STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: October 8, 10, 16, 17, 18, 2013 Provider Number: 15G440 Aims Number: 100244720 Facility Number: 000954 Surveyor: Mark Ficklin, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/30/13 by Ruth Shackelford, QIDP.	W000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
W000148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on record review and interview, the facility failed for 1 of 2 reviewed facility investigations (client #1) to promptly inform client #1's guardian of a fall with injury to client #1. Findings include: Record review of the facility's incident reports was done on 10/8/13 at 12:34p.m. An incident report on 8/5/13 indicated client #1 had fallen onto her buttocks while independently getting out of the facility van at the group home. The facility investigation indicated client #1 had complained of pain, had refused supper and was reluctant to bear weight. The report indicated client #1's guardian had been notified on 8/6/13. Record review for client #1 was done on 10/16/13 at 12:28p.m. Client #1's 5/9/13 individual support plan (ISP) indicated client #1's mother was her guardian. Interview of staff #3 (quality assurance) on 10/16/13 at 1:58p.m. indicated client #1 had a guardian. Staff #3 indicated the	W000148	The agency has a current policy on Communicating Significant Events to Guardians and Families. The Program Coordinator has the responsibility of reporting significant incidents to guardians and families as immediate as possible to the time of the incident. The Program Coordinator will receive training on this policy. The Program Manager will be responsible for implementing this training. The Program Manager will have the responsibility of monitoring Program Coordinators to assure compliance with this policy.	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
	guardian had not been promptly informed of the fall with injury to client #1. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
W000149	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, the facility failed for 1 of 2 allegations of client abuse/neglect reviewed (client #1), to implement policy and procedures to ensure clients received medical treatment/services as indicated by their medical needs. Findings include: Record review of the facility's incident reports was done on 10/8/13 at 12:34p.m. An incident report on 8/5/13 indicated client #1 had fallen onto her buttocks while independently getting out of the facility van at the group home. The facility investigation indicated on 8/5/13 client #1 had complained of pain, had refused supper and was reluctant to bear weight. The incident/investigation report indicated the 3 facility direct care staff that had worked on 8/5/13 had not reported all of the symptoms/complaints of client #1 to the facility nurse on 8/5/13. The staff had reported to the nurse, client #1 had fallen off the van running board onto her buttocks with no injuries and walked after the fall. Staff had later reported as "behavioral" that client #1 had put self on floor and refused to walk. The	W000149	The facility has developed and will consistently implement written policies that prohibit mistreatment, neglect or abuse of the client. The facility has policies and procedures that outline the definition of abuse, neglect, and mistreatment; reporting requirements, and the obligation and process for reporting. All staff including the Home Manager will complete training on the agencies policy on Individual Abuse/Neglect with an emphasis on defining and recognizing neglect. The Program Coordinator is responsible for implementing this training. All staff receives training on the agency policies concerning the recognition of, prevention of and reporting of abuse/ neglect/ exploitation and mistreatment upon hire and at least annually thereafter.All 3 of the staff that were present at the time of this incident were immediately placed off duty when the facility learned of the incident and were terminated from employment for their failure to follow agency procedures in reporting an injury to an individual served.	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT TERRE HAUTE, IN 47802	

(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
	incident report also indicated client #1 had refused to eat supper, which direct care staff had not reported to the nurse. Client #1 complained of pain on 8/6/13 and had a 4" (inch) x (by) 6" bruise on her right buttock. Client #1 went to the emergency room on 8/6/13 and was diagnosed with a buttock contusion. Client #1 received orders for a pain reliever and to use a walker as necessary with staff assistance. Record review of the facility's policy and procedures was done on 10/18/13 at 7:30a.m. The facility policy "Individual Abuse, Neglect, Exploitation and Mistreatment" dated 7/1/11 indicated neglect as: "depriving the individual of necessary support including food, drink, clothing, shelter, use of bathroom facilities, sleep, and medical care." Professional staff #4 was interviewed on 10/18/13 at 12:11p.m. Staff #4 indicated the facility's corrective action for the 8/5/13 incident, had included the termination of the 3 staff on duty on 8/5/13 (for failure to report all of client #1's symptoms/complaints), established a protocol for staff to client assistance with exiting the van and retrained facility staff on abuse/neglect and reporting policy. