

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3214 W ELLEN DR 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
W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: April 30, May 1, 4, 7, 11,</p> <p>Provider Number: 15G370 Aims Number: 100235090 Facility Number: 000884</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 5/15/12 by Tim Shebel, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G370		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/11/2012	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3214 W ELLEN DR 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			
W0242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (client #1, #2) to include training in client #1 and #2's annual Individual Support Plan (ISP) for their identified dental hygiene needs (#1) and self feeding (#2).</p> <p>The findings include:</p> <p>Record review of client #1 was done on 5/7/12 at 10:26a.m. Client #1's 3/14/12 dental exam indicated "needs assistance with brushing." Client #1's 3/15/12 ISP did not have a training program to address his identified dental hygiene needs.</p> <p>Record review of client #2 was done on 5/7/12 at 9:54a.m. Client #2's 12/6/11 dietician review indicated "needs stop and go card to reduce eating pace." Client #2's 3/15/12 ISP did not have a training program to address his identified dining skills training needs.</p>	W0242	<p>The QMRP is responsible to insure that all of the needs of each individual is addressed in their Individual Program Plan and addressed formally as recommended by the IDT. The QMRP 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. A formal program has been developed and implemented by the QMRP to address Client #1's programmatic need to address dental hygiene. The QMRP will monitor the data collected on a weekly basis and to determine progress and appropriateness of the program goal. The IDT for client #2 has met to discuss the necessity of the stop and go card. Client # 2 currently has not displayed evidence that there is an issue with the pace in which he consumes his food and feels he would not benefit from this type of program. The team will continue</p>	06/10/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/11/2012
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3214 W ELLEN DR 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	
	Interview of staff #1 on 5/7/12 at 11:40a.m. indicated client #1 was in need of dental hygiene training and did not have any formal dental hygiene training in place. Staff #1 indicated the facility had not addressed the 12/6/111 dietician recommendation and client #2 did not have stop and go cards or any dining training program in place. 9-3-4(a)		to monitor his dietary program closely and continue to consult with the Registered Dietician to meet Client #2 needs. The QMRP 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 QMRP 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 QMRP 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 Program Director 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 as identified in the comprehensive functional assessment or as they are identified by incident.		