

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/22/2011
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2429 S 11 1/2 ST TERRE HAUTE, IN47802
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Date of Survey: November 14, 15, 16, 17, 21, 22, 2011</p> <p>Provider Number: 15G441 Aims Number: 100235230 Facility Number: 000955</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance 460 IAC 9. Quality Review completed 12-8-11 by C. Neary, Program Coordinator.</p>	W0000		
W0149	<p>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, for 1 of 1 injury of an unknown origin (client #1), the facility failed to implement policy and procedures to immediately report a significant client injury of an unknown origin to the Bureau of Developmental Disabilities Services (BDDS) and to complete a thorough investigation.</p> <p>Findings include: Record review of the facility incident</p>	W0149	<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 investigation of unknown injuries. All staff receive training on these policies upon hire and annually thereafter. The training includes a review of the BDDS definitions of incidents and the process for reporting and investigating any incidents.</p> <p>All staff at the home, including the</p>	12/22/2011

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>reports was done on 11/16/11 at 12:14p.m. The incident report review indicated the following: The reportable incident report dated 10/27/11 indicated client #1 had an X-ray of the right foot and it indicated a healing fracture of the right 5th toe from a previous injury. There was no indication of the cause of the injury. A physician's order on 9/7/11 indicated x-ray results "probable nondisplaced fracture of 5th toe on right foot" and recommended wearing a walking boot until no pain or 6 weeks. There was no documented BDDS reportable incident report regarding the 9/7/11 injury until the 10/27/11 reportable report. There was no documented investigation to determine the cause of the injury of unknown origin.</p> <p>The facility's policy and procedures were reviewed on 11/21/11 at 11:08a.m. The facility policy "Incident Reporting Significant Incidents Policy and Investigation Procedures" dated 7/1/11, indicated: Injuries of an unknown origin are to be immediately reported to Quality Assurance, reported to BDDS within 24 hours and investigation completed to determine cause of injury.</p> <p>Staff #6 (quality assurance) was</p>		<p>Home Manager and Program Coordinator/QMRP will complete re-training on the facility policies and procedures regarding their responsibilities to insure that all incidents as defined by the policy are reported and investigated immediately. This training will include definitions of State reportable incidents and the documentation requirements and timelines for reporting. The Program Coordinator/ QMRP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Program Director is responsible for insuring that these incidents of unknown origin are thoroughly investigated and follow-up is completed within the established timelines. The Program Coordinator/ QMRP and Program Director will complete training on the agencies policy and procedure concerning Investigations of Unknown Injuries/Incidents.</p> <p>Once an initial incident report is completed, the facility has an established written process in which reports are then submitted to BDDS as indicated. The Director of Licensing and Compliance is responsible for insuring that reports are submitted to BDDS and to the Administrator within 24 hours. The Licensing and Compliance Department staff will complete re-training on this process and</p>		

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W0153	<p>interviewed on 11/21/11 at 1:18p.m. Staff #6 indicated the above identified incident of injury of an unknown origin had not been immediately reported to BDDS. Staff #6 indicated they did not receive any information regarding client #1's 9/7/11 injury and x-ray until the 10/27/11 follow up x-ray was reported. Staff #6 indicated there was no documented investigation to identify the cause of the 9/7/11 fracture. Interview of staff #1 (QMRP) on 11/21/11 at 12:24p.m. indicated they had been told the injury was from another client in a wheel chair accidentally running over client #1's foot. Staff #1 indicated there was no documentation of this and was not aware of any documented investigation. 9-3-2(a)</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 1 of 5 facility reportable incidents (client #1), to immediately report injuries of an unknown origin to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p>	W0153	<p>their responsibilities for reporting incidents. The Executive Director will be responsible for implementing this training.</p> <p>The facility will insure 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>The agency has current policies and procedures that prohibit the mistreatment, neglect and abuse</p>	12/22/2011	

