

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 12/17/2024
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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 recertification and state licensure survey. This visit included the investigation of complaint #IN00447681.</p> <p>Complaint #IN00447681: Federal and State deficiencies related to the allegation(s) are cited at W186, W192, W331 and W368.</p> <p>Dates of Survey: 12/11, 12/12, 12/16 and 12/17, 2024.</p> <p>Facility Number: 001105 Provider Number: 15G591 AIMS 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 1/7/25.</p>	W 0000		
W 0186  Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (clients A, B and C), the facility failed to ensure there was sufficient staff to care for client B during a change of condition and assist clients A and C after a fall.</p> <p>Findings include:</p> <p>A. The facility's Bureau of Disabilities Services (BDS) and investigations were reviewed on 12/11/24 at 12:00 pm. The review indicated the following:</p>	W 0186	<p><b>The facility will provide sufficient staff to manage and supervise clients in accordance with their individualized plan All staff in the home will be retrained on contacting their chain of command upon noting staffing levels in the home to not be sufficient. Program Manager will review all schedules to ensure adequate staffing is in place at</b></p>	01/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keyon Johnson	QIDP Manager	01/17/2025

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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	<p>A BDS report dated 9/14/24 at 11:00 am indicated, "[Client B] was a(n) [age, gender] who lived in a supported group living facility with seven other male roommates. [Client B] had primary diagnoses of Profound I/DD (intellectual/developmental disabilities) and Schizophrenia, Chronic, Unspecified. [Client B] had secondary diagnoses of Cerebral Palsy, Dandruff, Enuresis (uncontrolled bladder), Hemorrhoids, Hx (history) of Diverticulitis (inflammation of the colon), Laparoscopic Cholecystectomy (gallbladder surgery), Left Hemiparesis (paralysis), Microcephaly, and Mild Scoliosis (spine curvature). Upon arriving at beginning of shift, day shift staff checked on [client B] to administer morning medications and observed [client B] to appear cold to the touch with no observed respiration sounds. CPR initiated and 911 contacted. EMS (Emergency Medical Services) arrived at the home and continued resuscitation efforts on [client B] for approximately 30 minutes. Rescue efforts were unsuccessful and [client B] was pronounced deceased at approximately 10:50 AM....".</p> <p>An investigation dated 9/19/24 indicated, "...Factual Findings: Appropriate staffing for this location was 24-hour residential supports with two staff to eight persons served. Review of timecards for [name] Group Home indicated [Direct Support Professional (DSP) #1] was on shift on Friday 9/13/24 from 6:32 AM until 2:58 PM. [DSP #2] was staff on shift on Friday 9/13/24 from 2:58 PM until 11:52 PM. [Residential Manager (RM)] was staff on shift from Friday 9/13/24 at 11:50 PM until Saturday 9/14/24 at 9:47 AM. [DSP #3] was the staff on shift on Saturday 9/14/24 beginning at 9:02 AM...Appropriate staffing ratios were not in place during this</p>		<p><b>all locations and work with Human Resources to recruit to fill staff vacancies at home. The Area Supervisor is responsible for ensuring there is always sufficient staff in the home and reviewing and approving the staffing schedule weekly to ensure that adequate staffing is assigned. The staffing schedule has been reviewed for the home and the Area Supervisor will monitor that adequate staff are assigned daily. Program Manager will retrain the Area Supervisor on Job Responsibilities and ensuring adequate staffing in the home. Ongoing weekly and monthly observations and review will continue with the QIDP, Residential Manager, and Area Supervisor over the location. This will ensure all corrections are implemented per ResCare policy and regulations.</b></p>		

