not to attend any type of church services at this time. Permission may be given at a later date."</p> <p>Client A's IDT (interdisciplinary team) notes indicated the following (not all inclusive):</p> <p>-5/22/12 IDT met to review the client's behavior plan for "Sexual Inappropriateness." The IDT note indicated client A's guardian did not want the client to attend a sex education class at that time.</p> <p>-10/30/12 Client A would return to work</p>						

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	<p>after guardian approved.</p> <p>-11/7/12 "Team met regarding [client A's] possible return to work at [name of workshop]. Guardian [name of guardian] in attendance by phone. [Client A] will only be allowed to work at [name of workshop] and he works on buckets only. He will not be allowed to earn tokens or Gotcha awards. If he has behaviors, ResCare is to come and pick him up from the [name of workshop] (sic)."</p> <p>-11/20/12 "Team met guardian regarding [client A]...Discussed again that [name of guardian] request to move [client A] closer to her. Requests that [client A] not attend Church, Not be allowed to go to Circus and/or out to eat, and only work on buckets at [name of workshop] have been IDT and implemented (sic)... Weekly weights are to be faxed to [name of guardian] as well as any behavior reports that have resulted that week." Review of client A's 2012 IDT notes indicated the facility allowed the client's guardian to restrict the client's rights without due process in that the facility did not have its Human Rights Committee (HRC) review the rights restrictions and/or involve the HRC to give suggestions in regard to the guardianship. Client A's record also did not indicate the facility sought assistance from outside agencies (Protection and</p>						

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	<p>Advocacy and etc.) to assist with guardianship issues.</p> <p>Interview with staff #1 on 11/29/12 at 6:38 PM stated client A liked living at the group home and client A's guardian was still trying to get the client to move closer to her so she could "control" client A. Staff #1 indicated she contacted client A's guardian on a weekly basis as requested but would not always make contact with the guardian. Staff #1 indicated client A did not want to move out of the group home and was upset with his guardian as he could not go on any outings and activities with the other clients in the community. Staff #1 indicated client A would have to go and stay at another group home when they had planned activities. Staff #1 stated client A "cried when he could not go to the circus." Staff #1 indicated client A wanted to go but was not allowed to go by the guardian. Staff #1 indicated client A did not understand why his sister/guardian was restricting him from participating in the community. Staff #1 indicated client A was not allowed to spend his money. Staff #1 indicated client A could not purchase any new clothes for himself. Staff #1 indicated she had been asking for a winter coat since the fall and just received a coat for the client. Staff #1 indicated the guardian would not let her</p>						

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	<p>go and buy a new coat and/or clothes for the client. Staff #1 indicated she (staff #1) was only allowed to purchase clothes from a second hand store for the client per the request of the guardian. Staff #1 indicated client A wanted to go to church but was not allowed to attend church anymore. Staff #1 indicated the client had attended an African American Baptist church and was baptized. Staff #1 indicated the sister stopped the client from attending church as that was not the client's faith. Staff #1 indicated she will not let client A go to any church. Staff #1 indicated client A did not want to have to call his sister every Saturday and Sunday. Staff #1 indicated it would take the staff 45 minutes to an hour to calm the client down after speaking with his sister. Staff #1 indicated client A used to get awards at work for working well and certificates. Staff #1 indicated the client was no longer allowed to receive such items for his work due to the guardian.</p> <p>Interview with administrative staff #2 and the Director of Health Services (DHS) and administrative staff #1 by phone on 11/30/12 at 3:05 PM indicated they had concerns with client A's guardian. Administrative staff #1, #2 and the DHS indicated client A's guardian would not let the client go on any outings in the community, attend church and/or make</p>						

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	<p>any purchases. Administrative staff #2 stated the guardian wanted client A to have a vasectomy to not have kids, would take away the client's outing privileges, "controlled money" and took a long time to send a coat for the client.</p> <p>Administrative staff #2 indicated the guardian did not want client A to know how much money he had in his account.</p> <p>Administrative staff #2 stated the client's guardian would "raise her voice with him (client A)." Administrative staff #2 stated "She makes statements he (client A) does not have rights. I make the rules. I have rights." Administrative staff #2 indicated when he would speak with her about client A's rights and her approach with him, administrative staff #2 stated "She did not like that." Administrative staff #2 stated "She controls everything. She did not tell him he was moving into the group home when he came." Administrative staff #1 and #2 indicated the client was admitted to the group home from the sister's home after Adult Protection Services (APS) became involved.</p> <p>Administrative staff #1 and #2 stated no one would take the client as the sister/guardian "made the impression he is dangerous." Administrative staff #1 indicated client A was not like the sister had described. Administrative staff #1 indicated they had contacted APS, in the county where they were involved, where</p>				

