

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: December 17, 18, 19, 22 and 23, 2014</p> <p>Provider Number: 15G544 Aims Number: 100245350 Facility Number: 001058</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 30, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed for 1 of 4 sampled clients (#3) residing in the facility to meet the Condition of Participation: Client Protections, by failing to implement written policy and procedure to prevent neglect of client #3 in regards to: failure to notify the administrator and the Bureau of Developmental Disabilities Services (BDDS) within 24 hours of incidents of client significant injury and injury of</p>	W000122	<p>It is the primary function of every employee to assure the protection and safety of each person served by the facility. The facility has many established written policies and procedures that address and outline the prevention of, recognition of, reporting of and responding to client abuse, neglect, mistreatment or exploitation.</p> <p>The ResCare/ Normal Life of Indiana,</p>	01/23/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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
	<p>unknown origin, failure to document incident reports and thorough investigations for client's significant injury and injury of unknown origin.</p> <p>Findings include:</p> <p>See W149. The facility failed to implement written policy and procedures to ensure incident reporting and thorough investigations for significant client injury (#3) were done, to assist the facility with the monitoring of incidents and trends per home .</p> <p>See W153. The facility failed to ensure the facility administrator and BDDS were immediately notified of significant client injury incidents and incidents of an unknown origin (client #3).</p> <p>See W154. The facility failed to ensure a thorough investigation was documented in regards to client #3's significant injury and injury of unknown origin.</p> <p>9-3-2(a)</p>		<p>is very adamant that no person served by the facility is subject to abuse and neglect at any time. All staff are trained and show competency in the Abuse, Neglect and Mistreatment Policies and Procedures upon hire and at least annually thereafter. All allegations of abuse are reported and investigated according to the written policies of the facility. All staff receive training on the specific identified needs of each individual served, including those that assure individual health and safety.</p> <p>The agency has current policies and procedures that prohibit the mistreatment, neglect and abuse of individuals served as well as policies that specifically address the reporting of and completion of investigations of unknown injuries or incidents.</p> <p>The Leadership team will complete a review of these policies to ensure that they are current and continue to meet the needs of the individuals served. All staff receive training on these policies upon hire and annually thereafter. The training includes a review and competency of the process for reporting and investigating any incidents and unknown injuries.</p> <p>Please see the Plan of Correction responses for W149, W153 and W154 for specific actions the facility</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
W000126	<p>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 the facility failed for 1 of 4 sampled clients (#1) to allow spending opportunities for the clients.</p> <p>Findings include:</p> <p>Record review of the individual client financial files was done on 12/17/14 at 6:05p.m. The "Individual Personal Petty Cash Ledger" was reviewed for client #1. The financial ledger indicated client #1 had not made a community purchase with his personal funds since 9/14/14.</p> <p>Staff #1 was interviewed on 12/17/14 at 6:17p.m. Staff #1 indicated the facility had not provided client #1 the opportunity to spend his money during the past 3 months. Staff #1 indicated client should have been provided the opportunity to make community purchases.</p> <p>9-3-2(a)</p>	W000126	<p>has implemented in order to meet this Condition of Participation.</p> <p>The individuals in the home will have access to and will be assisted to plan opportunities to spend their money on at the least, a monthly basis.</p> <p>The Residential Manager will develop a schedule to include community outings and activities to occur in the weekend and evening hours. This schedule will include a specified day that each client can choose an individual recreational activity and will be assisted in purchasing their personal hygiene and other personal needs. This schedule will be posted monthly in the home so that individuals and staff are aware of the schedule and the opportunities. The QIPD will review the community participation log on at least a monthly basis and will report the activities the individual has participated in to the team during the quarterly review meeting. The Residential Manager will</p>	01/23/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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	
