

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/03/2023
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1970 E 45 1/2 CT TERRE HAUTE, IN 47802
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W 0000 Bldg. 00	<p>This visit was for the PCR (Post Certification Revisit) to the pre-determined full recertification and state licensure survey completed on 9/7/23.</p> <p>Survey Dates: 10/30/23, 10/31/23, 11/1/23, 11/2/23 and 11/3/23.</p> <p>Facility Number: 000954 Provider Number: 15G440 AIM Number: 100244720</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/4/23.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3) plus one additional client (client #4), the facility failed to implement its policies and procedures to prevent a pattern of peer to peer aggression for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 10/31/23 at 2:00 pm. The review indicated the following:</p> <p>1. A BDS report dated 9/6/23 at 9:16 am indicated, "Without prior incident [client #2] was attempting</p>	W 0149	<p>Client #1, Client #2, and Client #3 were established with external behavioral consulting firm Kestral Behavioral Health on 10/11/23. Behavioral clinicians from Kestrel have completed observations in client's home and day service setting to develop new plans to help better address and serve behavioral needs and reduce peer to peer aggression. Upon completion of new plans, all staff will be trained by behavioral clinician on new strategies identified in plans to</p>	12/03/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Vaughn	QA Manager	12/16/2023

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>to hit peers, then kiss other peers, and began coughing in peers face. Staff verbally redirected [client #2] and [client #2] refused. When peer [client #4] walked continually back and forth in [client #2's] room, [client #2] became further agitated and hit [client #4] on the arm twice. Staff intervened and separated individuals. Staff verbally prompted [client #2] to go to her room and [client #2] complied. [Client #2] calmed down on her own and resumed normal activity. Staff assessed [client #4] for injuries and no apparent injuries were observed. Nurse was notified.</p> <p>Plan to Resolve: Staff will continue to monitor both individuals and report any changes in their health. Staff will continue to monitor and report any changes to [client #2's] health and follow her BSP (behavior support plan) which addresses aggression. A C2C (client to client) investigation will be initiated."</p> <p>An investigation for the incident dated 9/13/23 indicated, "...Conclusion: Substantiated. [Client #2] was not feeling well and was pacing around the house and going out the back door. She would come up to consumers and staff and try to kiss them and cough in their faces. When [client #4] was walking back and forth through the home, [client #2] became more upset and hit [client #4] on the arm. Recommendations: Continue to follow [client #2] and [client #4's] BSPs for Inappropriate Social which addresses striking others and following others around/telling others what to do respectively. An IDT (interdisciplinary team) meeting will be held for [client #2] to discuss this incident. Self-advocacy with both consumers on how to resolve conflict without physical aggression."</p> <p>2. A BDS report dated 9/9/23 at 3:25 pm indicated,</p>		<p>help address behaviors. Client #4 was not the aggressor in any peer to peer incidents which occurred. Staff will be retrained to engage client 4 to remove herself from the area when other peers are observed becoming agitated or argumentative in the home and to intervene with redirection when required. All staff in the home will be retrained on the agency Abuse, Neglect, Exploitation and Mistreatment Policy. All staff in the home will be retrained on engaging individuals in active treatment in an effort to help lessen behavioral incidents. All staff working in the home will be retrained on Consumer Specific Training including ISPs, BSPs, and HRPs. Self Advocacy meeting to be held with individuals to address how to address frustrations with other peers in a positive manner which does not escalate to physical contact. Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations.</p>	

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	<p>"During (a) community outing, [client #3] refused to exit the van upon arrival to the park. Peer [client #1] began yelling at [client #3] and [client #3] called [client #1] a b----. Staff redirected clients, [client #1] slapped [client #3] in the face knocking her glasses off causing them to break. Staff separated clients, they calmed down and resumed normal activity. No injuries noted to [client #3], facility nurse notified. Plan to Resolve: [Client #3's] glasses to be repaired. Staff will continue to monitor and report changes to clients' health and follow behavior support plans which address inappropriate social behaviors for [client #3] and aggression for [client #1]. A C2C investigation will be conducted."</p> <p>An investigation for the incident dated 9/13/23 indicated, "...Description of incident: The ladies were out in the community, and [client #3] would not get out of the van and was yelling and got mad and hit [client #1], [client #1] grabbed a water bottle and hit [client #3] and broke her glasses. Were all behavior strategies followed appropriately and do the current behavior strategies address the above behavior? Yes, Staff talked to [client #3]. Staff need retrained on inappropriate social for [client #3]. Do any changes need to be made to prevent future occurrences? Yes, staff was not able to take either one to a quiet area per their plan as the incident occurred during a community outing at a park. The staff on duty was not able to separate the clients from the rest of the group to speak privately. Was there sufficient staff at the time of the incident? No. Seven clients went on the outing, with 1 staff on shift. Conclusion: Substantiated. [Client #1] did hit [client #3] after she called her a name. Recommendations: Staff will be retrained on deescalating situations prior to their (sic) escalating to physical aggression,</p>		Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.	

