

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/24/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4475 N 17TH ST TERRE HAUTE, IN 47805			
(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 a fundamental recertification and state licensure survey.</p> <p>Survey Dates: May 13, 15, 16, 20, and 24, 2013</p> <p>Provider Number: 15G508 Aims Number: 100245140 Facility Number: 001022</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed May 28, 2013 by Dotty Walton, QIDP.</p>			W000000			

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:  15G508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/24/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4475 N 17TH ST TERRE HAUTE, IN 47805			
(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
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed to ensure nursing services monitored current physician orders for 1 of 4 sampled clients (client #1). The facility failed to ensure client #1's current medication administration record (MAR) reflected the correct way she was to receive her medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/20/13 at 7:58a.m. Client #1's 5/13 MAR indicated client #1 was to receive the following medication crushed: Claritin (allergy), Synthroid (thyroid) and Ditropan (incontinent). Client #1 had 5 other tablet medications that the MAR did not indicate to crush. Interview of staff #4 on 5/20/13 at 7:58a.m. indicated they do not crush any of client #1's medication and they felt the MAR was wrong. Client #1 had a 4/26/13 medication order to crush medication and give with food. Client #1's current physician ordered diet was mechanical soft diet. Client #1's most recent Barium Swallow Evaluation (2/16/10) indicated "give medication whole with food."</p> <p>Professional staff #2 (nurse) was</p>			W000331	<p>The Medication Administration Record regarding client # 1's medications has been corrected and clarifies the physician's current order.</p> <p>It is the responsibility of the nurse assigned to the home to review changes from the current medication sheets and make the changes on the next month's Medication Administration Record as well as the triplicate copy of the Physician's Orders on at least a monthly basis. All current nurses will complete training on their expectations with this process. The Director of Health Services is responsible for completing this training.</p> <p>An audit of all clients Medication Administration Records will be conducted to assure all reflect the current physician's order and correct information. The Director of Health Services is responsible for assuring that this audit is completed and that any necessary changes are implemented. The Nurse assigned to the home will continue to monitor MAR orders for accuracy on a monthly basis.</p>		06/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/24/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4475 N 17TH ST TERRE HAUTE, IN 47805			
(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			
	interviewed on 5/20/13 at 10:40a.m. Staff #2 indicated they thought the order for 3 medications to be crushed on the current MAR was incorrect. Staff #2 thought client #1 received medications whole. Staff #2 indicated they would need to contact the physician to be sure they had the current physician's orders on the MAR.  9-3-6(a)						