			<p>insure that the individual has access to money in the home as requested for the chosen outing and any personal items needed. Guidelines are developed that specify the process for scheduling outings and the responsibilities of the Residential Manager to insure that spending opportunities are provided. All Residential Managers and QIPD's will receive training these guidelines and responsibilities.</p> <p>Formal program goals have been developed and implemented to support Client #1 in managing their financial affairs. The QIDP will monitor the data collected on at least a monthly basis and determine progress and appropriateness of each goal.</p> <p>The QIDP will monitor and audit the client personal funds on at least a quarterly basis and report on the financial activities during the Quarterly IDT Review. The Clinical Supervisor will complete an audit on at least a quarterly basis to ensure that all client funds are being handled appropriately and that spending opportunities have been provided for each client.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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	
W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed for 3 of 4 client	W000140	The Clinical Supervisor will on at least a quarterly basis, conduct a review of each ISP and client records including financial, to insure that specific individual needs are being addressed by programming and that all individuals are being afforded the right to manage their own personal funds either as part of a formal program or a more general, informal series of activities that are geared to the individual's functioning level. The results of this audit and the follow-up to identified issues are submitted to the Program Manager on at least a quarterly basis to insure completion. This audit includes checking each individuals cash and financial records at the home. In the future is issues are noted that individuals have not had ample opportunities to spend their own money, it will be discussed with the Residential Manager who is responsible to see that community outings are offered.. The Program Manager is responsible for reviewing the quarterly audits and follow-up. All client funds are currently secured and accounted for. The	01/23/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
	<p>finances reviewed (#1, #2, #4), to maintain their financial system to ensure client funds entrusted to the facility had no missing funds.</p> <p>Findings include:</p> <p>The client financial record book and cash on hand (at the group home) entrusted to the facility was reviewed on 12/17/14 at 6:05p.m. The clients' "Individual Personal Petty Cash Ledger" indicated: client #1 had a current balance of \$6.56. Client #1's actual cash on hand was \$5.88. Client #2 had a ledger balance of \$4.62 and an actual cash on hand of \$3.08. Client #4 had a ledger balance of \$9.58 and an actual cash on hand of \$8.58. Client #4 also had a receipt in his individual receipt packet that was not his. Staff #2, indicated on 12/17/14 at 6:17p.m., they were unsure whose receipt it was.</p> <p>Interview on 12/17/14 at 6:17p.m. of staff #2 indicated the clients' funds entrusted to the facility were kept locked in the office. Staff #2 indicated the clients' ledger and available funds should match. Staff #2 indicated client transactions and receipts were not being recorded on the petty cash ledger when the transactions had taken place.</p>		<p>agency has current policies and procedures regarding client's personal funds. All staff at the home along with the Residential manager and Clinical Supervisor will receive training on this policy and the procedures on proper documentation of transactions and on the securing of client personal funds. The Program Manager will be responsible for implementing this training. The Residential Manager and Clinical Supervisor will monitor and audit client personal funds on at least a weekly basis to assure that client funds are secured and accounted for. The Clinical Supervisor will also complete an audit on at least a quarterly basis to ensure that all client funds are being handled and secured according to facility policy and procedures. Any discrepancies noted will be resolved immediately.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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	<p>9-3-2(a)</p> <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 interview and record review, the facility failed for 3 of 5 allegations of client neglect reviewed (client #3), to implement policy and procedures to ensure allegations of neglect were immediately reported to the administrator, the Bureau of Developmental Disabilities Services (BDDS) and a thorough investigation was completed/documented.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 12/18/14 at 10:43a.m. The review included the following incidents for client #3:</p> <p>1) Record review of client #3 was done on 12/18/14 at 12:50p.m. A nursing note on 11/17/14 indicated staff #4 (Licensed Practical Nurse, LPN) had seen client #3 on 11/17/14. The nursing note indicated "no bruising from fall this morning, walking slowly but no signs of pain." A nursing note on 11/18/14 indicated client</p>	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 for allegations of such incidents; the obligation and responsibility of reporting abuse; and the process for reporting and appropriate follow up to any such allegations reported. The facility has a policy concerning the Investigation of Injuries of Unknown Origin. The policy outlines an established process, responsibility, and timelines for investigating unknown injuries. The Clinical Supervisor/QIDP is responsible for initiating an immediate investigation into the cause and prevention of an unknown injury. The Program Manager is responsible for insuring that reporting and follow up to these incidents is completed. The Clinical Supervisor will track and report any incident of unknown origin to the Safety Committee on at least	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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