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed for 1 of 2 investigations of alleged neglect/abuse reviewed (client #1), to ensure appropriate corrective action was identified. Findings include: Record review of the facility's incident reports was done on 10/8/13 at 12:34p.m. An incident report on 8/5/13 indicated client #1 had fallen onto her buttocks while independently getting out of the facility van at the group home. The facility investigation indicated client #1 had complained of pain, had refused supper and was reluctant to bear weight on 8/5/13. The incident/investigation report indicated the 3 facility direct care staff that had worked on 8/5/13 had not reported all of the symptoms/complaints of client #1 to the facility nurse on 8/5/13. The facility staff had not reported client #1 had refused to eat supper and had reported as behavioral client #1's resistiveness to programming prompts. Facility staff had been retrained on abuse/neglect/mistreatment and reporting. The investigation summary and staff training documented did not indicate facility staff had been retrained on	W000157	All staff including the Home Manager will complete training on recognizing signs and symptoms of injury or illness and on reporting injury or illness to the nurse and other management staff in a timely fashion. This training will include outlining when staff are to notify nursing. The nursing staff maintains a 24/ 7 on-call schedule. The Program Coordinator will be responsible for implementing this training with all staff members. Nursing and Management Team staff will be aware that if there are any future incidents of staff failing to report an incident or injury in a timely fashion, they will need to contact the Program Director so that re-training / or corrective action can be taken immediately.	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/18/2013
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT TERRE HAUTE, IN 47802	

(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
	reporting all signs and symptoms of client injury to the nurse. Professional staff #4 was interviewed on 10/18/13 at 12:11p.m. Staff #4 indicated the facility's corrective action for the 8/5/13 incident, had included retraining facility staff on abuse/neglect and reporting policy. Staff #4 indicated there was no documentation the facility staff had been retrained on reporting all signs and symptoms of client injury to the nurse. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) to ensure each client's active treatment program was coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP), by the QIDP not completing quarterly program reviews. Findings include: Record review for client #1 was done on 10/16/13 at 12:28p.m. Client #1's QIDP program reviews indicated client #1 had an individual support plan (ISP) dated 5/9/13. There were no documented QIDP program reviews during the time period of 5/9/13 through 10/16/13. Record review for client #2 was done on 10/16/13 at 1:34p.m. Client #2's QIDP program reviews indicated client #2 had an ISP dated 10/1/13. There were no documented QIDP program reviews between 10/4/12 (client #2's ISP) through the 10/1/13 ISP. Record review for client #3 was done on 10/16/13 at 11:24a.m. Client #3's QIDP	W000159	The QIDP is responsible to insure that all of the needs of each individual is addressed in their Individual Program Plan and addressed formally as recommended and prioritized by the IDT. The QIDP is responsible to provide information to the Home Manager and staff as to the protocols and formal objectives that they must initiate to meet each individuals needs and assist them toward independence.The QIDP and the Home Manager are responsible for the ongoing monitoring of the program plan implementation and data collection on at least a weekly basis and to follow up to issues immediately with staff. On a monthly basis, The QIDP reviews the data for the month and determines if progress has been made to meet the criteria of the objective and make revisions as necessary. On at least a quarterly basis, the QIDP facilitates a meeting with the IDT members to review progress with the ISP/ BSP plans. This review is to be documented and maintained in the individual record. The QIDP will receive additional training concerning their responsibilities in the at least quarterly review of each individual	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