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	<p>the client and sister lived. Administrative staff #1 indicated APS was not concerned about the guardianship as the client was no longer in the home and felt to be in a safe environment. Administrative staff #1, #2, and the DHS indicated the facility met with client A's guardian by phone every 2 weeks and the group home manager called the guardian weekly. Administrative staff #1 and #2 indicated they would have to have 2 people present when speaking with the guardian. Administrative staff #1 indicated he spoke with the guardian yesterday (11/29/12) by phone. Administrative staff #1 stated "She will cry and then be happy in the same conversation." Administrative staff #1 stated "She is upset as everyone thinks she is mistreating him (client A)." Administrative staff #1 stated client A's guardian is "afraid" if she lets him go out into the community client A will do something wrong. Administrative staff #1 stated he told client A's guardian "She needs to give us a chance to work with [client A]." Administrative staff #1 indicated he spoke with APS from the county he came from and they indicated since she allowed the client to be placed out of her home, they did not remove him. Administrative staff #1 stated "APS said it would be hard to get rid of guardian." Administrative staff #2 and DHS</p>			

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	<p>indicated client A was receiving counseling due to the issues with his sister. Administrative staff #1 and #2 indicated they had not contacted any outside services and/or HRC to assist with the guardianship concerns/issues.</p> <p>9-3-2(a)</p>				

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W0149	<p>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 1 of 4 allegations of abuse, neglect and injuries of unknown source reviewed, the facility failed to implement its policy and procedures to prevent abuse of client B, and failed to ensure the allegation of abuse was reported timely to the administrator.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 11/29/12 at 1:20 PM. The facility's 10/28/12 reportable incident report indicated "An allegation of physical abuse was made against staff [staff #3]..." toward client B.</p> <p>The facility's 10/29/12 Incident Investigation Review indicated "...He (staff #4) witnessed [staff #3] push [client B] down on his shower chair after [client B] punched [staff #3]. [Staff #4] indicated he witnessed [staff #3] slap [client B] in the back of the head, face and on his body...." The 10/28/12 investigative report indicated "...[Client F] indicated that he was walking outside the bathroom and that he noticed [staff #3] slapping [client B] in the face.</p>	W0149	<p>W149: Staff Treatment of Clients</p> <ul style="list-style-type: none"> - Staff will be retrained on the following related to ResCarePolicy: Abuse & Neglect, Bill of Rights, Grievance Policy, IncidentReporting (Immediately), Elder Law, & Chain of Command. - The facility will implement observations within the group hometo ensure that the home is free from Abuse & Neglect, as well as, to ensurethat staff members are reporting to Administration as required by ResCarePolicy & Procedure related to Incident Reporting and Abuse & Neglect. - The Program Coordinator will be trained on ensuring that theChain of Command is current and posted in the home and that the OperationsManger is notified immediately via phone call related to any allegations ofAbuse & Neglect. - The Operation Manager and Nurses will be trained on notifyingResCare Administration immediately via phone call and email regarding anyallegation of Abuse & Neglect. <p>PersonResponsible: Program Coordinator & Operations Manager</p>	01/12/2013	

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	<p>[Client F] indicated that he witnessed [client B] hit [staff #3] first. [Client F] indicated that [staff #3] was trying to give [client B] a shower. [Client F] indicated that he did not witness [staff #3] push [client B]...."</p> <p>The facility's 11/21/12 follow-up report indicated "...It was the consensus of the investigation committee that the allegation of physical abuse against staff [staff #3] was substantiated. An (sic) nursing assessment was completed on [client B] immediately following the allegation and no injury or marks were noted. [Client B] was taken to an after hours care facility to be assessed as a precautionary measure and no injury was noted...The following actions have been taken as a result of the investigation:</p> <p>1:) P & P (policy and procedure) termination of [staff #3]. 2:) Retrain all staff across the board on Abuse + (plus) Neglect policies, Client Rights and Elder Law. 3:) Retrain all the staff across the board on reporting procedures and Chain of Command. 4:) Grievance Policy and Bill of Rights with all clients in the home. 5:) IDT (interdisciplinary team) to review [client B's] BSP (Behavior Support Plan) for appropriateness.</p>			
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	<p>6:) Retrain Olmstead staff on [client B's] BSP and ISP (Individual Support Plan)."</p> <p>Interview with client F on 11/29/12 at 6:10 PM indicated he witnessed staff #3 hit client B.</p> <p>Interview with administrative staff #2 on 11/29/12 at 3:05 PM indicated the allegation of abuse was substantiated and staff #3 was terminated.</p> <p>The facility's policy and procedures were reviewed on 11/29/12 at 1:00 PM. The facility's 3/1/2009 Operational Procedure entitled Abuse/Neglect/Exploitation, Death, Incident Reporting & Investigation indicated "...Any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated...."</p> <p>The facility's 10/8/12 untitled policy indicated defined physical abuse as "...Includes knowingly or intentionally touching another in a rude, insolent or angry manner, including grabbing or shoving rudely or angrily, slapping or hitting, pushing, shoving, striking or kicking, throwing someone to the floor, etc...."</p> <p>2. The facility's policy and procedures were reviewed on 11/29/12 at 1:00 PM. The facility's 3/1/2009 Operational Procedure entitled</p>						

