

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G421	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711		
(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 fundamental recertification and state licensure survey.</p> <p>Survey dates: 1/10, 1/11, 1/12 and 1/17/12</p> <p>Facility Number: 000935 Provider Number: 15G421 AIM Number: 100235180</p> <p>Surveyor: Jenny Rida, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 2/6/12 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: 15G421		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711			
(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
W0388	<p>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices.</p> <p>Based on observation and interview for 1 of 4 sampled clients (#3), the facility failed to have proper labeling on his medication.</p> <p>Findings include:</p> <p>During the 1/11/12 5:00 AM medication administration client #3 was given 1 tablespoon of Ultra Tuss DM (Cold Medicine). The bottle did not have a pharmacy label.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 1/11/12 at 7:50 AM stated "[Client #3] just went to [name of Urgent Care] yesterday, so I got the medicine for him out of the first aid kit; I did not fill it through the pharmacy."</p> <p>Interview with RN (Registered Nurse) on on 1/11/12 at 8:00 AM stated "If any client is given a prescription it should be filled through the pharmacy and have the proper pharmacy label on it to ensure there is not a medication error."</p> <p>9-3-6(a)</p>			W0388	<p>- Nursing Department will be retrained on proper ordering procedures through the PAL Pharmacy, including new medication orders.- The Program Coordinator/designee will be retrained on completing medication storage checklist.- A nurse/designee will be retrained on completing a monthly medication storage checklist to ensure that medications are labeled properly.- The Program Coordinator/designee will be retrained on completing a weekly medication storage checklist to ensure that medications are labeled properly.Responsible Parties: Nurse / Designee & Program Coordinator / Designee</p>		02/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G421	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711
--	---

(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