

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 09/21/2011
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 107 A VILLA CT BRAZIL, IN47834
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 13, 15, 16, 19, 20, 21, 2011</p> <p>Provider Number: 15G592 Aims Number: 100240070 Facility Number: 001106</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9-3. Quality Review completed 9/28/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0125	<p>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, interview and record review for 1 of 4 sampled clients (#2), the facility failed to ensure client #2 had the right to due process in regard to activated door alarms placed on the doors to</p>	W0125	<p>The ISP for Client #2 is being amended to include the use of alarms on the facilities entrance/exit doors. The Program Coordinator/ QMRP is responsible for adding this restriction to the ISP and obtaining necessary HRC</p>	10/21/2011

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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W0130	<p>enter/exit the facility.</p> <p>Findings include:</p> <p>An observation was done at the group home on 9/15/11 from 4:14p.m. to 6:10p.m. An alarm sounded when the doors to enter/exit the group home were opened.</p> <p>Record review for client #2 was done on 9/19/11 at 12:45p.m. Client #2's 7/28/11 individual support plan (ISP) did not indicate the use of alarms on the facility's enter/exit doors.</p> <p>Staff #1 was interviewed on 9/20/11 at 10:32a.m. Staff #1 indicated the activated door alarms were to address client #4's behavior. Staff #1 indicated this restriction was not addressed in client #2's ISP.</p> <p>1.1-3-2(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 1 non-sampled client (#7) to ensure the client's privacy during toileting.</p> <p>Findings include:</p>	W0130	<p>approval. The Program Coordinator is responsible to assure staff are trained on the revised ISP. This will be completed by 10-21-11.</p> <p>The QMRP is responsible to insure that each individual's needs are addressed in their Individual Program Plan and addressed formally as recommended by the IDT.</p> <p>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.</p> <p>The staff at the home will receive training on client's right to privacy. This training will include and address client privacy during toileting and include staff responsibility to ensure privacy during that process. The Program</p>	10/21/2011	

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W0159	<p>An observation was done on 9/15/11 from 4:14p.m. to 6:10p.m. at the group home. At 4:57p.m., client #7 went to the toilet and left the door open. Client #7 could be seen on the toilet from the hallway. Staff #4 walked past the bathroom and saw client #7 on the toilet. Staff #4 did not prompt client #7 to shut the door nor did the staff shut the door for client #7.</p> <p>Staff #1 was interviewed on 9/20/11 at 10:32a.m. Staff #1 indicated client #7 should have been prompted to shut the bathroom door to ensure his privacy. 1.1-3-2(a)</p> <p>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 4 of 4 sampled clients (#1, #2, #3, #4) 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 client training program reviews during the past year for clients #1, #2, #3 and #4.</p> <p>Findings include: Record review for client #1 was done on</p>	W0159	<p>Coordinator is responsible for providing this training to staff by 10-21-11.</p> <p>The Home Manager and Program Coordinator will observe the home on a weekly basis as part of their regular audit visits to assure staff are ensuring client privacy.</p> <p>The QMRP is responsible for reviewing the individual program plan for each client on at least a monthly basis. Plans are reviewed for accurate staff implementation and progress toward the goal of the plan. On at least a quarterly basis or more often as evident in documentation of the program implementation, the QMRP is responsible for revising plans as progress or lack of progress is noted. The QMRP will facilitate a quarterly</p>	10/21/2011	