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	<p>knowing the warning signs and notification to chain of command pursuant to staffing levels. Clients will have Self Advocacy training done. Make adjustments to behavioral supports for [client #1] and [client #3] to include strategies for when they are in the community."</p> <p>3. A BDS report dated 9/17/23 at 12:30 pm indicated, "...While [client #2] was sitting in the living room watching TV with peers, peer [client #4] walked past [client #2] to talk to staff and [client #2] pinched [client #4] on her right lower arm without prior incident. When staff asked [client #2] why she pinched peer [client #4], [client #2] began to yell and use profanity towards staff and attempted to hit staff. [Client #2] was redirected and prompted to calm down in her bedroom. [Client #2] calmed down on her own and resumed normal activity. Staff assessed [client #4] for injury and no apparent injury was observed. Nurse was notified. Plan to resolve: Staff will continue to monitor all peers and report any changes in their health. Staff will continue to follow [client #2's] BSP, which addresses aggression. A C2C investigation will be conducted."</p> <p>An investigation for the incident dated 9/21/23 indicated, "...Conclusion: Substantiated. Without prior incident, [client #2] pinched [client #4] on the right lower arm when she walked by her, and when staff redirected [client #2], [client #2] began to yell, scream, and attempt to hit staff. Staff was able to prompt [client #2] to her room where she was able to calm down and resume normal activity. Witness Statements: [Client #4]: I just walked by [client #2] to go to the office and she stopped me and pinched my hand really hard, and when staff told her to stop, then she tried to hit me. [Client #2]: Did not provide any information</p>			

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	<p>relevant to this investigation. [Client #2] was unable to recall events related to this incident. [Client #1]: Did not see [client #2] pinch [client #4] but heard [client #2] yelling and screaming. [Client #3]: Did not provide any information relevant to this investigation. [Client #6]: Did not provide any information relevant to this investigation. [Client #7]: was laying down in her room and did not see anything happen but heard [client #2] yelling. [Client #5]: Was not in the home at the time of the incident. [DSP (Direct Support Professional) #1]: [Client #2] was sitting in the living room watching TV with a few of her peers. [Client #4] walked past [client #2] to talk to staff and [client #2] pinched [client #4] on her right lower arm. When I asked [client #2] why she hit, [client #2] began to yell and attempted to hit staff. I assessed [client #4] for injury and there were none. Recommendations: Continue to follow [client #2's] BSP for Inappropriate Social, which addresses aggression, which will be broken off into a separate plan specifically allowing for more direct approach to the aggressive behaviors. Self-advocacy on how to resolve conflict without physical aggression will be discussed. An IDT meeting will be held and [client #2's] BSP will be reviewed."</p> <p>4. A BDS report dated 9/20/23 at 8:15 am indicated, "...Without prior incident, during the van ride to ResCare Day Service, [client #2] was attempting to play with peer [client #1's] hair and [client #1] turned around and hit [client #2] on her stomach. Staff redirected [client #1] and spoke with [client #1] until she calmed down and resumed normal activity. Nurse was notified. Staff assessed [client #2] and no apparent injuries were observed. Plan to Resolve: Staff will continue to monitor both individuals and report any changes in their health. Staff will continue to follow [client #1's] BSP in place which addresses aggression. A C2C</p>			

