

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G544	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2011
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 887 BUNKERHILL DR TERRE HAUTE, IN47802
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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
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 7, 9, 10, 14, 2011</p> <p>Provider Number: 15G544 Aims Number: 100245350 Facility Number: 001058</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 11/22/11 by Tim Shebel, Medical Surveyor III.</p>	W0000		
W0352	<p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed for 1 of 4 sample clients (client #4) to ensure client #4 had an annual dental visit.</p> <p>Findings include:</p> <p>The record of client #4 was reviewed on 11/10/11 at 11:44a.m. Client #4's most recent documented dental visit was on 10/6/10.</p> <p>Interview on 11/14/11 at 2:18p.m., of staff #1, indicated client #4 had not had a dental exam since the 10/6/10 exam.</p>	W0352	<p>The dental appointment for client #4 was completed on 11-14-11. An earlier appointment for this individual had been scheduled, but was rescheduled resulting in the delay one month past the due date.</p> <p>All scheduled medical and dental appointments are documented on the house appointment calendar. The Home Manager is responsible for assuring that any</p>	12/14/2011

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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	9-3-6(a)		<p>appointments are documented on this calendar and that appointments are completed as scheduled. The Home Manager is responsible to complete all scheduled appointments or to designate a staff person responsible for the appointment. The Program Coordinator is responsible for weekly monitoring of scheduled appointments for completion. The Program Coordinator will follow -up immediately with the Home Manager should there be any issues noted with appointments scheduled or not completed in a timely manner. The nurse assigned to the home reviews appointments on an on-going basis and completes a monthly review of each individual's health status and appointments. In the event that the nurse finds that an appointment was not completed or needs to be scheduled, they will communicate such in writing to the Program Director who will immediately follow-up with the Program Coordinator for completion.</p> <p>The Home Manager and Program Coordinator at this home will receive training outlining their responsibilities in scheduling, assigning and follow-up to all appointments as needed for each individual.</p>		