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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711		
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	<p>Abuse/Neglect/Exploitation, Death, Incident Reporting & Investigation indicated "...Any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated. All employees receive training upon hire regarding definitions of different types of abuse/neglect, how to identify abuse/neglect/exploitation, how to report it and what to expect from an investigation...." The 3/1/09 policy indicated facility staff were to report all allegations using the facility's internal reporting system immediately.</p> <p>The facility failed to ensure staff reported an allegation of abuse to the administrator immediately. Please see W153.</p> <p>This federal tag relates to complaint #IN00118988.</p> <p>9-3-2(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure facility staff immediately reported an allegation of staff to client abuse to the administrator regarding client B.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 11/29/12 at 1:20 PM. The facility's 10/28/12 reportable incident report indicated "An allegation of physical abuse was made against staff [staff #3]... " toward client B.</p> <p>The facility's 10/29/12 Incident Investigation Review indicated "...He (staff #4) witnessed [staff #3] push [client B] down on his shower chair after [client B] punched [staff #3]. [Staff #4] indicated he witnessed [staff #3] slap [client B] in the back of the head, face and on his body...." The 10/28/12 investigative report indicated "...[Staff #5] indicated [staff #4] reported to her that he witnessed a staff member hit a client. [Staff #5] indicated that she told [staff #4]</p>	W0153	<p>W153: StaffTreatments of Clients</p> <ul style="list-style-type: none"> - Staff will be retrained on the following related to ResCarePolicy: Abuse & Neglect, Bill of Rights, Grievance Policy, IncidentReporting (Immediately), Elder Law, & Chain of Command. - The facility will implement observations within the group hometo ensure that the home is free from Abuse & Neglect, as well as, to ensurethat staff members are reporting to Administration as required by ResCarePolicy & Procedure related to Incident Reporting and Abuse & Neglect. - The Program Coordinator will be trained on ensuring that theChain of Command is current and posted in the home and that the OperationsManger is notified immediately via phone call related to any allegations of Abuse& Neglect. - The Operation Manager and Nurses will be trained on notifyingResCare Administration immediately via phone call and email regarding anyallegation of Abuse & Neglect. 	01/12/2013	

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	<p>that he needed to report the incident. [Staff #5] indicated that she contacted [staff #6] to ask who [staff #4] needed to report to. [Staff #5] indicated that [staff #4] called [(Waiver) Operations Manager (OM) #2 and (group home) OM #1]...." The facility's investigation indicated "... [OM #2] indicated that she received a text from [staff #6] asking her who needed to be contacted for an abuse allegation for group home. [OM #2] indicated that she told [staff #6] that if he was making an allegation that he could report it to her. [OM #2] indicated that she received a call from [staff #4] who said he got her number from [staff #6]. [OM #2] indicated that [staff #4] reported that a staff member was physically abusive towards a client. [OM #2] indicated that she told [staff #4] that he needed to contact his OM [OM #1]...."</p> <p>Interview with administrative staff #2 on 11/29/12 at 3:05 PM and on 11/30/12 at 2:45 PM indicated staff #4 did not report the staff to client allegation of physical abuse immediately to administrator as the staff called everyone except the manager, the Program Coordinator and the Operation Manager for the group home. Administrative staff #2 indicated he did not know why staff #4 did not know who to call as the phone numbers were posted in the office area of the group home.</p>		<p>PersonResponsible: Program Coordinator & Operations Manager</p>				

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	<p>Administrative staff #2 indicated the incident occurred during the morning shift on 10/28/12 but they were not notified of the allegation until sometime in the afternoon on 10/28/12. Administrative staff #2 stated all staff had been retrained in regard to reporting and the "Chain of Command."</p> <p>This federal tag relates to complaint #IN00118988.</p> <p>9-3-2(a)</p>				