

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834
--	--

(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 recertification and state licensure survey.</p> <p>Dates of Survey: October 29, 30, and 31, 2014.</p> <p>Provider Number: 15G400 Aims Number: 100244450 Facility Number: 000914</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 10, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#3), the facility failed to ensure client #3 had the right to keep/maintain his own personal hygiene items.</p> <p>Findings include:</p> <p>An observation was done on 10/29/14</p>	W000137	<p>Client #3 now has full access to his personal belongings. All of the client's personal hygiene supplies will be placed in the bedrooms so that they are accessible to them. All staff will be trained on client rights and rights restrictions that includes providing access to hygiene supplies. The Residential Manager/QIDP will be responsible for providing this</p>	12/01/2014

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: 15G400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834		
(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>from 3:50p.m. to 5:38p.m. at the group home. At 4:12p.m. client #3's personal hygiene container (tooth brush, tooth paste) was observed to be kept in the locked medication room/office. Staff # 4 was interviewed at 4:42p.m. Staff #4 indicated client #3's personal hygiene container was kept in the locked office because a former resident, that was client #3's roommate, used to get into client #3's things. Staff #4 indicated she was not aware of any reason for client #3's personal hygiene container to still be kept locked. Staff #4 indicated only staff had a key to the office.</p> <p>Record review for client #3 was done on 10/30/14 at 10:40a.m. Client #3's 4/25/14 individual support plan (ISP) did not indicate client #3's personal hygiene container would be kept locked in the office. Client #3 had no training program to address the locked personal hygiene items.</p> <p>Staff #1 was interviewed on 10/30/14 at 12:14p.m. Staff #1 indicated client #3 did not have a training program to address his locked personal hygiene items. Staff #1 indicated the personal hygiene items should not have been kept locked in the group home office.</p> <p>9-3-2(a)</p>		<p>training.</p> <p>In the event that the IDT or per assessment it is identified that a restriction must be in place for training or safety purposes, The QIDP is responsible to insure that any restrictions initiated against the rights of any client is to be addressed and approved by the IDT and the Human Rights Committee before any type of restriction can be implemented.</p> <p>The Residential Manager/QIDP will include monitoring that hygiene supplies are accessible as part of their weekly audits.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834			
(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			
W000159	<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 4 sampled clients (#2, #4) to ensure each client's active treatment program was coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP), by the QIDP not ensuring a guardian's written consent had been returned via the mail (#2, #4) and a behavior medication reduction for met criteria was addressed (#2).</p> <p>Findings include:</p> <p>1) The record of client #2 was reviewed on 10/30/14 at 9:58a.m. Client #2's 5/8/14 individual support plan (ISP) indicated client #2 had a guardian. The ISP indicated client #2 had a restrictive behavior support plan (BSP). There was documentation the ISP had been sent to the guardian. There was no documentation of guardian written informed consent for client #2's 5/8/14</p>	W000159	<p>All current QIPD's will receive training on the coordination and monitoring of client treatment programs. This training will include protocols for analyzing and complaining 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 to insure that each plan is current. The QIPD 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 training with</p>	12/01/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834			
(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>ISP.</p> <p>2) The record of client #2 was reviewed on 10/30/14 at 9:58a.m. Client #2's 5/8/14 individual support plan (ISP) indicated client #2 received the behavior medications Paxil and Abilify for Depression. Client #2's behavior data indicated client #2 had (0) documented (inappropriate social behavior) behavioral incidents from 4/14 through 8/14. Client #2's medication reduction plan indicated a medication reduction would be considered if client #2 had "no more than 7 episodes of inappropriate social behaviors per month across 3 consecutive months." There was no documentation the interdisciplinary team (IDT) had addressed a possible behavior medication reduction. There was no documentation client #3's medication had been reduced during the past year.</p> <p>3) The record of client #4 was reviewed on 10/30/14 at 11:18a.m. Client #4's 4/25/14 ISP indicated client #4 had a guardian. The ISP indicated client #4 had a restrictive behavior support plan. There was documentation the ISP had been sent to the guardian. There was no documentation of guardian written informed consent for client #4's 4/25/14 ISP.</p>		<p>the QIPD and Clinical Supervisor 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 client's treatment programs are not met.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834			
(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			
W000249	<p>Staff #1 (QIDP) was interviewed on 10/30/14 at 12:14p.m. Staff #1 indicated clients #2 and #4's guardians had been sent a copy of their ISPs but had not returned a written consent for the programs. Staff #1 indicated there was no documentation the QIDP had followed up on obtaining the guardian signature for client #2's 5/8/14 and client #4's 4/25/14 ISP. Staff #1 indicated the QIDP was responsible for the coordination and monitoring of obtaining guardian written consent and the monitoring of behavior data/criteria for client medication reductions.</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. Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (#1, #3) to ensure client #1's medication training program and client #3's communication training</p>	W000249	The training objectives form Client #1 and the training objective for Client #3 has been reviewed and all staff have been trained on the implementation of the program as	12/01/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834			
(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>program were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 10/29/14 from 3:50p.m. to 5:38p.m. at the facility group home. At 4:03p.m., client #1 received her medication. Client #1 was observed to receive the medication Dilantin 100 milligrams (mg). Client #1 was not prompted to identify any medication during the medication pass. At 5:04p.m., staff #5 verbally prompted client #3 to use the bathroom and to wash his hands. Staff did not demonstrate the sign for bathroom nor did she ask client #3 to show the sign for bathroom.</p> <p>Record review for client #1 was done on 10/30/14 at 11:28a.m. Client #1 had an individual support plan (ISP) dated 4/25/14. The ISP indicated client #1 had a medication training program to identify the purpose of her Dilantin medication (seizures) during all training opportunities.</p> <p>Record review for client #3 was done on 10/30/14 at 10:40a.m. Client #3 had an ISP dated 4/25/14. The ISP indicated client #3 had a communication program to sign bathroom with staff demonstrating the sign for him.</p>		<p>written. The QIDP is responsible to ensure that each 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.</p> <p>On a daily basis, the home manager and/or the QIPD will monitor all objectives to insure that staff are providing the appropriate opportunities to receive continues active treatment as determined by the ISP. The Home Manager is responsible for insuring that staff has the information and supplies required to assist with individual with programming needs.</p> <p>Staff responsible for the implementation each client's program plan will be re-trained regarding the program goals and implementation for the client's programming needs in the home. The QIDP will be responsible for providing the training.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834
--	--