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	<p>investigation will be initiated."</p> <p>An investigation for the incident dated 9/26/23 indicated, "...Witness Statements: [Client #1]: After multiple attempts, [client #1] refused to talk to investigator about this investigation. [Client #7]: [Client #2] would not stop touching [client #1], so [client #1] just punched her. Staff told [client #2] to stop touching [client #1]. [Client #6]: Could not provide any information relevant to this investigation. [Client #3]: Could not provide any information relevant to this investigation. [Client #4]: [Client #2] wouldn't leave [client #1] alone, even after I told her to stop, so [client #1] just hit her in the stomach. Staff was telling [client #2] to stop touching [client #1], but she wouldn't. [DSP #1]: [Client #2] was trying to play with [client #1's] hair while getting in the van to go to RDS. I redirected [client #2] by telling her to stop, but she wouldn't listen. [Client #1] punched [client #2] in the stomach. I redirected [client #1] and she calmed down. I evaluated [client #2] for injuries, none was (sic) present. Do any changes need to be made to prevent future occurrences? No. 5. Is there a pattern of occurrences between these two clients? No. 6. Was there sufficient staff at the time of the incident? Yes. 7. Conclusion: Substantiated: [Client #2] was trying to play with [client #1's] hair, and [client #1] hit [client #2]. Recommendations: Staff will continue to follow [client #1's] BSP for physical aggression, which addresses slapping, punching and hitting. We will also hold an IDT meeting to discuss behaviors in the home. Staff will continue to follow [client #2's] BSP for Inappropriate Social which addresses pulling others' hair, pushing and striking others. An IDT meeting will be held to discuss [client #2's] behaviors. Self-advocacy and how to resolve conflict without aggression will be discussed with all the clients in the home."</p>			
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	<p>5. A BDDS report dated 10/2/23 at 5:00 pm indicated, "[Client #1] became agitated during the van ride home from RDS due to recently breaking up with her boyfriend and boyfriend choosing to date peer/housemate [client #4] instead. Upon returning home, [client #1] began threatening to hit [client #4] and grabbed a butter knife from the kitchen and placed it inside her shirt. DSL (direct support lead) and QIDP (qualified intellectual disabilities professional) Manager present at the home immediately separated peers to prevent any further incident and continued verbal prompts for [client #1] to hand over the butter knife. [Client #1] refused redirection and reported to QIDP manager having harmful thoughts and wishing to be seen for psychiatric evaluation. Nurse notified and EMS (emergency medical services) contacted. Police arrived at the home and [client #1] complied with prompts from officers to hand over the knife without further incident. Police transported [client #1] to [hospital] for evaluation. [Hospital] referred [client #1] to [psychiatric hospital] Center where she was admitted for psychiatric placement on 10/03/23. [Client #1] presently has behavioral supports in place for aggression. No physical contact occurred between [client #1] and [client #4] during this incident. DSL and QIDP Manager spoke with all individuals in home following incident to provide emotional support and provide education on how to resolve conflict in a non-aggressive manner. A C2C investigation will be initiated. ResCare to remain in contact with [psychiatric hospital] pending discharge. An IDT meeting will be scheduled for [client #1] following discharge to determine if changes are needed to current plan in place.</p> <p>Recommendations: Staff will continue to follow [client #1's] BSP for physical aggression and will</p>			

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	<p>hold an IDT meeting to discuss this behavior. Self-advocacy on how to resolve conflict without aggression will be discussed with all the clients in the home. An IDT meeting will be held with [client #4] to discuss appropriate ways for the girls to handle this situation. At the time of the incident, the rights restriction did not include butter knives, an addition of which will be discussed at the IDT meeting."</p> <p>An investigation for the incident dated 10/3/23 indicated, "...Witness Statements: [Client #4]: while at RDS, [manager] tried to come in between [client #1] and [client #4] and keep them separated. [Client #1] did not touch [client #4]. [Client #1] got a butter knife and told [client #4] that she was going to harm her. [Client #1] called [client #4] a 'b----'. [Client #5]: [Client #1] was calling [client #4] names in the van on the way home. [Client #1] went to the kitchen and got a butter knife and threatened to harm her. Staff tried to get the knife. [QIDP Manager] called 911. [Client #7]: Not on the van or at home at the time of the incident. [Client #6]: 'Bye. Bye.' Could not provide any information relevant to this investigation. [Client #3]: 'Was it bad?' Could not provide any information relevant to this investigation. [Client #2]: '[Client #1] pulled a knife on [client #4]'. [Client #1: Not in the home at the time of the investigation. [DSP #2]: When we got home from RDS [client #1] went and grabbed a butter knife and put it in her shirt and threatened to harm [client #4] because [client #1] accused [client #4] of stealing her boyfriend. [Client #1] threatened to kick [client #4's] butt. [QIDP Manager] was here at that time, and he proceeded to call 911. They arrived and [client #1] gave the sheriff the butter knife and they took her to [hospital]. [DSP #2] and [QIDP Manager] tried several times to redirect [client #1] away from</p>			