	<p>was still walking slowly with no complaints of pain. Client #3 saw her primary care physician (PCP) on 11/19/14 and x-rays were ordered. The PCP noted on 11/21/14, regarding client #3, "possible fracture of coccyx." The PCP ordered Tylenol for pain, straight chairs and to consider physical therapy and a donut seat. The PCP indicated "will take 8-12 weeks for recovery." There was no documentation the facility had an incident report and an investigation to determine the cause of the fall with injury.</p> <p>Staff #2 (group home staff) was interviewed on 12/17/14 at 6:22p.m. Staff #2 indicated they were unsure how client #3 had fallen. Staff #2 indicated it was reported client #3 had slipped on ice going to the van and also indicated a peer had opened a van door into client #3.</p> <p>2) A nursing note on 12/1/14 indicated staff #4 (LPN) had seen client #3 at the facility's day services. The note indicated client #3's knuckles on her left hand were discolored. The note indicated client #3 reported she had fallen at her family's during a home visit. An x-ray on 12/4/14 indicated client #3 had a fracture of the left ring finger. There was no documentation the facility had an incident report and investigation to</p>				<p>a quarterly basis. The Clinical Supervisor/QIDP, Program Manager, Residential Manager and Nurse will receive additional training on the Investigation of Injuries of Unknown Origin policy, including their responsibilities in the reporting and investigation process. The Program Manager will be responsible to see that training is completed on at least an annual basis with all staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
	<p>determine the location and cause of the hand injury.</p> <p>3) An incident report on 12/4/14 indicated client #3 had fallen at the group home while she was assisted (by group home staff) with putting on a scarf. The report indicated client #3 had fallen backwards and reported no injury at the time of the fall. The report indicated client #3 had gone for x-rays on 12/4/14, and had a fractured right wrist and a fractured left ring finger. There was no documentation of a thorough investigation. There were no documented interviews of the clients and staff in regards to the fall with injury.</p> <p>The facility's policy and procedures were reviewed on 12/18/14 at 5p.m. The facility's 6/15/13 policy and procedure "Individual Abuse, Neglect, Exploitation and Mistreatment" indicated the facility shall prohibit any form of mistreatment, exploitation, neglect or abuse. The policy indicated "Neglect refers to the placement, knowingly or intentionally, of an individual in a situation that may endanger his/her life or health." The facility's 5/1/12 policy "Incident Reports" indicated: "Res Care-Terre Haute staff are required to complete a written incident report and follow-up communication when encountering either</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
	<p>minor or serious incidents including, but not limited to: any incident involving visible injury; any incident which has the potential for later injury (ex. falls); any discovery of injury." The policy indicated "serious incidents/unusual occurrences" which require reporting to outside agencies included neglect of a consumer, injuries of an unknown origin, significant injuries including, but not limited to, fractures and any injury that requires more than first aid. The policy indicated the incident reports are used for examining individual safety, are tracked through a data base and reviewed by the facility management team, support team and safety committee. The policy indicated the Program Coordinator is responsible to investigate all injuries of unknown origin within 24 hours of the written incident report. "This should be done by interviewing all staff, reading progress notes, reviewing individual history." Documentation of this investigation must be written on the "Injuries of Unknown Origin Report Form." The policy indicated "an injury of unknown origin is defined as any injury, in which the cause of that injury is not known, was not observed, the cause of the injury is questionable, or the specific cause was not reported."</p> <p>Professional staff #1 was interviewed on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
W000153	<p>12/19/14 at 10:51a.m. and on 12/23/14 at 9:20a.m. Professional staff #1 indicated the facility staff had failed to follow the facility's policy and procedures in regards to client #3's identified significant injuries and injury of unknown origin. Staff #1 indicated the facility should have completed/documented an incident report and a thorough investigation for the incidents on 11/17/14 and on 12/1/14. Staff #1 indicated the facility failed to have a thorough investigation of the 12/4/14 incident by having no documented interviews. Staff #1 indicated there has been a change at the facility with staff assignments (responsibilities) in regards to incident reporting and investigations.</p> <p>See W153. The facility failed to ensure significant client injuries and injuries of unknown origin were immediately reported to facility administrator and Bureau of Developmental Disabilities Services (client #3).</p> <p>See W154. The facility failed to ensure a thorough investigation was documented in regards to client #3's significant injury.</p> <p>9-3-2(a)</p>						