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	<p>Record review of the facility incident reports was done on 11/16/11 at 12:14p.m. The incident report review indicated the following: The reportable incident report dated 10/27/11 indicated client #1 had an X-ray of the right foot and indicated a healing fracture of the right 5th toe from a previous injury. There was no indication of the cause of the injury. A physician's order on 9/7/11 indicated x-ray results "probable nondisplaced fracture of 5th toe on right foot" and recommended wearing a walking boot until no pain or 6 weeks. There was no documented BDDS reportable incident report regarding the 9/7/11 injury until the 10/27/11 reportable report.</p> <p>Staff #6 (quality assurance) was interviewed on 11/21/11 at 1:18p.m. Staff #6 indicated the above identified incident of injury of an unknown origin had not been immediately reported to BDDS. Staff #6 indicated they did not receive any information regarding client #1's 9/7/11 injury and x-ray until the 10/27/11 follow up x-ray was reported.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>of the individuals served as well as policies that specifically address the reporting of and investigation of unknown injuries. All staff receive training on these policies upon hire and annually thereafter. The training includes a review of the BDDS definitions of incidents and the process for reporting and investigating any incidents.</p> <p>All staff at the home, including the Home Manager and Program Coordinator/QMRP will complete re-training on the facility policies and procedures regarding their responsibilities to insure that all incidents as defined by the policy are reported and investigated immediately. This training will include definitions of State reportable incidents and the documentation requirements and timelines for reporting. The Program Coordinator/ QMRP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Program Director is responsible for insuring that these incidents of unknown origin are thoroughly investigated and follow-up is completed within the established timelines. The Program Coordinator/ QMRP and Program Director will complete training on the agencies policy and procedure concerning Investigations of Unknown Injuries/Incidents.</p>		

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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed for 1 of 1 incident of injuries (client #1) of an unknown origin to ensure they are thoroughly investigated.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 11/16/11 at 12:14p.m. The incident report review indicated the following: The reportable incident report dated 10/27/11 indicated</p>	W0154	<p>Once an initial incident report is completed, the facility has an established written process in which reports are then submitted to BDDS as indicated. The Director of Licensing and Compliance is responsible for insuring that reports are submitted to BDDS and to the Administrator within 24 hours. The Licensing and Compliance Department staff will complete re-training on this process and their responsibilities for reporting incidents. The Executive Director will be responsible for implementing this training.</p> <p>The facility will have evidence that all alleged violations are thoroughly investigated. 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 investigation of unknown injuries. All staff receive training on these policies upon hire and annually thereafter. The training includes a review of the BDDS definitions of incidents and the process for</p>	12/22/2011

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W0159	<p>client #1 had an X-ray of the right foot and indicated a healing fracture of the right 5th toe from a previous injury. There was no indication of the cause of the injury. A physician's order on 9/7/11 indicated x-ray results "probable nondisplaced fracture of 5th toe on right foot" and recommended wearing a walking boot until no pain or 6 weeks. There was no documented investigation to indicate the cause of the injury (fracture) to client #1's right 5th toe.</p> <p>Staff #6 (quality assurance) was interviewed on 11/21/11 at 1:18p.m. Staff #6 indicated the above identified incident of injury of an unknown origin had not been investigated. Staff #6 indicated they did not receive any information regarding client #1's 9/7/11 injury and x-ray until the 10/27/11 follow up x-ray was reported. 9-3-2(a)</p> <p>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 4 sampled clients (#2, #3, #4) to ensure each client's active treatment program was coordinated and monitored by the facility's qualified</p>	W0159	<p>reporting and investigating any incidents. All staff at the home, including the Home Manager and Program Coordinator/QMRP will complete re-training on the facility policies and procedures regarding their responsibilities to insure that all incidents as defined by the policy are reported and investigated immediately. This training will include definitions of State reportable incidents and the documentation requirements and timelines for reporting. The Program Coordinator/ QMRP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Program Director is responsible for insuring that these incidents of unknown origin are thoroughly investigated and follow-up is completed within the established timelines. The Program Coordinator/ QMRP and Program Director will complete training on the agencies policy and procedure concerning Investigations of Unknown Injuries/Incidents.</p> <p>The facility will insure that each client's active treatment program is integrated, coordinated, and monitored by a qualified mental retardation professional (QMRP). The QMRP is</p>	12/22/2011	