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	[client #4]. [Client #1] was never out of line of sight. [QIDP Manager]: 'I arrived to Willa Villa Group Home yesterday afternoon for administrative monitoring. Upon entering the home, staff member [DSP #2] advised me that Person Served, [client #1] was stating that she was going to harm Person Served, [client #4] and had a butter knife in her possession. I approached [client #1] and asked for the knife, and she refused to surrender it after 5 mins of repeated prompting. I stood between [client #1] separating her from the rest of the clients in the other end of the home and called my supervisor, [Quality Assurance Manager (QAM)] followed by [Nursing Manager (NSM)]. [NSM] advised me to call 911. I called 911 and they said they would send someone from the Sheriff's Department. I continued to prompt [client #1] for the knife until the first deputy arrived. 2 deputies arrived one after the other 5 mins apart. The first deputy prompted [client #1] to surrender the knife and she did after 10 mins (minutes). At this time, the deputy placed handcuffs on her and took her to his squad car. 2. Were all behavior strategies followed appropriately and do the current behavior strategies address the above behavior? Yes 3. Are all clients safe? Yes 4. Do any changes need to be made to prevent future occurrences? No 5. Is there a pattern of occurrences between these two clients? No. 6. Was there sufficient staff at the time of the incident? Yes. Conclusion: Substantiated. [Client #1] did go into the kitchen and get a butter knife and threaten to harm [client #4]. [Client #1] did go to [hospital] and then to [psychiatric hospital]. All knives and sharps have been locked in the office per the rights restrictions in the house. All appropriate supports provided, and [client #1] had no contact with other clients during the course of the incident. Recommendations: Staff will continue to follow [client #1's] BSP for physical			

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	<p>aggression and will hold an IDT meeting to discuss this behavior. Self-advocacy on how to resolve conflict without aggression will be discussed with all the clients in the home. An IDT meeting will be held with [client #4] to discuss appropriate ways for the girls to handle this situation. At the time of the incident, the rights restriction did not include butter knives, addition of which will be discussed at the IDT meeting."</p> <p>6. A BDS report dated 10/17/23 at 8:14 am indicated, "Upon waking up, [client #2] began pulling the house cat's tail. Staff redirected and [client #2] began hitting the cat. Staff continued redirection and [client #2] resumed hitting the cat. Peer [client #4] asked [client #2] to not hit the cat and [client #2] smacked [client #4] three times in the shoulder followed by smacking staff one time in the shoulder. Staff used agency approved strike deflection technique, separated peers to prevent further aggression, and spoke with [client #2] explaining why the behavior is inappropriate. [Client #2] calmed down and resumed normal activity. Facility Nurse notified, no injuries noted to either client.</p> <p>Plan to Resolve: Staff will continue to monitor and report changes to [client #2's] health and follow her behavior support plan which addresses aggression. This incident was discussed in IDT on 10/17/2023 and increased behaviors will be further discussed in [client #2's] quarterly meeting on 10/19/23. Nursing Manager to discuss possible medication adjustment with psychiatrist. A C2C investigation will be conducted."</p> <p>An investigation for the incident dated 10/18/23 indicated, "...Witness Statements: [Client #6]: Did not provide any information relevant to this investigation. [Client #2]: Did not provide any information relevant to this investigation. [Client</p>			

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	<p>#7]: [Client #2] kept messing with the cat, pulling his tail and hitting him. Staff asked her to stop but she wouldn't, I asked her to stop, but she ignored me, and [client #4] asked her to stop, and she hit [client #4]. Staff told her it wasn't nice and then she tried to hit staff. [Client #1]: Did not provide any information relevant to this investigation.</p> <p>[Client #4]: [Client #2] was being mean to the cat. and I told her to stop, and she smacked me. [Client #5]: [Client #5] stated that [client #2] kept pulling the cat's tail and wouldn't stop. Staff asked her to stop, and she wouldn't listen, and when [client #4] asked her to stop, she hit her and hit the staff too.</p> <p>[Client #3]: Did not provide any information relevant to this investigation. [DSP #3]: [Client #2] kept hitting the cat. I tried to redirect her, but she wouldn't listen. [Client #4] asked her to stop, and she hit [client #4] on the shoulder and then when I redirected again, she tried to hit me. [Client #2] has not left the cat alone in several days. Were all behavior strategies followed appropriately and do the current behavior strategies address the above behavior? Yes...Do any changes need to be made to prevent future occurrences? Yes. Is there a pattern of occurrences between these two clients? No. Was there sufficient staff at the time of the incident? Yes. Conclusion: It is substantiated Person Served, [client #2] hit [client #4] without causing injury. Recommendations: [Client #2] has behavioral services in place with [name] Behavioral Health. An IDT meeting was held on 10/19/23 and this behavior was discussed with the recommendation of planned ignoring when [client #2] approaches the cat unless she is observed to exhibit aggressive behavior. Staff will verbally prompt [client #2] to be gentle when touching the cat and verbally prompt peers to not interject themselves into correcting [client #2's] behavior regarding the cat."</p>			
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	<p>DSP #4 was interviewed on 10/30/23 at 6:20 pm. DSP #4 stated clients #1, #2 and #3's behaviors included "aggression toward other clients". DSP #4 stated "I just try to get between them when they're fighting and redirect them."</p> <p>DSP #5 was interviewed on 10/31/23 at 9:30 am. DSP #5 stated "the ladies in the home get into it sometimes, [client #1] will punch and slap other clients, [client #2] will slap and pinch and [client #3] will hit at others."</p> <p>The Quality Assurance Coordinator (QAC) was interviewed on 11/2/23 at 10:00 am. The QAC stated the home "has had several client to client incidents". The QAC stated corrective measures developed to prevent further incidents of client to client abuse "have not been effective." The QAC stated the facility's policy for abuse and neglect should be followed "always".</p> <p>A Rescare Bill of Rights dated 3/2014 was reviewed on 11/1/23 at 9:15 am and indicated, "The rights of persons with mental retardation and developmental disabilities include, but are not limited to: ...The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality...The right to an appropriate, safe and sanitary living environment...The right to be free from emotional, psychological and physical abuse...".</p> <p>An Abuse, Neglect and Exploitation policy dated 11/14/2018 was reviewed on 11/1/23 at 9:30 am and indicated the following, "...ResCare will Ensure all persons served are treated with dignity and respect. Ensure that all persons served are free from abuse, neglect, or exploitation. Establish a protocol for reporting all incidents of abuse, neglect and exploitation to the ResCare Critical</p>			

