

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G505	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 333 TREELINE DR TERRE HAUTE, IN 47802
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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 the investigation of complaint #IN00150645.</p> <p>Complaint #IN00150645 - Substantiated, Federal/state deficiency related to the allegation is cited at W153.</p> <p>Survey Dates: June 25 and 26, 2014.</p> <p>Facility Number: 001019 Aim Number: 100235280 Provider Number: 15G505</p> <p>Surveyor: Mark Ficklin, QIDP.</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 2, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000153	<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.</p> <p>Based on record review and interview, the facility failed for 1 of 2 facility reportable incidents (client G) reviewed, to immediately report an allegation of verbal abuse to the Bureau of</p>	W000153	The facility has policies and procedures that outline the definition of abuse, neglect, and mistreatment; reporting requirements for allegations of such incidents; the obligation and	07/25/2014

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>Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>Record review of the facility incident reports and investigations was done on 6/25/14 at 1:52p.m. The incident report/investigation review indicated the following: The incident report/investigation dated 6/7/14 with a completion date of 6/9/14, indicated a direct care staff at the group home had allegedly yelled at client G and had made client G "uncomfortable." The report indicated the staff had yelled at client G and at other staff working in the home. There was no documentation the 6/7/14 allegation of verbal abuse to client G had been reported to BDDS.</p> <p>Professional staff #1 was interviewed on 6/25/14 at 4:24p.m. Staff #1 indicated the above identified incident of alleged verbal abuse by direct care staff to client G had not been reported to BDDS. Staff #1 indicated allegations of abuse/neglect should be reported to BDDS.</p> <p>This federal tag relates to complaint #IN00150645.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>responsibility of reporting abuse; and the process for reporting and appropriate follow-up to any such allegations reported. The facility will consistently implement written policies that prohibit mistreatment, neglect or abuse of the client and reporting such incident as required. A report has now been submitted to BDDS concerning this incident with Client G. In the case of this incident, the staff person involved was placed off duty immediately and an investigation was initiated according to facility policy. The investigation substantiated that the staff person had raised her voice and was insubordinate, and she was subsequently terminated. The facility did not fail to identify that the staff person's actions were verbally abusive in nature and separated her from the individuals in order to eliminate further opportunity. The incident was reported immediately to the administrator at the time. Using this incident as an example, as well as other established guidelines for identifying what incidents meet the criteria for being critical and reportable, the Administrator will review the information with the Program Manager, Clinical Supervisor, QA Director, and QIDP ensure that all are aware of the types and definitions of incidents that must be reported to BDDS and other established protocols.</p>	

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			The Program Manger is responsible to see that all incidents are documented and reported as required. The internal incident report form and Investigation follow-up form have an area added to indicate if the incident was reportable or not as a guide and prompt to the person that I completing the form ad follow-up. The Program Manager and /or Administrator will review both of these documents when they are complete and will insure that this information has been included on the forms. The QIDP and Clinical Supervisor are responsible for submitting incident reports to BDDS and other officials according to the established laws and facility policies.		