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	<p>9/19/11 at 11:28a.m. Client #1's QMRP program reviews indicated client #1 had an individual support plan (ISP) dated 7/28/11. There were no documented QMRP program reviews during the time period of 7/14/09 through 7/28/11.</p> <p>Record review for client #2 was done on 9/19/11 at 1:22p.m. Client #2's QMRP program reviews indicated client #2 had an individual support plan (ISP) dated 7/28/11. There were no documented QMRP program reviews during the time period of 7/09 through 7/28/11.</p> <p>Record review for client #3 was done on 9/19/11 at 12:45p.m. Client #3's QMRP program reviews indicated client #3 had an ISP dated 7/28/11. There were no documented QMRP program reviews during the time period of 9/1/09 through 7/28/11.</p> <p>Record review for client #4 was done on 9/19/11 at 10:24a.m. Client #4's QMRP program reviews indicated client #4 had an ISP dated 7/29/11. There were no documented QMRP program reviews during the time period from 2/10 through 7/29/11.</p> <p>Staff #1 (QMRP) was interviewed on 9/20/11 at 10:32a.m.. Staff #1 indicated the QMRP should be reviewing the</p>		<p>meeting with the interdisciplinary team to review progress toward goals and to discuss revisions as necessary. The quarterly meetings will be documented and maintained in each individuals file. All Individual Support Plans for the individuals at the home are current and appropriately implemented.</p> <p>The QMRP and the Home Manager are responsible for the ongoing monitoring of the program plan implementation and data collection on at least a weekly basis and to follow up to issues immediately with staff. The Operations Manager is responsible to monitor the completion of ISP's, Monthly/ Quarterly reports, data collection and follow-up on at least a quarterly basis.</p> <p>All QMRP's have received training on the coordination and monitoring of client active treatment programs. The Program Director will oversee that qualified mental retardation professionals provide continuous integration, coordination, and monitoring of client services by way of tracking quarterly review documentation of</p>		

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W0217	<p>clients' programs at least quarterly. Staff #1 indicated there was no documentation of quarterly QMRP program reviews for clients #1, #2, #3 and #4 during the past 12 months. Staff #1 indicated the previous QMRP's documentation could not be found.</p> <p>1.1-3-3(a)</p> <p>The comprehensive functional assessment must include nutritional status.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#1) to ensure client #1's nutritional status was identified for skills with eating and monitoring and supervision needs at mealtimes.</p> <p>Findings include:</p> <p>An observation was done on 9/15/11 from 4:14p.m. to 6:10p.m. At 5:45p.m., client #1 ate supper independently and with some hand over hand assistance. An observation was done on 9/16/11 from 7:02a.m. to 9:08a.m. Client #1 ate breakfast at 7:42a.m. Staff #6 custodially fed client #1.</p> <p>Record review for client #1 was done on 9/19/11 at 11:28a.m. Client #1 had an</p>	W0217	<p>client services.</p> <p>The swallow study evaluation for Client #1 has now been completed. The Program Coordinator is responsible to assure that recommendations from this study are implemented and that staff receive training on their responsibilities to assure the client's nutritional needs are being met by 10-21-11.</p> <p>The Home Manager and Program Coordinator is responsible for on-going monitoring to assure staff are consistent in following nutritional protocols. The Program Coordinator is responsible for continuing monitoring and the revising of client nutritional protocols when the need dictates.</p>	10/21/2011	

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W0249	<p>individual support plan (ISP) dated 7/28/11. The ISP indicated client #1 had a training program to feed self neatly with a spoon. Client #1 had a 9/17/10 swallow study with recommendations that staff feed client #1 to slow his rate of eating. Client #1 had a physician's order on 8/22/11 to repeat a swallow evaluation due to "poor appetite."</p> <p>Staff #2 (nurse) and staff #1 were interviewed on 9/20/11 at 10:32a.m. Staff #2 indicated the 8/22/11 swallow study evaluation to identify dining skills and monitoring was still in the process of being scheduled.</p> <p>1.1-3-4(a)</p> <p>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 of 4 sampled clients (#2, #4) to ensure the clients' communication, dining and behavior training programs were implemented when opportunities were present.</p> <p>Findings include:</p>	W0249	All staff at the home will receive training on each clients training programs. All staff at the home will also receive training and on implementing consistent active treatment. The Program Coordinator will be responsible for providing this training by 10-21-11.	10/21/2011	

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	<p>An observation at the group home was done on 9/15/11 from 4:14p.m. to 6:10p.m. and on 9/16/11 from 7:02a.m. to 9:08a.m. Client #4 had both his hands inside the front of his pants consistently throughout both observations. Staff #6, #7, #8 were not consistent with their verbal prompts to client #4 to remove his hands. At 7:42a.m. client #4 ate breakfast. Client #4 wiped off his face 3 times with the back of his hand during the meal. Client #4 had a napkin but was not prompted to use it. Clients #2 and #4 had drinks with their breakfast. Clients #2 and #4 were not prompted to sign drink/thirsty during the breakfast observation.</p> <p>The record of client #2 was reviewed on 9/19/11 at 12:45p.m. Client #2's 7/28/11 individual support plan (ISP) indicated client #2's communication training program was to sign drink at meal times with 2 prompts.</p> <p>The record of client #4 was reviewed on 9/19/11 at 10:24a.m. Client #4's 7/29/11 ISP indicated client #4 had training programs to sign thirsty, use a napkin and to redirect placing his hands in the front of his pants and to wash his hands.</p> <p>Interview of staff #1 on 9/20/11 at 10:32a.m. indicated client #2's</p>		The Home Manager and Program Coordinator will observe the home on a weekly basis as part of their regular audit visits to assure consistent active treatment is being implemented by the staff.	