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	<p>incident...".</p> <p>The review indicated there was only one staff on shift during the time of client B's change of condition.</p> <p>B. The facility's Bureau of Disabilities Services (BDS) and investigations were reviewed on 12/11/24 at 12:00 pm. The review indicated the following:</p> <p>1. A BDS report dated 8/20/24 at 7:30 am indicated, "...[Client C] then attempted to stand up and walk without using his walker or waiting for assistance. When staff attempted to assist [client C], he then straightened his legs and began sliding. Staff safely lowered [client C] to the ground. Upon staff attempting to assist [client C] to a standing position, [client C] refused and continued to straighten his legs. 911 was contacted for lift assist...".</p> <p>2. A BDS report dated 8/29/24 at 7:50 pm indicated, "...When [client C] was getting out of the shower, [client C] fell landing on the ground...Staff was unable to assist [client C] into a standing position, so 911 was contacted for lift assist...".</p> <p>3. A BDS report dated 10/25/24 at 2:00 am indicated, "While in the living room, when [client A] got up from the chair, he fell and landed on the ground...Staff was unable to assist [client A] into a standing position due to [client A] refusing to stand, so 911 was contacted for lift assist...".</p> <p>Client A's record was reviewed on 12/12/24 at 11:30 am. A High Risk for Falls Risk Plan dated 6/4/24 indicated, "Problem: Falls, risk of...Call 911 if...open fracture, protruding bone, suspected</p>			

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	<p>fracture..., wound with spurting stream of blood...".</p> <p>Client C's record was reviewed on 12/12/24 at 1:30 pm. A High Risk for Falls Risk Plan dated 6/4/24 indicated, "Risk of falls due to Neurological induced Parkinson's and Lithium induced tremors, akathisia (uncontrolled muscle movements), arthritis, lumbosacral disc disease (lower back disc degeneration), herniated lumbar disc, left lumbar radiculopathy (pinching of the nerves at the root), peripheral neuropathy lower extremities, herniated cervical disc and myelodysplastic syndrome lesion (poorly formed blood cells), iron deficiency and pain/weakness from all the above...In the event of an emergency take care of [client C] first then notify appropriate personnel (i.e., nurse, supervisor). Call 911 if ....., protruding bone, suspected fracture..., open fracture, wound with spurting stream of blood...".</p> <p>The review indicated only one staff was on shift at the time of client A and C's falls and clients A and C's plans did not include staff calling 911 for lift assist.</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 12/16/24 at 3:30 pm. The LPN indicated clients A and C were at a high risk for falls. The LPN indicated 1 staff was not enough to assist clients A and C up if they fell. The LPN stated there should be, "Two staff per shift in the evening and night and one staff during the day."</p> <p>The Registered Nurse/Manager of Nursing Services (RN) was interviewed on 12/16/24 at 3:30 pm. The RN stated, "There should be two staff per shift in the evening and night and one staff during the day."</p>				

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W 0192  Bldg. 00	<p>This federal tag relates to complaint #IN00447681.</p> <p>9-3-3(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients A and B), the facility failed to ensure staff were trained to competence regarding administering clients A and B's medications.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) and investigations were reviewed on 12/11/24 at 12:00 pm. The review indicated the following:</p> <p>1. A BDS report dated 9/14/24 at 11:00 am indicated, "[Client B] was a(n) [age, gender] who lived in a supported group living facility with seven other male roommates. [Client B] had primary diagnoses of Profound I/DD (intellectual/developmental disabilities) and Schizophrenia, Chronic, Unspecified. [Client B] had secondary diagnoses of Cerebral Palsy, Dandruff, Enuresis (uncontrolled bladder), Hemorrhoids, Hx (history) of Diverticulitis (inflammation of the colon), Laparoscopic Cholecystectomy (gallbladder surgery), Left Hemiparesis (paralysis), Microcephaly, and Mild Scoliosis (spine curvature). Upon arriving at beginning of shift, day shift staff checked on [client B] to administer morning medications and observed [client B] to appear cold to the touch with no observed respiration sounds. CPR initiated and 911 contacted. EMS (Emergency Medical Services) arrived at the home and</p>	W 0192	<p><b>The facility has policies and procedures in place to train employees who work with clients on skills and competencies directed towards clients' needs and programming objectives. All staff were retrained on competency-based consumer specific training to include following appropriate medication administration on 1/17/2025</b></p> <p><b>All clients have the potential to be affected by this deficiency. Consumer specific training and reviewing client needs remains a prominent component of the agencies all staff monthly meetings.</b></p> <p><b>Ongoing weekly and monthly observations and review will continue with the QIDP, Residential Manager, and Area Supervisor over the location. This will ensure all corrections are implemented per ResCare policy and regulations.</b></p>	01/19/2025	

