

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT 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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 09/09/15</p> <p>Facility Number: 000954 Provider Number: 15G440 AIM Number: 100244720</p> <p>At this Life Safety Code survey, Normal Life of Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was not sprinklered. The facility has a fire alarm system with smoke detection in corridors and common living areas. Client sleeping rooms are provided with battery powered smoke detectors. The facility has the capacity for 8 and had a census of 5 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K 0000		
------------------------	--	--------	--	--

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: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT 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
K S046 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.3.</p> <p>Quality Review on 09/14/15 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the master bedroom, a wet location client care area, was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects 2 of 5 clients.</p> <p>Findings include:</p>	K S046	The Facility will ensure that a GFI protected receptacle is installed for all personnel and clients in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. A GFI receptacle has been installed in this location and the Maintenance staff have conducted a check of all areas of the home to ensure that protection is provided to all. The Maintenance Director has been made aware of the requirements and will conduct a check at least monthly of the GFI receptacles throughout the home for appropriate operation and will follow-up to any issues immediately. Additionally, the Safety Committee conducts a checklist at the home on at least a quarterly basis to ensure safety and cleanliness. Checking for GFI's in kitchens and bathrooms is included on this list to ensure compliance.	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT 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
K S123 Bldg. 01	<p>Based on observation with the Clinical Supervisor on 09/09/15 at 4:30 p.m., the master bathroom had a receptacle on the wall within two feet of the hand sink. At the time of observation, the Clinical Supervisor acknowledged power was not interrupted at the master bed receptacle when tested with a GFCI testing device.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every bathroom door is designed to allow opening from the outside during an emergency when locked. 32.2.2.5.4, 33.2.2.5.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 bathroom doors could be opened from the outside during an emergency when locked. This deficient practice could affect any client.</p> <p>Finding includes:</p> <p>Based on observation on 09/09/14 from 4:30 p.m. to 4:35 p.m., the doors entering bathroom #2 and #3 could be locked from the inside. Based on an interview with the Clinical Supervisor at the time of observation, he was unable to provide the tool necessary to unlock to doors.</p>	K S123	<p>The facility will insure that all interior doors in the home will have push button lock type door knobs so that the locks can be easily unlocked using a variety of simple available items and to ensure that the doors could be opened from the outside during an emergency when locked. "Simple available items" could include a key, ink pen or pencil, paper clip, etc. All staff will be made aware of the operation of such type of locks and how to unlock the door in the event of an emergency. The Maintenance staff have been made aware of their responsibility to ensure that only push button-type door knobs are used in all interior areas of the home. They have conducted a check throughout the home and replaced any door knobs that are not of the appropriate type. The Safety Committee conducts a visit</p>	10/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2015
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT 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	
K S147 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 Based on record review and interview, the facility administration failed to have a written fire safety plan to protect 5 of 5 clients. This deficient practice affects all clients in the facility.	K S147	to the home on at least a quarterly basis. Checking that all interior doors have push button lock doors that are easily unlocked in the event of an emergency has been added to the checklist to ensure that this is addressed and monitored. The Program Manager is responsible for ensuring that any issues identified by the Safety Committee are communicated and follow-up immediately. The facility will ensure that there is a written Fire Safety plan that is specific to the individuals that resident in the home available at all times and that all staff receive training on their responsibilities in	10/09/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2015
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT 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	
K S148 Bldg. 01	<p>Findings include:</p> <p>Based on record review and interview on 09/09/15 at 4:25 p.m., the Clinical Supervisor acknowledged the facility was unable to provide a written fire safety plan.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1</p> <p>Based on record review and interview, the facility failed to enforce 1 of 1 smoking policies. This deficient practice could affect any of the 5 clients in the facility.</p> <p>Findings include:</p> <p>Based on interview on 09/09/15 at 4:27 p.m., the Clinical Supervisor stated the designated smoking area for the clients</p>	K S148	<p>the provision of safety in the event of a fire emergency. The Clinical Supervisor is responsible for ensuring that the written plan is consistently up to date and revised as the needs of the individuals change. Staff are to receive training on and practice the plan upon hire, at least every two months, and as the plan is revised. All staff will receive retraining on the plan and will be aware of their responsibilities in the event of an emergency as outlined in the written plan. The Program Manager is responsible to review the plans on at least an annual basis to ensure compliance and accuracy. The Safety Committee review fire drills/ staff training on at least a quarterly basis. The</p> <p>The facility is not certain of the intent of this citation. The facility has a policy that designates smoking areas for the home. This smoking policy is for all employees, visitors, and clients and its intent is to provide safety and individual rights for all. The facility written smoking policy is an overall policy for the all services provided by the agency. It states "Individuals served by the agency may smoke within their home if it has been</p>	10/09/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2015
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1970 E 45 1/2 CT 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	
	was outside of the home on the front porch. The written smoking policy titled "Smoking" dated 08/01/09 which was provided during the record review process at 4:26 p.m., stated "Individuals served by the agency may smoke within their home if it has been determined that it does not violate the rights of others in the home, which will be determined by each individual's interdisciplinary team".		determined that it does not violate the rights of others in the home, which will be determined by each individual's interdisciplinary team". The intent of this is to make an acceptance for those individuals served by the agency that live in their own apartment or home and their smoking would not necessarily infringe on the rights of others living in the home. This would be discussed by and documented by each individual support team. The Smoking Policy will be reviewed by the Leadership Team to determine if revisions are needed. The policy will be reviewed with all staff in the home to insure that they are aware of and compliant with the policy. The Residential Manager is responsible for ensuring that all staff are aware of and are compliant with the facility Smoking Policy.		