STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G440	A. BUILDING -- B. WING	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 10/03/24 Facility Number: 000954 Provider Number: 15G440 AIM Number: 100244720 At this Emergency Preparedness survey, Normal Life of Indiana was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has eight certified beds. All eight beds are certified for Medicaid. At the time of the survey, the census was six. Quality Review completed on 10/04/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 10/03/24 Facility Number: 000954 Provider Number: 15G440 AIM Number: 100244720 At this Life Safety Code survey, Normal Life of Indiana was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Vaughn	QA Manager	10/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G440	A. BUILDING 01 B. WING	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

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	Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story building was determined to be non-sprinklered. The facility has a fire alarm system with smoke detection in corridors, all living areas, and heat detectors within the unused attic space. The facility has battery operated smoke detectors installed in each of the five bedrooms. The facility has a capacity of eight and had a census of six at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of .52. Quality Review completed on 10/04/24			
K S712 Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 33.7.3 states "Emergency egress and relocation drills shall be conducted in accordance with 33.7.3.1 through 33.7.3.6. This deficient practice affects all clients and staff. Findings include: Based on records review with the QIDP Manager on 10/03/24 at 3:50 p.m., documentation of a fire drill conducted on the day shift in the fourth quarter (October, November, and December) of 2023/2024 could not be provided to review. Based	K S712	**The facility has implemented Task Master Pro for scheduling, completing and documenting emergency drills. Drills are scheduled in Task Master Pro, one for each shift of every three months. All staff have been trained on entering drill reports in TMP. Unless there is inclement weather during the drill, all residents are evacuated from the home during each drill conducted at the home on all shifts.**	10/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G440	A. BUILDING 01 B. WING	10/03/2024

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	on interview at the time of record review, the QIDP Manager checked records for a fire drill and was unable to locate one at the time of the survey and confirmed a day shift fire drill was missing from the fourth quarter. This finding was reviewed with the QIDP Manager during the exit conference.		**The Area Supervisor and all staff will receive training concerning their responsibilities to ensure drills are completed as scheduled. QIDPM/QIDP/QAC will drive compliance of completing monthly drills appropriately during monthly house meetings and QIDP monitoring. The Quality Assurance Manager will track the completion of emergency drills and evacuations monthly. If any discrepancies are noted, they are reported to the Program Manager for follow up with the Supervisor. The Safety Committee reviews the timely completion of any issues noted during fire and storm drill on at least a quarterly basis. The Program Manager is responsible for submitting, reviewing, and following up on recommendation with the Safety Committee.**	