

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 04/27/2022
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 411 N PINE BRAZIL, IN 47834
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of survey: 4/19, 4/20, 4/21, 4/26, and 4/27/22.</p> <p>Facility Number: 001105 Provider Number: 15G591 AIM Number: 100245580</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/20/22.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 5 allegations of abuse and/or neglect reviewed (client #5), the facility failed to ensure all allegations of peer to peer abuse were investigated.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations were reviewed on 4/19/22 at 3:35 pm. The review indicated:</p> <p>A BDDS report dated 4/12/22 at 10:00 am indicated, "While at Residential Day Program, [day service peer] was beating on the table, like he was playing drums. [Client #5] told [day service peer] to stop beating on the table, which caused [day service peer] to get upset. [Day service peer]</p>	W 0154	<p>Timeliness and thoroughness of Investigations remains an ongoing issue. All trained investigators will be trained on the operations investigative process to ensure five-day completion and thoroughness of investigations. The facility will have evidence that all Client to Client Aggression incidents are thoroughly investigated and reported to BDDS per reporting guidelines. All trained investigators will complete re-training on the facility policies and procedures regarding their responsibilities to ensure that all incidents as defined by the policy are</p>	06/12/2022

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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W 0240 Bldg. 00	<p>left the room and then ran back in, knocking [client #5] out of his chair, onto his left side. Staff helped to safely assist [client #5] to his feet and evaluated him for injuries. Staff redirected [day service peer] and both peers resumed normal activity. Nurse notified. No injuries observed on [client #5]. Plan to Resolve: Staff will continue to monitor and report any changes to [client #5's] health. Staff will continue to follow peer's BSP (behavior support plan) in place which addresses aggression. A C2C (client to client) investigation will be conducted."</p> <p>The review indicated there was no investigation for this incident.</p> <p>An interview was conducted with the facility's Qualified Intellectual Disabilities Professional Manager (QIDPM) on 4/27/22 at 3:00 pm. The QIDPM indicated there was not an investigation for this client to client abuse incident. The QIDPM indicated there should have been an investigation for this client to client abuse incident.</p> <p>An interview was conducted with the facility's Quality Assurance Manager (QAM) on 4/19/22 at 5:00 pm. The QAM stated, "I do not have a copy of that investigation." The QAM indicated there should have been an investigation for this client to client abuse incident. The QAM stated, "It is our policy to investigate all client to client abuse incidents to ensure the safety of the clients."</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p>		<p>reported and investigated. The QIDP is responsible for initiating and completing initial Client to Client Aggression incidents. The Quality Assurance Manager is responsible for ensuring that these Client to Client Aggression incidents are thoroughly investigated, and follow-up is completed within the established timelines. The agency has implemented an electronic tracking systems and calendar reminders to ensure the administrator is able to implement corrective actions if the allegation is substantiated.</p>		

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	<p>Based on observation, interview and record review for 1 of 3 sampled clients (client #2), the facility failed to update client #2's risk plan after a decline in functioning.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 4/19/22 at 3:35 pm. The review indicated the following:</p> <p>A BDDS report dated 1/27/22 at 7:02 pm indicated, "Staff was assisting [client #2] to the bathroom and as he stood up from his chair, [client #2] fell hitting the upper back of his head. [Client #2] ambulates with staff assistance, and the use of a gait belt and walker. Staff was able to assist [client #2] with standing and assess for injuries. [Client #2] was noted to have a one inch reddened area on the back of his head and a one inch abrasion on his left elbow. Plan to Resolve: Twenty-four hour head tracking initiated. Staff will continue to monitor and report changes to [client #2's] health and follow his risk plan for falls."</p> <p>A BDDS report dated 2/24/22 at 8:45 pm indicated, "Fifteen minutes after assisting [client #2] to bed, staff heard noise from [client #2's] room. Upon entering [client #2's] room, staff observed [client #2] on the floor next to peer's bed. [Client #2] ambulates with a gait belt, walker and assistance from staff, but [client #2] got out of bed without calling staff for help. Facility nurse notified and staff assessed for injuries noting an abrasion one inch in diameter on the back right side of [client #2's] head. Plan to resolve: Twenty-four hour head tracking initiated. Staff will continue to monitor and report changes to [client #2's] health."</p>	W 0240	<p>Client #2's High Risk Health Plan was updated on 5/4/2022. All staff in the home have been trained on the updated plan. Facility Nurse will receive retraining to ensure all risk plans are appropriate to meet the health needs of the clients. Facility Nurse will review all charts for the home to ensure risk plans remain appropriate for meeting the health needs of the clients. Ongoing, Health Services Manager will review all charts on a quarterly basis to ensure client risk plans remain appropriate for meeting their health needs.</p>	06/12/2022	

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	<p>Observations were conducted at the home on 4/26/22 from 3:30 pm through 6:15 pm and on 4/27/22 from 6:15 am through 8:15 am. On 4/26/22 at 4:20 pm, client #2 returned from day service. He was pushed into the home in a wheelchair by Direct Support Professional (DSP) #1. At 5:25pm client #2 was sitting in a wheelchair watching television. At 5:45 pm, the Qualified Intellectual Disabilities Professional (QIDP) assisted client #2 to the bathroom to wash his hands for dinner. The QIDP then pushed client #2 in his wheelchair to the dining room table. At 5:50 pm, DSP #1 transferred client #2 from the wheelchair to the dining room table with the assistance of a gait belt.</p> <p>On 4/27/22 at 6:15 am, client #2 was sitting at the dining room table in a dining room chair. At 7:35 am, DSP #1 transferred client #2 from the dining room chair to the wheelchair using the gait belt. DSP #1 then assisted client #2 to the medication room. At 7:50 am, after receiving his medications, client #2 was then transferred from his wheelchair back to the dining room chair by DSP #1 with the assistance of his gait belt. At 8:10 am, client #2 was transferred back to his wheelchair from the dining room chair with assistance of DSP #1 and the gait belt. DSP #1 then pushed client #2's wheelchair out to the van. Client #2 was not observed to ambulate throughout the observations.</p> <p>Client #2's record was reviewed on 4/26/22 at 10:45 am. The review indicated the following:</p> <p>Comprehensive High Risk Health Plan for Falls dated 10/6/2021 indicated in part, "1. Staff will encourage [client #2] to remain ambulatory while using his walker. 2. [Client #2] will use PRN (as needed) wheelchair for outings, long distances</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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	<p>and appointments."</p> <p>Interdisciplinary Team Meeting notes dated 3/15/22 indicated in part, "[Client #2's] adaptive equipment goal will be deleted because he does not use walker anymore due to him being in the wheelchair full time."</p> <p>The facility's Licensed Practical Nurse (LPN) was interviewed on 4/27/22 at 3:00 pm. The LPN stated client #2 "had physical therapy last July but it was discontinued because he wasn't cooperative. He then had exercises to do in the home but he refused to do them." The LPN indicated client #2 had a decline in functioning and he was in the wheelchair more. The LPN indicated client #2 had a high risk health plan for falls. The LPN indicated the risk plan should have been updated.</p> <p>The facility's Director of Nursing (DON) was interviewed on 4/27/22 at 3:00 pm. The DON indicated client #2 had a high risk health plan for falls. The DON indicated the risk plan should have been updated with client #2's decline in functioning.</p> <p>9-3-4(a)</p>				