

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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
W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: December 2, 3, 6, 9 and 10, 2013.</p> <p>Provider Number: 15G489 Aims Number: 100235260 Facility Number: 001003</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 December 13, 2013 by Dotty Walton, QIDP.</p>	W000000		
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL 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 1 of 4 sampled clients (#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 identified training programs were documented and data had been</p>	W000159	The exercise program for client #4 has been implemented. All staff in the home have received training on the implementation of the program and documenting progress. The Home Manager and QIPD is responsible for at least weekly monitoring in the home to assure all programs are being implemented and for providing on-going staff training and support as needed. The	01/10/2014

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:  15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/10/2013
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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	
	<p>collected.</p> <p>Findings include:</p> <p>Record review for client #4 was done on 12/9/13 at 12:54p.m. Client #4's 11/22/05 physical therapy (PT) note recommended "home exercise program (HEP) to enhance stability and possibly reduce right knee pain." An 11/29/05 PT note indicated "exercises to be done 3 times a week every Monday, Wednesday and Friday. Staff are to assist her and document they are being done on the medication administration record (MAR)." Client #4's 12/5/13 physician's orders indicated client #4 was to do a HEP three times a week. There was no documentation the HEP was being done three times a week.</p> <p>Staff #2 (QIDP) was interviewed on 12/10/13 at 10:02a.m. Staff #2 indicated client #4 had a physician's order to do home exercises three times a week. Staff #2 indicated they were not aware if client #4 had been doing the HEP. Staff #2 indicated there was no documentation of client #4 completing the HEP.</p> <p>9-3-3(a)</p>		<p>QIPD is responsible for monthly progress monitoring of each program goal and to insure that staff has the information and supplies required to assist each individual with programming needs. The QIPD is responsible for implementing further documented training or corrective measures in instances where expectations regarding client programs are not met. All current Home Managers and QIDP's will receive training on the coordination and monitoring of client active treatment programs. The Program Manager will implement this training. The Program Manager will oversee that QIDP's provide continuous integration, coordination, and monitoring of client services. The Program Manager will be responsible for implementing further training or corrective measures in instances where the expectation for providing monitoring of client's active treatment programs is not met. Addendum as requested 1-29-14: Initially for 30 days, the Home Manager and the QIPD provided daily observations and monitoring to insure that staff were consistently implementing individual training programs as opportunities arose and allowed. All staff have received additional training concerning their responsibilities in implementing each individuals ISP as determined by the team. As a</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/10/2013
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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	
W000249	<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 non-sampled clients (#6, #7), to ensure the clients' medication training programs</p>	W000249	<p>follow up to compliance, during the month of February 2014, the Home Manager, QIPD, and the Clinical Supervisor/ Program Manager will each complete a weekly home visit (resulting in at least 3 visits a week at a variety of times/ shifts) to conduct an observation during time when staff and individuals are home. The observation will focus on the implementation of training plans/ goals. Any issues will be addressed with staff immediately and additional training will be provided. These observations will be documented on a Home Audit Checklist and submitted to the Program Manager for tracking and follow-up. After this time, the QIPD is responsible for conducting a home visit at least weekly in each home, documenting the visit and follow-up and submitting the documentation to the Program Manager for follow-up.</p> <p>All staff in the home will receive training on implementing the medication training objectives for clients #6 and #7 as written. The QIPD will be responsible for</p>	01/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G489		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/10/2013	
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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			
	<p>were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 12/2/13 from 4:04p.m. to 6:22p.m. Client #7 received her medication at 4:22p.m. Client #7 received the medication Seroquel for bi-polar disorder. Client #7 was given her medication without any medication training. Client #6 received her medication at 4:24p.m. Client #6 received Ferrous Sulfate for anemia with no medication training.</p> <p>The record of client #6 was reviewed on 12/9/13 at 2:22p.m. Client #6's 9/27/13 individual support plan (ISP) indicated client #6 had a medication training program to state the reason she takes Ferrous Sulfate.</p> <p>The record of client #7 was reviewed on 12/9/13 at 2:15p.m. Client #7's 9/13/13 ISP indicated client #7 had a medication training program to state the reason she takes Seroquel.