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	<p>continued resuscitation efforts on [client B] for approximately 30 minutes. Rescue efforts were unsuccessful and [client B] was pronounced deceased at approximately 10:50 AM....".</p> <p>An investigation dated 9/19/24 indicated, "...Factual Findings: ...[Direct Support Professional (DSP) #1] reported she was unable to administer [client B's] evening feeding and medications on 9/13/24...[DSP #1] stated she did not reach out to [LPN] to report having issues with giving [client B] his feeding and medications...[DSP #1] stated she reported to [Residential Manager (RM)] that she had been unsuccessful with administering [client B's] feeding and meds...[RM] reported finding the syringe for [client B] to be blocked when attempting to give [client B] his feeding and meds late. [RM] stated she was unable to resolve the issue and [client B] did not receive his evening feeding and medications...[RM] reported that she had not administered medications to [client B] on the morning of 9/14/24 either...".</p> <p>2. A BDS report dated 10/5/24 at 7:56 am indicated, "...staff observed [client A] was administered peer [client D's] meds of ASA (aspirin) chw (sic) Tab (tablet) 81 mg (milligrams), benztropine (anticholinergic) Tab 1mg, DOK (stool softener) Tab 100mg, Furosemide (diuretic) Tab 40mg, Linzess Cap (for constipation) 145 mCg (micrograms), Loratadine (for allergies) Tab 10mg, Mag Ox Tab (supplement) 400mg, Memantine (for dementia)...Tab 10mg, Olanzapine Tab (antipsychotic) 7.5mg, Pantoprazole (for gastric reflux) Tab 40mg, and Paroxetine (for depression) Tab 20mg. The nurse was notified and advised staff to administer [client A's] 7am medication of Simethicone chw (sic) 125 mCg, but hold the rest of [client A's] regular medications...staff was also</p>			

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W 0331  Bldg. 00	<p>instructed to check vials every 30-60 minutes throughout the day...".</p> <p>3. A BDS report dated 10/6/24 at 4:37 pm indicated, "...staff observed that [client A] did not receive his 7AM dose of lacosamide (for seizures) 200 mg (milligrams) on 10/6/24...".</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 12/16/24 at 3:30 pm. The LPN indicated all staff are Core A and B trained. The LPN indicated all staff are trained on administering feeding and medication via GTubes. The LPN indicated clients A and B did not get their medications as ordered by their physicians. The LPN stated staff "can start by calling the nurse and then follow the chain of command." The LPN stated, "I don't think they crushed the meds all the way. The nipple of the syringe was fully clogged." The LPN stated, "Staff needed further training on meds and troubleshooting Gtubes."</p> <p>The Registered Nurse/Nursing Services Manager (RN) was interviewed on 12/16/24 at 3:30 pm. The RN indicated clients A and B did not get their medications as ordered by their physician. The RN stated, "There were a couple of med errors." The RN stated, "Yes, clients should get their meds as ordered by the doctor and yes, staff should be competently trained on administering medications."</p> <p>This federal tag relates to complaint #IN00447681.</p> <p>9-3-3(a) 483.460(c) NURSING SERVICES</p>	W 0331	Client B is deceased as of	01/19/2025	

