

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G621	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4217 N 13 1/2 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
W 0000  Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: July 14, 15, 16 and 17, 2015</p> <p>Provider Number: 15G621 Aims Number: 100245680 Facility Number: 001158</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0159  Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</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 2 of 3 sampled clients (#1, #2) to ensure clients' #1 and #2's active treatment programs were coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP). The QIDP failed to have documentation in regards to the follow up to the interdisciplinary team meeting (IDT) recommendation for client #1 to have a hand bike for therapy. The QIDP failed to ensure client #2's range of</p>	W 0159	<p>All current QIDP's will receive training on the coordination and monitoring of client treatment programs. This training will include protocols for analyzing and compiling collected data and timelines for completing reports on the result. On a quarterly basis, the QIDP facilitates a meeting with the IDT to review progress and needs with team members. Monthly and quarterly reports will be completed in insure the plan is current. The</p>	08/14/2015

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:  15G621		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  07/17/2015	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4217 N 13 1/2 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
	<p>motion (ROM), ankle stretches, program had been done at the group home.</p> <p>Findings include:</p> <p>Record review for client #1 was done on 7/16/15 at 11:00a.m. Client #1 had an IDT meeting on 5/15/15. The IDT indicated a hand bike would be purchased for client #1 to use to assist with physical mobility. There was no further documentation in regards to the hand bike.</p> <p>Record review for client #2 was done on 7/16/15 at 9:38a.m. Client #2's 6/29/15 physician's orders indicated client #2 had a plan of treatment to do ankle stretches for ROM. There was no documentation to indicate if client #2 had been doing the ROM exercises.</p> <p>Professional staff #1 (QIDP) was interviewed on 7/16/15 at 11:33a.m. Staff #1 indicated they did not think client #1 had received a hand exercise bike and there was no documented follow up to the 5/15/15 IDT meeting. Staff #1 indicated client #2 had ROM exercises indicated on his plan of treatment but there was no documentation to indicate if client #2 had been doing the exercises. Staff #1 indicated documentation should have been on the medication</p>				<p>QIDP will be responsible to see that all monitoring and plans are current.</p> <p>The Clinical Supervisor will oversee that the QIDP provides continuous integration, coordination and monitoring of client services by way of monthly tracking and quarterly meetings with the interdisciplinary team by conducting at least a quarterly audit of each Individual Support Plan and following up accordingly. The Program Manager will conduct trainings with the QIDP and Clinical Supervisors as to their responsibilities in the coordination and monitoring of treatment plans. The Program Manager will be responsible for implementing further training or corrective measures in instances where the expectations for providing monitoring of the client's treatment programs are not met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G621	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4217 N 13 1/2 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
W 0249 Bldg. 00	<p>administration record (MAR). Staff #1 indicated the QIDP was responsible to monitor the clients' programs to ensure there was follow up to program recommendations.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients (#1, #2) to ensure client #2's identified behavior support plan (BSP) and client #1's dining training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 7/15/15 from 4:02p.m. to 6:20p.m. at the facility group home. Throughout the observation time, client #2 licked his hands without consistent redirection. At 5:47p.m., client</p>	W 0249	<p>The training objective for client #1 to use pictures to identify objects has been reviewed and all staff will be trained on the implementation of the program as written.</p> <p>The BSP for client #2 has been reviewed and all staff will be retrained on the implementation of the BSP.</p> <p>On a weekly basis, the Residential Manager and/or the QIDP will monitor all objective to insure that staff are providing the appropriate opportunities to receive continuous active treatment as determined by</p>	08/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G621		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/17/2015	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4217 N 13 1/2 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
	<p>#1 was at the dining room table for supper. No communication pictures were used with client #1 during his dining.</p> <p>Record review for client #1 was done on 7/16/15 at 11:00a.m. Client #1 had an individual support plan (ISP) dated 5/22/15. The ISP indicated client #1 had a dining training program to identify a picture of "eat" prior to eating.</p> <p>Record review for client #2 was done on 7/16/15 at 9:38a.m. Client #2 had a BSP dated 6/1/15. The BSP indicated client #2 had a program to address him licking his hands. The BSP indicated when client #2 licks his hands, staff should give him a verbal prompt to stop and to place his hands on his lap. If he continued to lick his hands, staff were to continue to redirect and to redirect client #2 to an activity that involved the same muscle group.</p> <p>Professional staff #1 was interviewed on 7/16/15 at 11:33a.m. Staff #1 indicated client #2's BSP addressed his identified stereotypical behavior of licking his hands. Staff #1 indicated facility staff should redirect client #2 to stop licking his hands and to an activity if he continued. Staff #1 indicated client #1 had a dining program to identify the picture "eat" prior to meals. Staff #1</p>				<p>the ISP and BSP. The Residential Manager is responsible for insuring that staff have the information and supplies required to assist each individual with programming needs.</p> <p>Staff responsible for implementing each client's program plan will be re-trained regarding the program goals and implementation for the clients programming needs in the home. The QIDP will be responsible for providing this training.</p> <p>The Residential Manager is responsible for observing staff during implementation and documentation completion on at least a weekly basis. The QIDP will observe in the home weekly to ensure that all clients program are being run correctly and documented accordingly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G621	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  07/17/2015
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 4217 N 13 1/2 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	
	indicated this training program should have been implemented at meal opportunities  9-3-4(a)				