</p> <p>Interview of staff #2 on 12/9/13 at 2:31p.m. indicated clients #6 and #7's medication training programs were current training programs and should</p>		<p>re-training all staff on the client's medication training goals. The QIPD and/or Home Manager will complete daily observations at the home for 30 days to insure that staff are implementing and documenting programs as written and as opportunities are available. Any noted issues will be addressed immediately with staff to insure compliance and competency with training and client needs. The Program Manager will insure that daily observations are completed as expected and that any issues are addressed as needed. Following the 30 day observation period, the QIPD and/or Home Manager will conduct at least weekly observations in the home during the time that active treatment is in process and individuals are home. These observations will be documented on a Weekly Home Visit checklist that is submitted to the Program Manager for review. The QIPD is responsible to ensure that the progress of each client's treatment program is reviewed on a monthly basis. The QIPD is responsible to determine if the plan is successfully addressing the clients needs and that it is properly being implemented.</p> <p>Addendum as requested 1-29-14: As stated in the original POC, the QIPD and/or Home Manager completed daily observations at the home for 30 days to insure that staff are</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/10/2013
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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	
	have been implemented at all opportunities.  9-3-4(a)		implementing and documenting programs as written and as opportunities are available. As a follow up to compliance, during the month of February 2014, the Home Manager, QIPD, and the Clinical Supervisor/ Program Manager will each complete a weekly home visit (resulting in at least 3 visits a week at a variety of times/ shifts) to conduct an observation during time when staff and individuals are home. The observation will focus on the implementation of training plans/ goals. Any issues will be addressed with staff immediately and additional training will be provided. These observations will be documented on a Home Audit Checklist and submitted to the Program Manager for tracking and follow-up. After this time, the QIPD is responsible for conducting a home visit at least weekly in each home, documenting the visit and follow-up and submitting the documentation to the Program Manager for follow-up.		
W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview, for 3 of 4 sample clients (#2, #3, #4) and 3 additional clients (#6, #7, #8), the facility failed to encourage the clients to wash their hands before their	W000455	All staff in the home will receive further training on infection control to include prompting client's on hand washing protocols and expectations, especially during meals and medication administration times.	01/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/10/2013
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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	
	<p>medication passes.</p> <p>Findings include:</p> <p>An observation was done at the group home on 12/2/13 from 4:04p.m. to 6:22p.m. The following clients came to the medication room and received their medication without washing their hands prior to coming to the medication room and did not wash their hands prior to receiving their medications:</p> <p>At 4:15p.m., client #8; at 4:22p.m., client #7 took her medication; at 4:24p.m., client #6 took her medication; at 4:28p.m., client #2 took her medication; at 4:32p.m., client #3 took her medication; and at 4:36p.m., client #4 took her medication.</p> <p>Staff #4, who administered the medications, did not prompt the clients to wash their hands.</p> <p>Interview of staff #1 (nurse) on 12/9/13 at 2:31p.m. indicated all clients should be washing their hands prior to receiving their medications. Staff #1 indicated client hand washing was part of the facility's medication administration protocol.</p>		<p>The QIPD will be responsible for this training. All staff receive initial training on infection control at the time of hire and annually thereafter. Staff also complete training on infection control and hand washing policies/ protocols during their Core A and B Medication Administration Certification. The QIPD and Home Manager will be responsible for completing at least weekly monitoring/ observation to assure staff are meeting infection control protocols at a time of medication administration. The Home Manager will be responsible for assuring further ongoing training and if necessary corrective action in instances where protocols are not being followed by staff.</p> <p>Additionally, the QIPD will discuss with each individuals IDT to determine if formal training programs addressing hand washing are a priority at this time. Addendum as requested 1-29-14: Initially for 30 days, the Home Manager and the QIPD provided daily observations and monitoring to insure that staff were consistently implementing individual training programs and infection control procedures (specifically during medication administration) as opportunities arose and allowed. All staff have received additional training concerning their responsibilities in implementing each individuals ISP and following infection control</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/10/2013
NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 7469 KINGSWOOD ST 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	
	9-3-7(a)		procedures. As a follow up to compliance, during the month of February 2014, the Home Manager, QIPD, and the Clinical Supervisor/ Program Manager will each complete a weekly home visit (resulting in at least 3 visits a week at a variety of times/ shifts) to conduct an observation during time when staff and individuals are home. The observation will focus on the implementation of training plans/ goals. Any issues will be addressed with staff immediately and additional training will be provided. These observations will be documented on a Home Audit Checklist and submitted to the Program Manager for tracking and follow-up. After this time, the QIPD is responsible for conducting a home visit at least weekly in each home, documenting the visit and follow-up and submitting the documentation to the Program Manager for follow-up.		