STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G591	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORMAL LIFE OF INDIANA	411 N PINE 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
W0000	This visit was for a recertification and state licensure survey. Dates of Survey: September 5, 6, 11, 17, 18, 20, 2012 Provider Number: 15G591 Aims Number: 100245580 Facility Number: 001105 Surveyor: Mark Ficklin, Medical Surveyor III This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 9/25/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

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.

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL 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 2 of 4 sampled clients (#2, #3) 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 quarterly program reviews. Findings include: Record review for client #2 was done on 9/17/12 at 2:04p.m. Client #2's QMRP program reviews indicated client #2 had an individual support plan (ISP) dated 6/15/12. There were no documented QMRP program reviews during the time period of 7/22/11 through 6/15/12. Record review for client #3 was done on 9/17/12 at 1:30p.m. Client #3's QMRP program reviews indicated client #3 had an ISP dated 6/5/12. There were no documented QMRP program reviews during the time period of 10/28/11 through 6/5/12. Staff #1 (QMRP) was interviewed on 9/18/12 at 3:00p.m.. Staff #1 indicated the	W0159	A Quarterly review of all clients' programs has been completed. The Program Coordinator that was assigned to this location is no longer with the agency. 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 analyzing and compiling collected client program data, and timelines for completing reports on the results. The Program Manager will implement this training. The Program Manager 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 Executive Director to validate completion. In instances where the	10/19/2012

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	QMRP should be reviewing the clients' programs at least quarterly. Staff #1 indicated quarterly QMRP program reviews had not been done for clients #2 and #3 during the past 12 months. 9-3-3(a)		expectation for providing monitoring of client's active treatment programs is not met by the qualified mental retardation professional or Program Manager corrective action will be implemented.	