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W0259	<p>communication training program and client #4's communication, dining and behavior training programs should have been implemented at all opportunities. 1.1-3-4(a)</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3, #4) to ensure the clients' comprehensive functional assessments (CFA) had been reviewed during the past year.</p> <p>Findings include:</p> <p>Record review for client #1 was done on 9/19/11 at 11:28a.m. Client #1's QMRP program reviews indicated client #1 had an individual support plan (ISP) dated 7/28/11. There were no documented CFA reviews from 7/14/09 through 7/28/11.</p> <p>Record review for client #2 was done on 9/19/11 at 1:22p.m. Client #2's QMRP program reviews indicated client #2 had an individual support plan (ISP) dated 7/28/11. There were no documented CFA reviews from 7/09 through 7/28/11.</p>	W0259	<p>All QMRP's will receive training on the completion and documentation expectations in reviewing client comprehensive functional assessments. The Program Director will implement this training by 10-21-11</p> <p>The Program Director will oversee that qualified mental retardation professionals provide continuous integration, coordination, and monitoring of client services by way of on-going tracking that includes annual ISP's, comprehensive functional assessment reviews, and quarterly review documentation of client services.</p>	10/21/2011	

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	<p>Record review for client #3 was done on 9/19/11 at 12:45p.m. Client #3's QMRP program reviews indicated client #3 had an ISP dated 7/28/11. There were no documented CFA reviews from 9/1/09 through 7/28/11.</p> <p>Record review for client #4 was done on 9/19/11 at 10:24a.m. Client #4's QMRP program reviews indicated client #4 had an ISP dated 7/29/11. There were no documented CFA reviews from 2/10 through 7/29/11.</p> <p>Staff #1 (QMRP) was interviewed on 9/20/11 at 10:32a.m.. Staff #1 indicated the interdisciplinary team should be reviewing the clients' CFA at least annually. Staff #1 indicated there was no documentation of annual CFA review since 2009 for clients #1, #2, #3 and #4 Staff #1 indicated the previous QMRP's documentation could not be found. 1.1-3-4(a)</p>				
W0449	<p>The facility must investigate all problems with evacuation drills and take corrective action. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#2) to ensure client #2's refusal to evacuation drills was addressed.</p>	W0449	<p>A training program has been developed for Client # 2 regarding refusals to participate in evacuation drills. The Program Coordinator is responsible for developing</p>	10/21/2011	

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	<p>Findings include:</p> <p>Record review of the facility's evacuation drills was done on 9/13/11 at 11:48a.m. Evacuation drill reports were reviewed for the time period from 9/1/10 through 9/13/11. The following was indicated from the reports: 2/13/11 client #2 "refused"; 6/5/11 client #2 "refused;" 7/2/11 client #2 slept through alarm, had to be prompted; 7/15/11 client #2 "refused."</p> <p>Staff #1 was interviewed on 9/20/11 at 10:32a.m. Staff #1 indicated client #2 had some refusals during evacuation drills. Staff #1 indicated the facility had not addressed client #2's refusals to evacuation drills and indicated client #2 was need of a training program for this. 1.1-3-7(a)</p>		<p>and implementing the program. All staff will receive training on how to implement the training program by 10-21-11.</p> <p>The Home Manager and Program Coordinator are responsible for on-going monitoring for any continuing issues related to refusals fro evacuation drills.</p> <p>The Program Director is responsible for tracking evacuation drills as well as reviewing for any trends or patterns that indicate a problem with an individual's ability to safely evacuate. The Program Director reports evacuation drill results as well as any concerns to the Safety Committee on a quarterly basis for further review and analysis. The Program Director is responsible for following up with any Safety Committee recommendations that result from quarterly reviews.</p>		