483.420(d)(2)							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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
	<p>STAFF TREATMENT OF CLIENTS</p> <p>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 2 of 5 facility reportable incidents (client #3) reviewed, to immediately report allegations of possible abuse/neglect to the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 12/18/14 at 10:43a.m. The review included:</p> <p>1) Record review of client #3 was done on 12/18/14 at 12:50p.m. A nursing note on 11/17/14 indicated staff #4 (Licensed Practical Nurse) had seen client #3 on 11/17/14. The nurse note indicated "no bruising from fall this morning, walking slowly but no signs of pain." A nursing note on 11/18/14 indicated client was still walking slowly with no complaints of pain. Client #3 saw her primary care physician (PCP) on 11/19/14 and x-rays were ordered. The PCP noted on 11/21/14 regarding client #3, "possible fracture of coccyx." The PCP ordered</p>	W000153	<p>The facility will have evidence that all incidents/injuries of unknown origin are thoroughly investigated and documented.</p> <p>The agency has current policies and procedures that prohibit the mistreatment, neglect and abuse of the individuals served as well as policies that specifically address the reporting of and completion of investigations of unknown injuries or incidents.</p> <p>The Leadership Team will complete a review of these policies to ensure that they are current and continue to meet the needs and safety of the individuals served. All staff will receive training on these policies upon hire and annually thereafter. The training includes a review and competency of the process for reporting and investigating any incidents and unknown injuries.</p> <p>The Residential Manager, Clinical Supervisor/QIDP will complete are training on the facility policies and procedures regarding their responsibilities to insure that all incidents as defined by policy are</p>	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
	<p>Tylenol for pain, straight chairs and to consider physical therapy and a donut seat. The PCP indicated "will take 8-12 weeks for recovery." There was no documentation the facility administrator and BDDS had been informed of the 11/17/14 incident.</p> <p>2) Record review of client #3 was done on 12/18/14 at 12:50p.m. A nursing note on 12/1/14 indicated staff #4 had seen client #3 at the facility day services. The note indicated client #3's knuckles on her left hand were discolored. The note indicated client #3 reported she had fallen at her family's during a home visit. An x-ray on 12/4/14 indicated client #3 had a fracture of the left ring finger. There was no documentation the facility administrator and BDDS had been informed of the 12/1/4 discovery of client #3's unknown injury while on a home visit.</p> <p>Professional staff #1 was interviewed on 12/19/14 at 10:51a.m. and on 12/23/14 at 9:20a.m. Professional staff #1 indicated the above identified incidents for client #3 of significant client injury and an injury of unknown origin had not been immediately reported to the administrator and BDDS. Staff #1 indicated all allegations of abuse/neglect and unknown origin should be immediately reported to</p>		<p>reported and investigated immediately. The Clinical Supervisor/QIDP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Program Manager is responsible for insuring that these incidents of unknown origin are thoroughly investigated and follow up is completed within the established guidelines.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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
W000154	<p>the administrator and BDDS.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 3 of 4 incidents of client significant injury, (client #3) and of unwitnessed origin reviewed to ensure all injuries of an unknown origin were thoroughly investigated.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 12/18/14 at 10:43a.m. The review included the following incidents for client #3:</p> <p>1) Record review of client #3 was done on 12/18/14 at 12:50p.m. A nursing note on 11/17/14 indicated staff #4 (Licensed Practical Nurse, LPN) had seen client #3 on 11/17/14. The nursing note indicated "no bruising from fall this morning, walking slowly but no signs of pain." A nursing note on 11/18/14 indicated client was still walking slowly with no</p>	W000154	<p>The facility will have evidence that all incidents/injuries of unknown origin are thoroughly investigated and documented.</p> <p>The agency has current policies and procedures that prohibit the mistreatment, neglect and abuse of the individuals served as well as policies that specifically address the reporting of and completion of investigations of unknown injuries or incidents.</p> <p>The Leadership Team will complete a review of these policies to ensure that they are current and continue to meet the needs and safety of the individuals served. All staff will receive training on these policies upon hire and annually thereafter. The training includes a review and competency of the process for reporting and investigating any incidents and unknown injuries.</p>	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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	