(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
W000316	<p>Professional staff #1 was interviewed on 10/30/14 at 12:14p.m. Staff #1 indicated client #3 had a communication program to sign bathroom at all opportunities. Staff #1 indicated client #1 had a medication training program to identify her Dilantin medication. Staff #1 indicated these training programs should have been implemented at all opportunities</p> <p>9-3-4(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#2) who received behavior control medications, to ensure client #2 received an annual medication reduction.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 10/30/14 at 9:58a.m. Client #2's 5/8/14 individual support plan (ISP) indicated client #2 received the behavior medications Paxil and Abilify for Depression. Client #2's behavior data</p>	W000316	<p>The BSP for all individuals in the home, as well as Client # 2 have been reviewed to insure that a medication reduction plan is in place and are current.</p> <p>The QIDP is responsible to monitor the progress of behavior support goals and report the progress of lack of progress to the physician that monitors the individual's behavior medications. The QIDP reports this progress to the physician and to the team on at least a quarterly basis for</p>	12/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 605 W CRAIG BRAZIL, IN 47834		
(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>indicated client #2 had (0) documented (inappropriate social behavior) behavioral incidents from 4/14 through 8/14. Client #2's medication reduction plan indicated a medication reduction would be considered if client #2 had "no more than 7 episodes of inappropriate social behaviors per month across 3 consecutive months." There was no documentation the interdisciplinary team (IDT) had addressed a possible behavior medication reduction. There was no documentation client #3's medication had been reduced during the past year.</p> <p>Interview of staff #1 on 10/30/14 at 12:14p.m. indicated the facility's IDT had not met and discussed a possible annual reduction for client #2. Staff #1 indicated client #2 had met the criteria for a behavior medication reduction.</p> <p>9-3-5(a)</p>		<p>review. The QIDP will assure that a medication reduction plan is included in each individual Behavior Support Plan and that a medication reduction is initiated on at least an annual basis. Each QIDP will receive training on their responsibilities for monitoring and reporting progress to the IDT and physician.</p> <p>The Clinical Supervisor and/or designee is responsible for reviewing each individual client record on at least a quarterly basis to assure that client needs are being assessed appropriately by the team and that goals are being reviewed and revised as needed by the IDT.</p>		