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	<p>Incident Database. Ensure all incidents of abuse, neglect, and exploitation are reported to the appropriate authority as defined by state and local regulations...The policy applies to all persons served by ResCare. ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. Supervisors, managers, or employees are not permitted to, engage in retaliation, retribution, or any form of harassment directed against any employee who, in good faith, reports allegations or suspected incidents or abuse, neglect or exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate corrective action will be taken to ensure prevention of any further occurrence...'Abuse' means the infliction of physical or psychological harm, unreasonable confinement, intimidation, punishment with resulting physical pain or mental anguish or deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm."</p> <p>The facility's Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights dated 7/10/19 was reviewed on 11/1/23 at 9:45 am and indicated the following, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines. ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights."</p>			

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W 0186 Bldg. 00	<p>This deficiency was cited on 9/7/23. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus one additional client (client #4), the facility failed to ensure the home had sufficient direct care staff to effectively implement plans for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>Observations were completed in the home on 10/30/23 from 4:00 pm until 7:05 pm. On 10/30/23 at 4:00 pm, clients #1, #2, #3, #4, #5 and #6 were in the home and Direct Support Professional (DSP) #4 stated client #7 "is at work right now, we have to pick her up at 7:00 (pm)." Direct Support Professional (DSP) #4 was the only direct support staff in the home throughout the observations.</p> <p>The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 10/31/23 at 2:00 pm. The review indicated the following:</p>	W 0186	<p>The facility will provide sufficient staff to manage and supervise clients in accordance with their individualized plan. The home has recently experienced turnover that has initiated extra recruiting and training efforts to meet the needs of the individuals in the home.</p> <p>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.</p> <p>Program Manager will review all schedules to ensure adequate staffing is in place at all locations and work with Human Resources to recruit to fill staff vacancies in impacted homes.</p>	12/03/2023
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	<p>1. A BDS report dated 9/9/23 at 3:25 pm indicated, "During (a) community outing, [client #3] refused to exit the van upon arrival to the park. Peer [client #1] began yelling at [client #3] and [client #3] called [client #1] a b----. Staff redirected clients, [client #1] slapped [client #3] in the face knocking her glasses off causing them to break. Staff separated clients, they calmed down and resumed normal activity. No injuries noted to [client #3], facility nurse notified.</p> <p>Plan to Resolve: [Client #3's] glasses to be repaired. Staff will continue to monitor and report changes to clients' health and follow behavior support plans which address inappropriate social behaviors for [client #3] and aggression for [client #1]. A C2C (client to client) investigation will be conducted."</p> <p>An investigation for the incident dated 9/13/23 indicated, "...Description of incident: The ladies were out in the community, and [client #3] would not get out of the van and was yelling and got mad and hit [client #1], [client #1] grabbed a water bottle and hit [client #3] and broke her glasses... Were all behavior strategies followed appropriately and do the current behavior strategies address the above behavior? Yes, Staff talked to [client #3]. Staff need retrained on inappropriate social for [client #3]. Do any changes need to be made to prevent future occurrences? Yes, staff was not able to take either one to a quiet area per their plan as the incident occurred during a community outing at a park. The staff on duty was not able to separate the clients from the rest of the group to speak privately. Was there sufficient staff at the time of the incident? No. Seven clients went on the outing, with 1 staff on shift. Conclusion:</p>		<p>The Area Supervisor is responsible for ensuring that there is sufficient staff in the home at all times. The Area Supervisor is responsible to review and approve 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 train the Area Supervisor on Job Responsibilities ensuring adequate staffing in the home. Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations. Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.</p>	