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	<p>mental retardation professional (QMRP), by the QMRP not completing program reviews.</p> <p>Findings include:</p> <p>Record review for client #2 was done on 11/20/11 at 9:27a.m. Client #2's QMRP program reviews indicated client #2 had an individual support plan (ISP) dated 10/20/11. There were no documented QMRP program reviews during the time period of 10/1/10 through 10/20/11.</p> <p>Record review for client #3 was done on 11/18/11 at 10:44a.m. Client #3's QMRP program reviews indicated client #3 had an ISP dated 10/20/11. There were no documented QMRP program reviews during the time period of 11/1/10 through 10/20/11.</p> <p>Record review for client #4 was done on 11/16/11 at 2:54p.m. Client #4's QMRP program reviews indicated client #4 had an ISP dated 10/20/11. There were no documented QMRP program reviews during the time period from 10/1/10 through 10/20/11.</p> <p>Staff #1 (QMRP) was interviewed on 11/21/11 at 12:24p.m.. Staff #1 indicated the QMRP should be reviewing the clients' programs at least quarterly. Staff</p>		<p>responsible for reviewing and documenting the individual program plan for each client on at least a monthly basis. Plans are reviewed for accurate staff implementation and progress toward the goal of the plan. On at least a quarterly basis or more often as evident in documentation of the program implementation, the QMRP is responsible for revising plans as progress or lack of progress is noted. The QMRP will facilitate a quarterly meeting with the interdisciplinary team to review progress toward goals and to discuss revisions as necessary. The quarterly team meetings will be documented and maintained in each individuals file. All current qualified mental retardation professionals will receive training on the coordination and monitoring of client active treatment programs. The Program Director will implement this training. The Program Director will monitor each individuals plan on at least a quarterly basis to insure that program reviews are complete and documented in each clients program file. The Program Director is responsible to insure that the qualified mental retardation professionals provide continuous integration, coordination, and monitoring of client services by way of tracking quarterly review documentation of client services.</p>		

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W0186	<p>#1 indicated there was no documentation of quarterly QMRP program reviews for clients #2, #3 and #4 during the past 12 months prior to their 10/20/11 annual ISP. 9-3-3(a)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>The facility failed for 1 of 4 sampled clients (#3) and two non-sample clients (#5, #7) to provide sufficient staff to provide supervision to manage client behaviors.</p> <p>Findings include:</p> <p>An observation was done at the group home on 11/15/11 from 7:36a.m. to 9:30a.m. At 7:57a.m., there were 3 staff and 7 clients at the group home. One staff was in the facility office passing client medications (one client at a time), one staff was in the kitchen preparing breakfast with clients #2 and #4 (client #4 was currently on a special staffing need of a staff within arms length) and one staff was in the bathroom assiting with client #7. During this time client #5 was in client #7's bedroom and taking client #7's personal items out of the bedroom. Client #3 was in a bedroom she shared with client #6. Client #3 was going through client #6's dresser of clothes. Staff #5 who was assisting client #7 in the bathroom had yelled out for assistance with client #7 but no staff were available to respond. There were no staff available</p>	W0186	The facility will provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. This home is a Developmental level home and the previous staffing patterns were meeting the staffing limits of the home, however the individuals that live in this home do require continuous supervision in order to insure that their safety and that active programming needs are provided. The facility has reviewed the staffing patterns at the home to insure that there is adequate staff to manage and supervise all individuals. An additional 12 hours of staffing have been added to the staffing pattern each day during waking hours in order to provide additional supervision to meet the current needs of the individuals. The Home Manager	12/22/2011

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W0249	<p>to redirect client #3 and #5 from going through peers' personal items.</p> <p>Interview of staff #1 on 11/21/11 at 12:24p.m. indicated there should be enough staff to provide each client with their identified assistance/training needs. Staff #1 indicated there were usually 3 staff on duty in the morning. Staff #1 indicated more staff were needed due to client #4's staffing need recently implemented for a staff to be in arms length of client #4. 9-3-3(a)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and</p>	W0249	<p>is responsible to insure that staff are scheduled according the needs of the individuals of the home on a daily basis. The Program Coordinator/ QMRP is responsible for oversight to insure that staff is maintained at a level that provides sufficient direct care staff to manage and supervise clients in accordance with the individual program plan. At times, in order to insure adequate staffing, the Home Manager, Program Coordinator/ QMRP, or other management level staff person may work in the capacity of a direct care staff in order to insure that the staffing levels are met. The Home Manager is responsible to insure that coverage is adequate at all times and is on-call 24 hours a day to insure that staffing is adequate. The Program Director will monitor the staffing hours for each home on at least a weekly basis to insure that adequate coverage is provided to insure that there is sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>The Program Coordinator is responsible to ensure that each</p>	12/22/2011	