	<p>complaints of pain. Client #3 saw her primary care physician (PCP) on 11/19/14 and x-rays were ordered. The PCP noted on 11/21/14, regarding client #3, "possible fracture of coccyx." The PCP ordered Tylenol for pain, straight chairs and to consider physical therapy and a donut seat. The PCP indicated "will take 8-12 weeks for recovery." There was no documentation the facility had an incident report and an investigation to determine the cause of the fall with injury.</p> <p>Staff #2 (group home staff) was interviewed on 12/17/14 at 6:22p.m. Staff #2 indicated they were unsure how client #3 had fallen. Staff #2 indicated it was reported client #3 had slipped on ice going to the van and also indicated a peer had opened a van door into client #3.</p> <p>2) A nursing note on 12/1/14 indicated staff #4 (LPN) had seen client #3 at the facility's day services. The note indicated client #3's knuckles on her left hand were discolored. The note indicated client #3 reported she had fallen at her family's during a home visit. An x-ray on 12/4/14 indicated client #3 had a fracture of the left ring finger. There was no documentation the facility had an incident report and investigation to determine the location and cause of the</p>		<p>The Residential Manager, Clinical Supervisor/QIDP will complete re training on the facility policies and procedures regarding their responsibilities to insure that all incidents as defined by policy are reported and investigated immediately. The Clinical Supervisor/QIDP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Program Manager is responsible for insuring that these incidents of unknown origin are thoroughly investigated and follow up is completed within the established guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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			
	<p>hand injury.</p> <p>3) An incident report on 12/4/14 indicated client #3 had fallen at the group home while she was assisted (by group home staff) with putting on a scarf. The report indicated client #3 had fallen backwards and reported no injury at the time of the fall. The report indicated client #3 had gone for x-rays on 12/4/14, and had a fractured right wrist and a fractured left ring finger. There was no documentation of a thorough investigation. There were no documented interviews of the clients and staff in regards to the fall with injury.</p> <p>Professional staff #1 was interviewed on 12/19/14 at 10:51a.m. and on 12/23/14 at 9:20a.m. Staff #1 indicated the facility should have completed/documented an incident report and a thorough investigation for the incidents on 11/17/14 and on 12/1/14. Staff #1 indicated the facility failed to have a thorough investigation of the 12/4/14 incident by having no documented interviews. Staff #1 indicated there has been a change at the facility with staff assignments (responsibilities) in regards to incident reporting and investigations.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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
W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. Based on record review and interview, the facility failed for 1 of 3 sampled clients (#2) who received behavior control medications, to ensure client #2 received an annual medication reduction.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 12/18/14 at 2:13p.m. Client #2's 11/22/13 behavior support plan (BSP) indicated client #2 received the behavior medication Lexapro for Depression. Client #2's behavior data indicated client #2 had (1) documented (resistive behavior) behavioral incident from 1/14 through 10/14. Client #2's medication reduction plan indicated a medication reduction would be considered if client #2 had "no more than 3 resistive behaviors per month across a 6 month period." There was no documentation the interdisciplinary team (IDT) had addressed a possible behavior medication reduction. There was no documentation by the psychiatrist regarding a contraindication to a medication reduction. There was no documentation</p>	W000316	<p>The Behavioral Support Plans (BSP) for all individuals in the home, as well as Client # 2 have been reviewed to insure that a medication reduction plan is in place and are current. The QIDP is responsible to monitor the progress of behavior support goals and report the progress of lack of progress to the physician that monitors the individual's behavior medications. The QIDP reports this progress to the physician and to the team on at least a quarterly basis for review. The QIDP will assure that a medication reduction plan is included in each individual Behavior Support Plan and that a medication reduction is initiated on at least an annual basis. Each QIDP will receive training on their responsibilities for monitoring and reporting progress to the IDT and physician. The Clinical Supervisor is responsible for reviewing each individual client record on at least a quarterly basis to assess accuracy and timeliness, including monitoring that each BSP includes a plan for the reduction of medications. The Program Manager will insure that the quarterly audits are completed and any issues</p>	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/23/2014
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR 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	
	<p>client #2's medication had been reduced during the past year.</p> <p>Interview of staff #1 on 12/19/14 at 10:54a.m. indicated the facility's IDT had not met and discussed a possible annual reduction for client #2. Staff #1 indicated client #2 had met the criteria for a behavior medication reduction.</p> <p>9-3-5(a)</p>		identified are resolved.		