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	<p>Substantiated. [Client #1] did hit [client #3] after she called her a name. Recommendations: Staff will be retrained on deescalating situations prior to their (sic) escalating to physical aggression, knowing the warning signs and notification to chain of command pursuant to staffing levels. Clients will have Self Advocacy training done. Make adjustments to behavioral supports for [client #1] and [client #3] to include strategies for when they are in the community."</p> <p>The review of the investigation indicated there was 1 direct care staff on duty in the home at the time of the incident.</p> <p>2. A BDS report dated 9/17/23 at 12:30 pm indicated, "...While [client #2] was sitting in the living room watching TV with peers, peer [client #4] walked past [client #2] to talk to staff and [client #2] pinched [client #4] on her right lower arm without prior incident. When staff asked [client #2] why she pinched peer [client #4], [client #2] began to yell and use profanity towards staff and attempted to hit staff. [Client #2] was redirected and prompted to calm down in her bedroom. [Client #2] calmed down on her own and resumed normal activity. Staff assessed [client #4] for injury and no apparent injury was observed. Nurse was notified. Plan to resolve: Staff will continue to monitor all peers and report any changes in their health. Staff will continue to follow [client #2's] BSP, which addresses aggression. A C2C investigation will be conducted."</p> <p>An investigation for the incident dated 9/21/23 indicated, "...Conclusion: Substantiated. Without prior incident, [client #2] pinched [client #4] on the right lower arm when she walked by her, and when staff redirected [client #2], [client #2] began</p>			

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	<p>to yell, scream, and attempt to hit staff. Staff was able to prompt [client #2] to her room where she was able to calm down and resume normal activity. Witness Statements: [Client #4]: I just walked by [client #2] to go to the office and she stopped me and pinched my hand really hard, and when staff told her to stop, then she tried to hit me. [Client #2]: Did not provide any information relevant to this investigation. [Client #2] was unable to recall events related to this incident. [Client #1]: Did not see [client #2] pinch [client #4] but heard [client #2] yelling and screaming. [Client #3]: Did not provide any information relevant to this investigation. [Client #6]: Did not provide any information relevant to this investigation. [Client #7]: was laying down in her room and did not see anything happen but heard [client #2] yelling. [Client #5]: Was not in the home at the time of the incident. [DSP (Direct Support Professional) #1]: [Client #2] was sitting in the living room watching TV with a few of her peers. [Client #4] walked past [client #2] to talk to staff and [client #2] pinched [client #4] on her right lower arm. When I asked [client #2] why she hit, [client #2] began to yell and attempted to hit staff. I assessed [client #4] for injury and there were none.</p> <p>Recommendations: Continue to follow [client #2's] BSP for Inappropriate Social, which addresses aggression, which will be broken off into a separate plan specifically allowing for more direct approach to the aggressive behaviors. Self-advocacy on how to resolve conflict without physical aggression will be discussed. An IDT meeting will be held and [client #2's] BSP will be reviewed."</p> <p>The review indicated DSP #1 was the only direct care staff interviewed for the investigation of client to client abuse involving clients #2 and #4.</p>				

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	<p>3. A BDS report dated 9/20/23 at 8:15 am indicated, "...Without prior incident, during the van ride to ResCare Day Service (RDS), [client #2] was attempting to play with peer [client #1's] hair and [client #1] turned around and hit [client #2] on her stomach. Staff redirected [client #1] and spoke with [client #1] until she calmed down and resumed normal activity. Nurse was notified. Staff assessed [client #2] and no apparent injuries were observed. Plan to Resolve: Staff will continue to monitor both individuals and report any changes in their health. Staff will continue to follow [client #1's] BSP in place which addresses aggression. A C2C investigation will be initiated".</p> <p>An investigation for the incident dated 9/26/23 indicated, "...Witness Statements: [Client #1]: After multiple attempts, [client #1] refused to talk to investigator about this investigation. [Client #7]: [Client #2] would not stop touching [client #1], so [client #1] just punched her. Staff told [client #2] to stop touching [client #1]. [Client #6]: Could not provide any information relevant to this investigation. [Client #3]: Could not provide any information relevant to this investigation. [Client #4]: [Client #2] wouldn't leave [client #1] alone, even after I told her to stop, so [client #1] just hit her in the stomach. Staff was telling [client #2] to stop touching [client #1], but she wouldn't. [DSP #1]: [Client #2] was trying to play with [client #1's] hair while getting in the van to go to RDS. I redirected [client #2] by telling her to stop, but she wouldn't listen. [Client #1] punched [client #2] in the stomach. I redirected [client #1] and she calmed down. I evaluated [client #2] for injuries, none was (sic) present. Do any changes need to be made to prevent future occurrences? No. Is there a pattern of occurrences between these two clients? No. Was there sufficient staff at the time of the incident? Yes. Conclusion: Substantiated:</p>			