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	<p>interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3, #4) and one non-sample client (#6) to ensure the clients' communication and dining training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 11/14/11 from 3:44p.m. to 5:24p.m. client #1 wore a walking boot on his left foot throughout the observation.</p> <p>An observation at the group home was done on 11/15/11 from 7:36a.m. to 9:30a.m. Client #1 had a walking boot on his right foot. Interview of staff #1 at 8a.m. indicated client #1 should have the walking boot on his right foot for a healing right toe fracture. Clients #1, #2, #3 and #4 were all non-verbal. Clients #1, #2, #3 and #4 did not use nor were they prompted to use any communication books or sign language during the observation which included activities and breakfast. At 8:50a.m., client #6 was given a glass of juice. The juice was regular style, no thickener added. Record review on 11/15/11 at 8:39a.m. of the facility 10/18/11 "Diet Report" indicated client #6 was to receive nectar liquids.</p> <p>The record of client #1 was reviewed on</p>		<p>client's treatment program is reviewed on at least a monthly basis to determine that written objectives are being implemented and to determine the success of the plan. On a weekly basis, the Program Coordinator will monitor all objectives to insure that staff are providing the appropriate opportunities to receive continuous active treatment as determined by the ISP. The Program Coordinator is responsible for insuring that staff has the information and supplies required to assist each individual with programming needs. The Program Coordinator is responsible for implementing further documented training or corrective measures with any staff observed to not be providing active treatment. Staff will be re-trained regarding the program goals and implementation for each clients program plan needs. Staff will also receive re-training on implementation of Active Habilitation and Meaningful Opportunities Guidelines in order to meet the activity needs of the individuals and provide choices of activities to participate in. This training will include demonstrating competency through simulated examples. The Program Coordinator is responsible for providing this training. The Home Manager and Program Coordinator are responsible for observing staff during implementation and</p>		

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	<p>11/17/11 at 1:50p.m. Client #1's 10/20/11 individual support plan (ISP) indicated client #1's communication training program was to use a communication book to point to a picture of a plate. The ISP indicated client #1 was to wear a walking boot on his right foot due to a nondisplaced fracture.</p> <p>The record of client #2 was reviewed on 11/21/11 at 9:27a.m. Client #2's 10/20/11 ISP indicated client #2's communication training program was to sign quarter, mother and medications.</p> <p>The record of client #3 was reviewed on 11/18/11 at 10:44a.m. Client #3's 10/20/11 ISP indicated client #3's communication training program was to use her communication book to indicate toilet, chores and activities.</p> <p>The record of client #4 was reviewed on 11/16/11 at 2:54p.m. Client #4's 10/20/11 ISP indicated client #4 had training programs to use his communication book to point picture of bed.</p> <p>Interview of staff #1 on 11/21/11 at 12:24p.m. indicated client #1, #2, #3 and #4's communication training programs and client #6's dietary program (nectar drink) should have been implemented at all opportunities. Staff #1 indicated client</p>		documentation completion on at least a weekly basis. The Program Coordinator will observe in the home weekly to ensure that all clients programs are being run correctly and document same on Program Coordinator Audit forms and these forms will be turned into the Program Director on a weekly basic to be reviewed. The Program Director is responsible for follow up with the Program Coordinator if the weekly audit schedule is not met.		

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W0369	<p>#1 should have worn his walking boot on his right foot. 9-3-4(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 clients observed to receive medications administered by staff (client #3), to ensure client #3 received her medication without error.</p> <p>Findings include:</p> <p>Observation was done at the group home on 11/14/11 from 3:49p.m. to 5:24p.m. Client #3 was observed to receive medication at 4:12p.m. Client #3 received Actos 15 milligrams (mg.) for non-insulin diabetes management. Client #3 did not eat with her medication. Client #3 had not eaten any food from 3:49p.m. through 5:24p.m. Interview of staff #4 at 4:54p.m., indicated supper would be served around 6p.m. on 11/14/11.</p> <p>Record review of the facility's 11/11 medication administration record (MAR) on 11/14/11 at 4:18p.m. indicated client #3 was to receive Actos 15mg. with</p>	W0369	<p>The medication administration time for Client #3's Actos has been modified so that it will be given with the evening meal time as indicated by the physicians order. Staff will be trained on the medication administration change for client #3. The Program Coordinator is responsible for implementing this training. The Program Coordinator and Home Manager will be responsible for weekly monitoring to assure that the medication is being administered properly. The nurses will review all client medication regimes to insure that all medications are scheduled to be given according to the physicians order and the type of medication. This type of review will be conducted on a monthly basis when completing the nursing monthly review. As needed the Medication Administration Record will be revised to reflect any changes needed and staff will receive training on the revisions.</p>	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2011
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2429 S 11 1/2 ST TERRE HAUTE, IN47802		
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	<p>supper. Record review for client #3 was done on 11/18/11 at 10:44a.m. Client #3 had physician's orders on 10/26/11 that indicated client #3 was to receive Actos 15mg. with supper for diabetes management.</p> <p>Interview of staff #2 (nurse) on 11/21/11 at 12:24p.m. indicated client #3 should have received her Actos with supper. Staff #2 indicated the medication was for diabetes management.</p> <p>9-3-6(a)</p>				