

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G060	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2014
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 106 ALLENDALE TERRE HAUTE, IN 47802
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(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: May 20, 21, 22, 23, 27, 28, 2014</p> <p>Provider Number: 15G060 Aims Number: 100233640 Facility Number: 000612</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 6/5/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 1 of 1 investigation of alleged neglect/abuse reviewed (client #2), to ensure appropriate identified corrective action was taken.</p> <p>Findings include:</p>	W000157	The facility has a "zero-tolerance" policy for abuse, neglect or mistreatment of individuals served. The facility will actively and aggressively investigate all allegations of abuse, neglect, and/ or mistreatment. All incidents are to be reported immediately according to the facility procedures and will be followed up accordingly.	06/27/2014

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.

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	<p>Record review of the facility's investigation reports was done on 5/27/14 at 3:04p.m. A 5/5/14 investigation report indicated on 4/28/14 a group home staff member had intentionally attempted to scare client #2 and had spoken with disrespect to client #2. The facility's 5/5/14 investigation substantiated the allegation and the staff was terminated. The investigation also identified the need to retrain current staff on active treatment, positive interactions and abuse/neglect. Record review of staff training was done on 5/27/14 at 3:20p.m. There was no documentation the facility had retrained current staff on the identified corrective action for the 4/28/14 incident.</p> <p>Professional staff #2 was interviewed on 5/27/14 at 3:25p.m. Staff #2 indicated the facility's corrective action identified for the 4/28/14 incident, had included retraining facility staff on active treatment, positive interactions and abuse/neglect. Staff #2 indicated as of 5/27/14, there was no documentation the facility staff had been retrained on the identified corrective action.</p> <p>9-3-2(a)</p>		<p>At the conclusion of each investigation, the Executive Director or Program Manager will complete an Investigation Checklist to review that the facility's established investigation process, required time lines, and follow-up to recommendations or needs identified have been addressed according to facility and regulatory guidelines. This post- review of the investigation will eliminate the opportunity for the facility to fail to follow-up to recommendations. The completed checklist will be filed with the Investigation Packet once it is completed. Both the Executive Director and the Program Manager have reviewed their responsibilities in concluding and closing an investigation.</p> <p>All staff including the Home Manager will complete training on active treatment and positive interactions as indicated in the investigation. All staff including the home manager will complete training on the agency's abuse/neglect policy including recognizing and reporting allegations. The Program Coordinator/QIDP will be responsible for implementing this training with all staff members. The Home Manager and/ or Program Coordinator/QIDP will complete weekly monitoring/ observations at the home to ensure interactions between staff</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			and residents are appropriate at all times and to maintain consistent face to face contact with staff and individuals in the home.		