

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/09/2012
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NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 N 6TH ST TERRE HAUTE, IN 47804
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Date of Survey: April 3, 4, 5, and 9, 2012</p> <p>Provider Number: 15G657 Aims Number: 100468760 Facility Number: 001185</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 4/16/2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 2 sampled clients (#1, #2) to ensure the clients' rights to be free from unnecessary locked items (towels, linens) located in a locked hallway closet, to which only staff had a key.</p> <p>Findings include:</p> <p>Observation of clients #1 and #2 was done at the group home on 4/4/12 from 7:00 a.m. to 8:04 a.m. At 7:50 a.m., staff #3 had a key and unlocked a hallway closet that contained household towel and linen supplies. Staff #3 put household towels into the closet and locked the door. Interview of staff #3 on 4/4/12 at 7:52 a.m. indicated the towels and linens were kept locked and only staff had a key. Staff #3 indicated they were not aware of any client misuse of the towels and linens.</p> <p>Record review for client #1 was done on 4/5/12 at 10:12 a.m. Client #1 had an individual support plan (ISP) dated 1/28/11. There was no documentation to</p>	W0125	The towels and linens have been removed from the locked closet. All staff at the home along with the QMRP and Home Manager will receive training on client rights and restrictions. The Program Director will be responsible for providing this training. The Home Manager and Program Coordinator will provide on-going weekly monitoring to assure that towels or other linens are not kept locked and that staff are supporting client access to these items.	05/08/2012			

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	<p>indicate client #1 was in need of locked towels and linens.</p> <p>Record review for client #2 was done on 4/5/12 at 11:34 a.m. Client #2 had an ISP dated 1/28/11. There was no documentation to indicate client #2 was in need of locked towels and linens.</p> <p>Staff #1 (operations manager) was interviewed on 4/5/12 at 10:37 a.m. Staff #1 indicated they were not aware the towels and linens were kept locked in the group home. Staff #1 indicated there were no clients in the group home that needed the towels and linens kept locked. Staff #1 indicated the towels and linens should not have been locked.</p> <p>9-3-2(a)</p>				

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W0159	<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.</p> <p>Based on record review and interview, the facility failed for 2 of 2 sampled clients (#1, #2) to ensure each client's active treatment program was coordinated and monitored by the facility's qualified mental retardation professional (QMRP), by the QMRP not completing annual and quarterly program reviews (#1, #2) and to ensure guardian approval was attempted to be obtained (#2).</p> <p>Findings include:</p> <p>Record review for client #1 was done on 4/5/12 at 10:12 a.m. Client #1's QMRP program reviews indicated client #1 had an individual support plan (ISP) dated 1/28/11. There were no documented QMRP program reviews during the time period of 1/28/11 through 4/5/12.</p> <p>Record review for client #2 was done on 4/5/12 at 11:34 a.m. Client #2's QMRP program reviews indicated client #2 had an individual support plan (ISP) dated 1/28/11. There were no documented QMRP program reviews during the time period of 1/28/11 through 4/5/12. Client #2's ISP indicated client #2 had a</p>	W0159	<p>The guardian approvals for client # 2 regarding Abilify have been resolved.</p> <p>All current qualified mental retardation professionals will receive training on the coordination and monitoring of client active treatment programs. This training will include protocols for obtaining guardian approvals as well as analyzing and compiling collected client program data, and timelines for completing reports on the results. The Program Director will implement this training.</p> <p>The Program Director will oversee that qualified mental retardation professionals provide continuous integration, coordination, and monitoring of client services by way of monthly tracking of quarterly review documentation of client services. This monthly tracking will be submitted to the Director of Licensing and Compliance to validate completion. In instances where the expectation for providing monitoring of client's active treatment programs is not met by the qualified mental retardation professional corrective action will be implemented.</p>	05/08/2012			

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	<p>guardian. Client #2's ISP indicated he received a behavior medication (Abilify) for mood disorder. There was documentation the guardian had been sent a copy of the 1/28/11 ISP. There was no documentation the guardian had returned a signed copy of the ISP. There was no documentation the QMRP had followed up with the guardian to ensure written approval (ISP) was obtained.</p> <p>Staff #1 (operations manager) was interviewed on 4/5/12 at 10:37 a.m.. Staff #1 indicated the QMRP should be reviewing the clients' programs at least quarterly. Staff #1 indicated quarterly QMRP program reviews had not been done for clients #1 and #2 during the past 12 months. Staff #1 indicated client #1 and #2's last documented ISPs were dated 1/28/11. Staff #1 indicated there was no documentation the facility had attempted to obtain client #2's guardian approval of his ISP since it was initially mailed to the guardian 1/28/11.</p> <p>9-3-3(a)</p>			

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W0260	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview, the facility failed for 2 of 2 sampled clients (#1, #2) to at least annually review and revise client #1 and #2's individual support plans (ISPs).</p> <p>Findings include:</p> <p>Record review for client #1 was done on 4/5/12 at 10:12 a.m. Client #1's training program reviews indicated client #1's current documented annual ISP was over a year old and was dated 1/28/11.</p> <p>Record review for client #2 was done on 4/5/12 at 11:34 a.m. Client #2's training program reviews indicated client #2's current documented annual ISP was over a year old and was dated 1/28/11.</p> <p>Interview of staff #1 (operations manager) on 4/5/12 at 10:37 a.m., indicated client #1 and #2's current ISPs were completed on 1/28/11. Staff #1 indicated the annual ISPs had not been completed annually (within 365 days).</p> <p>9-3-4(a)</p>	W0260	The annual ISP's for clients #1 and #2 have been completed. All QMRP's will receive training on the expectations and timelines for completing annual ISP's. The Program Director will be responsible for providing this training. The Program Director will conduct an audit of all clients in the home to assure that all clients ISP's are current.	05/08/2012			

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