STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00178580. Complaint #IN00178580 - Substantiated. Federal/State deficiencies related to the allegation are cited at W186 and W249. Dates of Survey: August 4, 5, 6, 2015 Provider Number: 15G592 Aims Number: 100240070 Facility Number: 001106 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients (A, B, C, D) and four non-sample clients (E, F, G, H) to	W 0186	The facility will provide sufficient staff to manage and supervise clients in accordance with their individualized plan. The home is a developmental level (8.0)	09/04/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	provide sufficient staff to provide supervision to manage client training and behavioral programs. Findings include: An observation was done at the group home on 8/6/15 from 12:43p.m. to 2:00p.m. During the observation from 12:43p.m. to 1:47p.m. there were 8 clients and 2 staff on duty. At 1:47p.m., 2 additional staff came on shift, for a 4 staff to 8 client ratio. At 12:43p.m. staff #4 was feeding client B and staff #5 was getting laundry out of the dryer (dryer located between dining room and kitchen). Client D had his hands in the front of his pants without redirection from staff. Clients E and G were seated at the dining room table and had finished eating. Both clients E and G required staff assistance with transfers from the dining room table to their wheelchair (E) and walker (G). At 12:50p.m., staff #4 fed client H and staff #5 was cleaning in the kitchen with client E. Client A was in the activity room by himself and clients B, C, D, and F were in the living room with the television on. Client B grabbed surveyor by the wrist and attempted to pull surveyor around the house, no staff were in the area at this time. Staff #4 redirected client B after she overheard the surveyor redirecting client B. At 1:18p.m.		licensure and the base schedule for the home includes staffing hours beyond that licensure level due to the needs of the individuals. The home has recently experienced turnover that has initiated extra recruiting and training efforts in order to meet the needs of the individuals in the home. The Program Manager will conduct training with the Clinical Supervisor and the Residential Manager to insure that they are aware of their responsibilities and the scheduling requirements of the home. The Residential Manager is responsible for insuring that there is sufficient staff in the home at all times. The Clinical Supervisor is responsible to review and approve the staffing schedule weekly to insure that adequate staff are assigned. The staffing schedule has been reviewed for the home and the Clinical Supervisor will monitor that adequate staff are assigned on a daily basis. The Program Manager will review the schedules and staffing hours for the home on at least a weekly basis ongoing to insure that adequate staff is being scheduled in order to meet the needs of the individuals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	client A got off the couch in the activity room and began moving furniture around before a staff saw him from the living room and redirected him. At 1:24p.m. client G was assisted with a transfer from the dining room chair to his walker. It took both staff to assist with the transfer and 1 staff trailed him as he walked. During this time, client B went into the kitchen and grabbed some bananas from the cabinet and squeezed them. Client B got some on his hands and put some banana into his mouth before a staff saw him and intervened. Staff #4 redirected client B to the dining room and gave him a slinky to hold. Throughout the rest of the observation client B would attempt to get into the kitchen cabinet when staff were not with him. Throughout the observation client D had his hand in the front and back of his pants without redirection. At 1:45p.m. staff #4 went to the restroom and this left 1 staff with 8 clients who were located in the kitchen, dining room and living room area. During the observation time: clients A, B, C, D, F and H were not able to independently stay on a task without staff redirection, client G was a 2 staff transfer from his chair to his walker, clients B and H were custodially fed by staff and client E needed stand by staff assist with transfers.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	The record of client A was reviewed on 8/5/15 at 3:45p.m. Client A's 8/8/14 individual support plan (ISP) indicated client A had a training program to be offered several leisure choices and to be encouraged to participate in a small group activity. The record of client B was reviewed on 8/5/15 at 4:17p.m. Client B's 8/8/14 ISP indicated client B had training programs to wash his hands, redirect from food stealing and encourage activity with a peer. The record of client C was reviewed on 8/5/15 at 4:04p.m. Client C's 8/8/14 ISP indicated client C had training programs to wash his body, sign drink and to use a raised tray when eating. The record of client D was reviewed on 8/5/15 at 2:58p.m. Client D's 8/8/14 ISP indicated client D had a training program to redirect client D from putting his hands in his pants. Staff were to redirect client D to wash his hands and to be given a choice of leisure activities. Staff #5 was interviewed on 8/6/15 at 12:50p.m. Staff #5 indicated there were supposed to be 3 staff on duty when all 8 clients were home. Staff #5 indicated they were short 1 staff today until			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	1:45p.m. The home manager was coming in around that time. Staff #5 indicated several of the clients had individual care needs. Staff #5 indicated the needs were met but this would leave one staff with the rest of the clients. Staff #5 indicated clients B and H were fed by staff and client F had a g-tube (gastrostomy tube) feeding at noon. Staff #5 indicated only clients E and G were able to self direct themselves with activity. Interview of staff #1 on 8/6/15 at 2:38p.m. indicated there should be at least 3 staff on duty during waking hours when all the clients were in the group home. Staff #1 indicated clients B and D had issues with food/drink stealing. Staff #1 indicated clients A, B, C, D, F and H were unable to self direct their leisure time and to stay on a task. This federal tag relates to complaint #IN00178580. 