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	<p>[Client #2] was trying to play with [client #1's] hair, and [client #1] hit [client #2].</p> <p>Recommendations: Staff will continue to follow [client #1's] BSP for physical aggression, which address slapping, punching and hitting. We will also hold an IDT meeting to discuss behaviors in the home. Staff will continue to follow [client #2's] BSP for Inappropriate Social which addresses pulling others' hair, pushing and striking others. An IDT meeting will be held to discuss [client #2's] behaviors. Self-advocacy and how to resolve conflict without aggression will be discussed with all the clients in the home."</p> <p>The review indicated DSP #1 was the only direct care staff interviewed for the investigation of client to client abuse involving clients #1 and #2.</p> <p>4. A BDDS report dated 10/2/23 at 5:00 pm indicated, "[Client #1] became agitated during the van ride home from RDS due to recently breaking up with her boyfriend and boyfriend choosing to date peer/housemate [client #4] instead. Upon returning home, [client #1] began threatening to hit [client #4] and grabbed a butter knife from the kitchen and placed it inside her shirt. DSL (direct support lead) and QIDP (qualified intellectual disabilities professional) Manager present at the home immediately separated peers to prevent any further incident and continued verbal prompts for [client #1] to hand over the butter knife. [Client #1] refused redirection and reported to QIDP manager having harmful thoughts and wishing to be seen for psychiatric evaluation. Nurse notified and EMS (emergency medical services) contacted. Police arrived at the home and [client #1] complied with prompts from officers to hand over the knife without further incident. Police transported [client #1] to [hospital] for evaluation. [Hospital] referred [client #1] to [psychiatric hospital] Center where</p>			

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	<p>she was admitted for psychiatric placement on 10/03/23. [Client #1] presently has behavioral supports in place for aggression. No physical contact occurred between [client #1] and [client #4] during this incident. DSL and QIDP Manager spoke with all individuals in home following incident to provide emotional support and provide education on how to resolve conflict in a non-aggressive manner. A C2C investigation will be initiated. ResCare to remain in contact with [psychiatric hospital] pending discharge. An IDT meeting will be scheduled for [client #1] following discharge to determine if changes are needed to current plan in place.</p> <p>Recommendations: Staff will continue to follow [client #1's] BSP for physical aggression and will hold an IDT meeting to discuss this behavior. Self-advocacy on how to resolve conflict without aggression will be discussed with all the clients in the home. An IDT meeting will be held with [client #4] to discuss appropriate ways for the girls to handle this situation. At the time of the incident, the rights restriction did not include butter knives, an addition of which will be discussed at the IDT meeting."</p> <p>An investigation for the incident dated 10/3/23 indicated, "...Witness Statements: [Client #4]: while at RDS, [manager] tried to come in between [client #1] and [client #4] and keep them separated. [Client #1] did not touch [client #4]. [Client #1] got a butter knife and told [client #4] that she was going to harm her. [Client #1] called [client #4] a 'b----'. [Client #5]: [Client #1] was calling [client #4] names in the van on the way home. [Client #1] went to the kitchen and got a butter knife and threatened to harm her. Staff tried to get the knife. [QIDP Manager] called 911. [Client #7]: Not on the van or at home at the time</p>			

