

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2304 CRUFT AVE TERRE HAUTE, IN 47803
--	--

(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 fundamental recertification and state licensure survey.</p> <p>Survey Dates: October 17, 18, 23, 24, 25, 2013</p> <p>Provider Number: 15G662 Aims Number: 100245260 Facility Number: 001207</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/30/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed to exercise operating direction over the facility to provide a safe environment for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) living in the group home.</p> <p>Findings include:</p>	W000104	<p>The agency takes any concerns with client safety seriously. The two chairs in question were removed and replaced on 10/18. A new chair set has been ordered for the home. The home undergoes a Safety Committee inspection each quarter that includes observation of the home furniture. The QMRP and Home Manager are</p>	11/18/2013

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:  15G662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/25/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2304 CRUFT AVE TERRE HAUTE, IN 47803			
(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>An observation of clients #1, #2, #3, #4, #5, #6, #7 and #8 (at the group home) was done on 10/17/13 from 4:49p.m. to 6:24p.m. The observation included the following environmental condition: there were two metal dining room table chairs with their back legs bent inward. The two chairs, when (surveyor) scooted backwards, were easier to tip than the other chairs. Clients #1 and #8 sat in the broken chairs during the supper observation.</p> <p>Staff #4 was interviewed on 10/17/13 at 5:23p.m. Staff #4 indicated clients #1 and #8 usually sat in the two broken dining room chairs. Staff #4 was not aware of any client incidents while sitting in the chairs. Staff #4 indicated client #1 had tipped his chair over when pushing it up to the table when finished eating.</p> <p>Staff #2 was interviewed on 10/17/13 at 5:26p.m. Staff #2 indicated a new table and chairs had been ordered for this group home.</p> <p>Interview of staff #1 on 10/24/13 at 1:32p.m. indicated a new table and chairs had been ordered. Staff #1 indicated the two dining room chairs with bent legs had been replaced and were no longer being used.</p>		<p>responsible for at least weekly visits to the home for overall observation and staff training. In the meantime any safety concerns with the home environment are expected to be reported by the Home Manager and documented on a Maintenance Request Form. Addendum added: The Home Manager at this home had only recently started in her position and was not familiar with her responsibility and the protocol for reporting maintenance issues at the time. She has since received further training in her responsibilities and the process for reporting maintenance issues, as well as insuring the safety of the individuals by removing any hazards within the home. It was not acceptable that individuals would be sitting in or utilizing chairs that may cause them to be in an unsafe situation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/25/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2304 CRUFT AVE TERRE HAUTE, IN 47803			
(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
W000227	<p>9-3-1(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#1) to ensure client #1's individual support plan (ISP) had a training program in place to address his identified need of managing his cigarettes.</p> <p>Findings include:</p> <p>Record review for client #1 was done on 10/23/13 at 11:29a.m. Client #1's 10/17/13 ISP indicated staff monitored client #1's cigarettes by allowing client #1 to smoke hourly between 6a.m. to 9p.m., "due to his inability to manage his cigarettes." The ISP indicated client #1 "would utilize an objective in the area of responsibility with specific regard to his cigarettes." Client #1 did not have a documented objective to address this identified need.</p> <p>Staff #2 was interviewed on 10/24/13 at 1:42p.m. Staff #2 indicated client #1</p>			W000227	<p>The training program regarding managing cigarettes for client #1 has been implemented. The Program Coordinator will receive training on expectations to assure all identified needs from an individuals ISP are addressed. The Program Coordinator will review all client ISP's for the home to assure all identified needs are being addressed. The Program Manager will be responsible for this training and assuring ISP audit is completed. Addendum added: The QIDP is responsible to insure that each individual's needs are addressed in their Individual Program Plan and addressed formally as recommended by the IDT. The QIDP is responsible to provide information to the Home Manager and staff as to the protocols and formal objectives that they must initiate to meet each individuals needs and assist them toward independence. The QIDP has met with the IDT and has developed an individual program plan designed to address the training needs for Client #1 in managing cigarettes.</p>		11/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2304 CRUFT AVE TERRE HAUTE, IN 47803
--	--

(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
W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.		The QIDP will provide training to all staff in the home on the specific implementation of the plan. Data will be collected by staff in order to track progress of the plan. The QIDP will monitor data collected on at least a monthly basis to determine any issues or progress made and will revise as needed. The QIDP is responsible to ensure that any specific needs that may be identified throughout the year are reviewed by the IDT as needed and revised the individual program plan as determined by the IDT. The QIDP is responsible for reviewing the individual program plans with the IDT on at least a quarterly basis to review progress made or needed revisions. The QIDP is responsible for providing staff with on-going training concerning individual program plans and objectives that are in place to address the specific needs of each client. The Clinical Supervisor and/or the Program Manager is responsible for reviewing each client's individual program plan on at least a quarterly basis to ensure that objectives are being initiated as written and that needs are being addressed and monitored for progress.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/25/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2304 CRUFT AVE TERRE HAUTE, IN 47803			
(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>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3, #4) and 4 additional clients (#5, #6, #7, #8), the facility failed to encourage clients to participate in meal preparation to the extent they were capable.</p> <p>Findings include:</p> <p>During the 10/24/13 observation period between 4:49p.m. to 6:24p.m. at the group home, facility staff did not encourage clients, who were available to assist (#1, #2, #3, #4, #5, #6, #7, #8), to participate in all aspects of the meal preparation. At 5:00p.m., staff #4 put water in a measuring cup and added the water to a pan and put the pan on the stove top. Staff #4 stirred the stir fry chicken. Staff got frozen vegetables out of the freezer and added them to the chicken. Staff got frozen garlic bread out of the freezer. Staff put foil on a baking sheet, sprayed it with oil and put the bread on the baking sheet. Staff put family style bowls of fruit cocktail and pasta salad onto the dining room table. At 6p.m. staff #4 made a drink mix in a pitcher and stirred it with client #6 watching him. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were available to assist during the observation.</p> <p>Interview of professional staff #2 on</p>	W000488	<p>All staff at the home will receive training on protocols and expectations for active treatment and family style dining. The Program Coordinator is responsible for this training. The Program Coordinator and Home Manager will each conduct weekly visits to the home to assure expectations with client meals are being met. Addendum added: All staff receive training on active treatment, client participation, and family style dining upon hire and annually. On at least a daily basis for two weeks, the Home Manager and/or QIPD will monitor and observe at least one meal time a day to insure that staff are providing the appropriate opportunities to each individual in the home to receive continuous active treatment as determined by the ISP and that staff are providing individuals opportunities to participate in the general routine of the home on an ongoing basis. The Home Manager is responsible for insuring that staff has the information and supplies required to assist each individual with active treatment and programming needs. The Home Manager and the QIDP are each responsible for observing a meal (prep and eating) in the home on at least a weekly ongoing basis and for completing a home audit checklist documenting the outcome of that observation. The</p>	11/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/25/2013
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2304 CRUFT AVE TERRE HAUTE, IN 47803		
(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	
	10/24/13 at 1:42p.m. indicated all the clients were capable of assisting with the meal preparation with some staff assistance. Staff #2 indicated the clients should have been more involved with the family style meal. 9-3-8(a)		Program Manager tracks home audits that indicate that observations have been conducted at the home weekly and insures that follow-up has been initiated as needed.		