9-3-3(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	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. Based on observation, record review, and interview, the facility failed for 4 of 4 sampled clients (A, B, C, D), to ensure the clients' dining, leisure and behavioral training programs were implemented when opportunities were present. Findings include: An observation was done at the group home on 8/4/15 from 4:41p.m. to 6:09p.m. Throughout the observation time, client D had his hands in and out of the front and back of his pants. Staff did not consistently redirect client D to remove them and to wash his hands. Staff did not redirect client D to an activity when he had his hands in his pants. At 5:34p.m., clients A, B, C and D ate supper. Clients B and C did not wash their hands before supper. Client C did not use sign language for drink and he ate from a plate positioned at table top level (not on a raised tray). An observation was done at the group home on 8/6/15 from 12:43p.m. to 2:00p.m. Throughout the observation	W 0249	The training objectives will be reviewed and all staff will complete training on the implementation of the program as written. The QIDP is responsible to ensure that each client's treatment program is reviewed on at least a monthly basis to determine that written objectives are being implemented and to determine the success of the plan. On at least a weekly basis, the home manager and/or the QIPD will monitor all objectives and data collected to insure that staff are providing the appropriate opportunities to receive continues active treatment as determined by the ISP. The Home Manager is responsible for insuring that staff has the information and supplies required to assist with individual with programming needs. Staff responsible for the implementation each client's program plan will receive client specific training regarding the program goals and implementation	09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	client D had his hands in the front and back of his pants without redirection from staff. Throughout the observation (except when eating) client A was in the activity room by himself. Client A was not encouraged to participate in a small group activity with peers. At 1:24p.m., client B went into the kitchen and grabbed some bananas from the cabinet. Client B squeezed them, got some on his hands and put some banana into his mouth before a staff saw him and intervened. Staff #4 redirected client B to the dining room and gave him a slinky to hold. Throughout the rest of the observation client B would attempt to get into the kitchen cabinet when staff were not with him. The record of client A was reviewed on 8/5/15 at 3:45p.m. Client A's 8/8/14 individual support plan (ISP) indicated client A had a training program to be offered several leisure choices and to be encouraged to participate in a small group activity. The record of client B was reviewed on 8/5/15 at 4:17p.m. Client B's 8/8/14 ISP indicated client B had training programs to wash his hands, redirect from food stealing and encourage activity with a peer.		for the client's programming needs as well as training concerning active habilitation guidelines outlining programming opportunities.. The Clinical Supervisor will be responsible for providing and documenting the training with each staff person working at the home. Following training, The QIDP, Clinical Supervisor, Program Manager, and Residential Manager will conduct additional coaching and observation in the home for at least two hours a day for a two week period to insure that they had observed each staff person implementing each client's program plan and goals as the opportunities arose. The additional monitoring and observations insured that staff was knowledgeable of the plans and of their responsibilities in implementing them. The QIDP and Residential Manager are responsible for continuing to provide staff training and observation on at least a weekly basis to insure staff continue to follow-through with and maintain an understanding of the individual program plans. The Program Manager is responsible to insure that the Clinical Supervisor monitors the QIDP and Residential Manager in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	107 A VILLA CT BRAZIL, IN 47834

(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
	The record of client C was reviewed on 8/5/15 at 4:04p.m. Client C's 8/8/14 ISP indicated client C had training programs to wash his body, sign drink and to use a raised tray when eating. The record of client D was reviewed on 8/5/15 at 2:58p.m. Client D's 8/8/14 ISP indicated client D had a training program to redirect client D from putting his hands in his pants. Staff were to redirect client D to wash his hands and to be given a choice of leisure activities. Staff #1 was interviewed on 8/6/15 at 2:38p.m. Staff #1 indicated all clients should be encouraged to wash their hands before meals. Staff #1 indicated staff should be redirecting client D when he had his hands in his pants. Staff #1 indicated clients A, B, C and D's individual training programs should have been implemented at all opportunities. This federal tag relates to complaint #IN00178580. 9-3-4(a)		conducting their face to face observations and training in the homes on an ongoing basis.	