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	<p>Based on record review and interview for 1 of 3 sampled clients (client B), the facility's nursing services failed to ensure 1) there were no discrepancies in client B's oxygen administration orders, 2) client B had a risk plan for chronic pain, 3) client B had blood pressure parameters on his Medication Administration Record (MAR) and Risk Plan indicating when to call the nurse and 4) all medications on client B's MAR indicated the correct route of administration.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) and investigations were reviewed on 12/11/24 at 12:00 pm. The review indicated the following:</p> <p>A BDS report dated 9/14/24 at 11:00 am indicated, "[Client B] was a [age, gender] who lived in a supported group living facility with seven other male roommates. [Client B] had primary diagnoses of Profound I/DD and Schizophrenia, Chronic, Unspecified. [Client B] had secondary diagnoses of Cerebral Palsy, Dandruff, Enuresis (uncontrolled bladder), Hemorrhoids, Hx (history) of Diverticulitis (inflammation of the colon), Laparoscopic Cholecystectomy (gallbladder surgery), Left Hemiparesis (paralysis), Microcephaly, and Mild Scoliosis (spine curvature). Upon arriving at beginning of shift, day shift staff checked on [client B] to administer morning medications and observed [client B] to appear cold to the touch with no observed respiration sounds. CPR initiated and 911 contacted. EMS (Emergency Medical Services) arrived at the home and continued resuscitation efforts on [client B] for approximately 30 minutes. Rescue efforts were unsuccessful and [client B] was pronounced deceased at approximately 10:50 AM....".</p>		<p><b>09/14/24 and is no longer receiving services.</b></p> <p><b>Nursing Manager retrained all nurses on 1/14/25 on ensuring client risk plans are updated with no discrepancies between MAR and risk plans, including parameters for when nursing should be notified on MAR and risk plans, ensuring risk plans are in place for all listed diagnosed for individuals, and ensuring the correct route for medication administration is listed on all orders and MAR. Nursing Manager to perform quarterly review of health risk plans and MARs to monitor and ensure compliance.</b></p>	

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	<p>Client B's record was reviewed on 12/16/24 at 1:00 pm. The review indicated the following:</p> <p>1. A Physician's Order Sheet dated September 2024 did not have an order for client B's oxygen.</p> <p>Client B's MAR dated September 2024 indicated there was an order for client B to be administered "1L (liters) of oxygen via nasal cannula at all times".</p> <p>Client B's Risk Plan for Potential for low oxygen levels...dated 6/4/24 indicated, "...2L of oxygen...".</p> <p>The review indicated the facility's nursing staff did not address the discrepancies noted in the amount of oxygen client B was supposed to wear.</p> <p>2. A MAR dated September 2024 indicated client B had an order for Hydroco/APAP 10/325mg (opioid analgesic) give one tablet per gtube three times per day for chronic pain. A Physician's Order Sheet dated September 2024 indicated client B had a diagnosis of "chronic pain". A review of client B's high risk plans indicated client B did not have a risk plan that addressed chronic pain or the use of an opiate pain medication.</p> <p>3. A MAR dated September 2024 indicated client B had an order for Hydrochlorothiazide 25 mg...for hypertension...Losartan 50mg...Dx: HTN...Daily Blood Pressure checks, check blood pressure daily, alternating between morning and evening."</p> <p>A High Risk Plan for Impaired Cardiac Function dated 6/4/24 indicated, "...Triggers to notify nurse: Blood Pressure is elevated...".</p> <p>The review indicated client B had a diagnosis of</p>			

