

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 02/03/2012
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST LONGRIDGE 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	
W0000	<p>This visit was for a post certification revisit (PCR) to the recertification and state licensure survey completed on 11/22/11.</p> <p>Survey Dates: February 2, 3, 2012</p> <p>Provider Number: 15G441 Aims Number: 100235230 Facility Number: 000955</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 2/13/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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: 15G441		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2012	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST LONGRIDGE 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			
W0369	<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 2 clients (#3) observed to receive medication, to ensure client #3 received her medication without error.</p> <p>Findings include:</p> <p>Observation was done at the group home on 2/2/12 from 7:12a.m. to 8:30a.m. Client #3 was observed to receive medication at 7:40a.m. Client #3 received Risperdal 2 milligrams.</p> <p>Client #3's 2/12 medication administration record (MAR) was reviewed on 2/2/12 at 7:44a.m. The MAR indicated client #3 had physician's orders to receive 1 1/2 milligrams of Risperdal at 7a.m. for mood disorder.</p> <p>Interview on 2/2/12 at 7:47a.m. of staff #3 indicated client #3 had received 2 milligrams of Risperdal during the 7:40a.m. 2/2/12 medication pass. Staff #3 indicated client #3 should have only received 1 1/2 milligrams of Risperdal. Staff #3 indicated the a.m. and p.m. dose boxes had been put in the wrong storage area which contributed to the medication error.</p>	W0369	<p>The facility will administer medications to the individuals without error.</p> <p>All staff members have received additional training on medication administration protocols. This training includes a review of the specific steps involved to complete a medication administration pass, medication storage, and a review of specific individual programs related to medication administration. The Director of Nursing and the Program Coordinator are responsible for completing this training.</p> <p>Documented monitoring of the staff's competency with medication administration skills will be conducted with each staff person. Each staff person will be observed conducting a medication pass. Any staff person not meeting the performance standards of the medication pass observation will be required to complete further training. Weekly spot checks of staff that successfully pass the competency observation will be conducted. The agency nurse, Home Manager, and Program Coordinator will be responsible for implementing this monitoring.</p>	02/27/2012			

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 02/03/2012
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST LONGRIDGE 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	
	9-3-6(a) This deficiency was cited on 11/22/11. The facility failed to implement a systemic plan of correction to prevent recurrence.		The staff responsible for the medication error to client # 3 has received corrective action and additional re-training which included observation and coaching during the medication administration process. In effort to eliminate medication errors in the future, a buddy check observation system for staff passing medications has been implemented. The buddy check system will involve a documented staff peer review following each medication administration to insure that all medications are administered according to physician orders. The Home Manager and Program Coordinator will be responsible for implementing this system and monitoring at least weekly to assure the system is utilized properly. Nursing will assess each client's medication administration times to assure that the client's medication routine provides the most beneficial schedule for the medications involved and the individual's routine. The Director of Health Services will be responsible for this review. Additionally, the nurse assigned to the home will complete a review of the medication storage area on at least a weekly basis to ensure that all medications are stored in a proper, organized manner to eliminate		

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 02/03/2012
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST LONGRIDGE 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	
			opportunities for staff error. The nurse will submit a weekly checklist to the Director of Health Services and resolve any issues noted immediately. This home has recently moved to a new location (replacement home). The area in which medications are stored and are administered is larger and provides for a more organized area for medications to be administered.		