	program reviews indicated client #3 had an ISP dated 5/9/13. There were no documented QIDP program reviews during the time period of 5/9/13 through 10/16/13. Professional staff #1 was interviewed on 10/17/13 at 3:04p.m. Staff #1 indicated the QIDP should be reviewing the clients' programs at least quarterly. Staff #1 indicated quarterly QIDP program reviews had not been done for clients #1, #2 and #3. 9-3-3(a)		ISP/ BSP. The Program Manager will be responsible for providing and documenting this training. The Clinical Supervisor and/ or the Program Manager will conduct at least a quarterly review of all ISP/ BSP plans to insure that they have been reviewed on at least a quarterly basis by the QIDP and reviewed by the IDT. All Individual Support Plans for the individuals at the home will be reviewed by the Program Manager or designee to insure that they are current and appropriately implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
W000240	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, the facility failed for 1 of 3 sampled clients (#1) to include interventions/guidelines in client #1's individual support plan (ISP) in regards to client #1's staff assistance needs with ambulation, performing tasks and personal care. Findings include: Record review of the facility's incident/investigations was done on 10/8/13 at 12:54p.m. An incident report dated 8/5/13 for client #1, indicated client #1 had fallen while exiting from a van. Client #1 had been diagnosed with a back injury to Lumbar spine on 8/29/13. Client #1 had a 9/9/13 physician's order to "use a wheelchair for long distances. May use walker minimally." Client #1 had a 9/12/13 nursing note that indicated client #1 had a physical therapy order to work on walking only, no pushing or pulling. There was no documentation in client #1's current ISP (dated 5/9/13) to guide staff that worked with client #1 in regards to her assistance needs with walking, personal hygiene and what household/day program tasks she could perform. Client #1 had a nursing note on 10/2/13 that indicated client #1 had a follow up appointment with her doctor on 10/24/13 for re-evaluation. Interview of staff #2 (nurse) on 10/17/13 at 3:46p.m. indicated the 9/9/13 physician's orders were the most current documented orders. Staff #2 indicated client #1 did not have documented staff	W000240	An IDT was held on 11/7/13 to address client # 1's assistance needs. All staff including the Home Manager will complete training on the protocols for client # 1's assistance needs. The Program Coordinator will implement this training. The Program Coordinator and Home Manager will conduct weekly observations to assure staff are meeting the expectations with providing client assistance. Is situations were the expectation is not met the Home Manager and Program Coordinator will provide further training or corrective action if appropriate.	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
	interventions for the assistance needs of client #1 for ambulation, tasks she could perform and personal care. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
W000259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) to ensure the clients' comprehensive functional assessments (CFA) had been reviewed during the past year. Findings include: Record review for client #1 was done on 10/16/13 at 12:28p.m. Client #1's program reviews indicated client #1 had an individual support plan (ISP) dated 5/9/13. Client #1 had no documented CFA reviews from 1/1/12 through 10/16/13. Record review for client #2 was done on 10/16/13 at 1:34p.m. Client #2's program reviews indicated client #2 had an ISP dated 10/1/13. Client #2 had no documented CFA reviews from 9/6/12 through 10/16/13. The ISP indicated client #2 had been admitted to the facility on 9/6/12. Record review for client #3 was done on 10/16/13 at 11:24a.m. Client #3's program reviews indicated client #3 had an ISP	W000259	The Comprehensive Functional Assessment will be reviewed by the QIPD for each of the individuals in the home to assure that they are accurate and current. The CFA is to be reviewed by the Interdisciplinary Team at least annually or as needs change for an individual. The Program Coordinator is responsible to see that the CFA is updated and reviewed on at least an annual basis. The Program Coordinator will receive training on the completion and documentation expectations in reviewing client comprehensive functional assessments. The Program Manager will implement this training. The Program Manager will oversee that Program Coordinators provide continuous integration, coordination, and monitoring of client services by way of on-going tracking that includes annual ISP's, comprehensive functional assessment reviews, and quarterly review documentation of client services.	11/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(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
	dated 5/9/13. Client #3 had no documented CFA reviews from 5/7/12 through 10/16/13. Professional staff #1 was interviewed on 10/17/13 at 3:04p.m.. Staff #1 indicated the facility's interdisciplinary team should review the clients' CFAs at least annually. Staff #1 indicated there was no documentation the facility had completed an annual CFA review for clients #1, #2 and #3. 9-3-4(a)			