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	<p>hypertension and was prescribed blood pressure medications. The review also indicated client B had an order for blood pressure checks daily but there were not parameters noted as to when to call the nurse. The review indicated client B's high risk plan also did not have parameters to call the nurse when client B's blood pressure is elevated.</p> <p>4. A MAR dated September 2024 indicated client B had an order to be NPO (nothing by mouth). The MAR also indicated client B's Calcium (supplement), cozaar (for blood pressure), maxtussin (for cough) and Milk of Magnesia (for constipation) indicated the route to administer was by mouth.</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 12/16/24 at 3:30 pm. The LPN indicated there should be no discrepancies in client B's oxygen administration orders. The LPN indicated client B should have had a risk plan for chronic pain. The LPN indicated client B should have had blood pressure parameters on his Medication Administration Record (MAR) and Risk Plan indicating when to call the nurse. The LPN stated, "Yes, all medications on [client B's] MAR should have the right route."</p> <p>The Registered Nurse/Nursing Services Manager (RN) was interviewed on 12/16/24 at 3:30 pm. The RN indicated there should be no discrepancies in client B's oxygen administration orders. The RN indicated client B should have had a risk plan for chronic pain. The RN indicated client B should have had blood pressure parameters on his MAR and Risk Plan indicating when to call the nurse. The RN stated, "Yes, all medications on [client B's] MAR should have the correct route."</p> <p>This federal tag relates to complaint #IN00447681.</p>			

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W 0368  Bldg. 00	<p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure client A's medications were administered as ordered.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) and investigations were reviewed on 12/11/24 at 12:00 pm. The review indicated the following:</p> <p>A BDS report dated 10/5/24 at 7:56 am indicated, "...staff observed [client A] was administered peer [client D's] meds of ASA (aspirin) chw (sic) Tab (tablet) 81 mg (milligrams), benzotropine (anticholinergic) Tab 1mg, DOK (stool softener) Tab 100mg, Furosemide (diuretic) Tab 40mg, Linzess Cap (for constipation) 145 mCg (micrograms), Loratadine (for allergies) Tab 10mg, Mag Ox Tab (supplement) 400mg, Memantine (for dementia)...Tab 10mg, Olanzapine Tab (antipsychotic) 7.5mg, Pantoprazole (for gastric reflux) Tab 40mg, and Paroxetine (for depression) Tab 20mg. The nurse was notified and advised staff to administer [client A's] 7am medication of Simethicone chw (sic) 125 mCg, but hold the rest of [client A's] regular medications...staff was also instructed to check vials every 30-60 minutes throughout the day...".</p> <p>A BDS report dated 10/6/24 at 4:37 pm indicated, "...staff observed that [client A] did not receive his 7AM dose of lacosamide (for seizures) 200 mg</p>	W 0368	<p><b>The facility implemented QuickMar for electronic recording and monitoring of medication administration. All staff have been trained on the use of QuickMar, including medication administration, following physician orders as noted, and ordering and documentation requirements. Area Supervisors and Nursing have received training on verifying medication orders per physician orders, ordering medications, and monitoring medication administration in real-time using the QuickMar program.</b></p> <p><b>All staff in the home will be retrained on medication administration procedure to include following Physician Orders as noted in QuickMar.</b></p> <p><b>Area Supervisors and Nurses will continue to review the QuickMar documentation daily to ensure medication administration is completed without issue per agency polices and physician orders. Ongoing weekly and monthly observations and review will continue with the QIDP,</b></p>	01/19/2025

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NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 411 N PINE BRAZIL, IN 47834		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
	<p>(milligrams) on 10/6/24...".</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 12/16/24 at 3:30 pm. The LPN indicated client A did not get his medications as ordered by his physicians. The LPN stated, "Yes, clients should get their medications as ordered by their doctors."</p> <p>The Registered Nurse/Nursing Services Manager (RN) was interviewed on 12/16/24 at 3:30 pm. The RN indicated client A did not get his medications as ordered by his physician. The RN stated, "There were a couple of med errors." The RN stated, "Yes, clients should get their meds as ordered by the doctor."</p> <p>This federal tag relates to complaint #IN00447681.</p> <p>9-3-6(a)</p>		<p><b>Residential Manager, and Area Supervisor over the location. This will ensure all corrections are implemented per ResCare policy and regulations.</b></p>		