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	<p>of the incident. [Client #6]: 'Bye. Bye.' Could not provide any information relevant to this investigation. [Client #3]: 'Was it bad?' Could not provide any information relevant to this investigation. [Client #2]: '[Client #1] pulled a knife on [client #4]'. [Client #1: Not in the home at the time of the investigation. [DSP #2]: When we got home from RDS [client #1] went and grabbed a butter knife and put it in her shirt and threatened to harm [client #4] because [client #1] accused [client #4] of stealing her boyfriend. [Client #1] threatened to kick [client #4's] butt. [QIDP Manager] was here at that time, and he proceeded to call 911. They arrived and [client #1] gave the sheriff the butter knife and they took her to [hospital]. [DSP #2] and [QIDP Manager] tried several times to redirect [client #1] away from [client #4]. [Client #1] was never out of line of sight. [QIDP Manager]: 'I arrived to Willa Villa Group Home yesterday afternoon for administrative monitoring. Upon entering the home, staff member [DSP #2] advised me that Person Served, [client #1] was stating that she was going to harm Person Served, [client #4] and had a butter knife in her possession. I approached [client #1] and asked for the knife, and she refused to surrender it after 5 mins of repeated prompting. I stood between [client #1] separating her from the rest of the clients in the other end of the home and called my supervisor, [Quality Assurance Manager (QAM)] followed by [Nursing Manager (NSM)]. [NSM] advised me to call 911. I called 911 and they said they would send someone from the Sheriff's Department. I continued to prompt [client #1] for the knife until the first deputy arrived. 2 deputies arrived one after the other 5 mins apart. The first deputy prompted [client #1] to surrender the knife and she did after 10 mins (minutes). At this time, the deputy placed handcuffs on her and took her to his squad car. Were all behavior</p>			
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	<p>strategies followed appropriately and do the current behavior strategies address the above behavior? Yes. Are all clients safe? Yes. Do any changes need to be made to prevent future occurrences? No. Is there a pattern of occurrences between these two clients? No. Was there sufficient staff at the time of the incident? Yes. Conclusion: Substantiated. [Client #1] did go into the kitchen and get a butter knife and threaten to harm [client #4]. [Client #1] did go to [hospital] and then to [psychiatric hospital]. All knives and sharps have been locked in the office per the rights restrictions in the house. All appropriate supports provided, and [client #1] had no contact with other clients during the course of the incident.</p> <p>Recommendations: Staff will continue to follow [client #1's] BSP for physical aggression and will hold an IDT meeting to discuss this behavior. Self-advocacy on how to resolve conflict without aggression will be discussed with all the clients in the home. An IDT meeting will be held with [client #4] to discuss appropriate ways for the girls to handle this situation. At the time of the incident, the rights restriction did not include butter knives, addition of which will be discussed at the IDT meeting."</p> <p>The review indicated DSP #2 was the only direct care staff interviewed for the investigation of client to client abuse involving clients #1 and #4.</p> <p>5. A BDS report dated 10/17/23 at 8:14 am indicated, "Upon waking up, [client #2] began pulling the house cat's tail. Staff redirected and [client #2] began hitting the cat. Staff continued redirection and [client #2] resumed hitting the cat. Peer [client #4] asked [client #2] to not hit the cat and [client #2] smacked [client #4] three times in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G440	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/03/2023
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 1970 E 45 1/2 CT TERRE HAUTE, IN 47802
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	<p>the shoulder followed by smacking staff one time in the shoulder. Staff used agency approved strike deflection technique, separated peers to prevent further aggression, and spoke with [client #2] explaining why the behavior is inappropriate. [Client #2] calmed down and resumed normal activity. Facility Nurse notified, no injuries noted to either client.</p> <p>Plan to Resolve: Staff will continue to monitor and report changes to [client #2's] health and follow her behavior support plan which addresses aggression. This incident was discussed in IDT on 10/17/2023 and increased behaviors will be further discussed in [client #2's] quarterly meeting on 10/19/23. Nursing Manager to discuss possible medication adjustment with psychiatrist. A C2C investigation will be conducted."</p> <p>An investigation for the incident dated 10/18/23 indicated, "...Witness Statements: [Client #6]: Did not provide any information relevant to this investigation. [Client #2]: Did not provide any information relevant to this investigation. [Client #7]: [Client #2] kept messing with the cat, pulling his tail and hitting him. Staff asked her to stop but she wouldn't, I asked her to stop, but she ignored me, and [client #4] asked her to stop, and she hit [client #4]. Staff told her it wasn't nice and then she tired to hit staff. [Client #1]: Did not provide any information relevant to this investigation. [Client #4]: [Client #2] was being mean to the cat. and I told her to stop, and she smacked me. [Client #5]: [Client #5] stated that [client #2] kept pulling the cat's tail and wouldn't stop. Staff asked her to stop, and she wouldn't listen, and when [client #4] asked her to stop, she hit her and hit the staff too. [Client #3]: Did not provide any information relevant to this investigation. [DSP #3]: [Client #2] kept hitting the cat. I tried to redirect her, but she</p>			

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	<p>wouldn't listen. [Client #4] asked her to stop, and she hit [client #4] on the shoulder and then when I redirected again, she tried to hit me. [Client #2] has not left the cat alone in several days. Were all behavior strategies followed appropriately and do the current behavior strategies address the above behavior? Yes...Do any changes need to be made to prevent future occurrences? Yes. Is there a pattern of occurrences between these two clients? No. Was there sufficient staff at the time of the incident? Yes. Conclusion: It is substantiated Person Served, [client #2] hit [client #4] without causing injury.</p> <p>Recommendations: [Client #2] has behavioral services in place with [behavioral consultant]. An IDT meeting was held on 10/19/23 and this behavior was discussed with the recommendation of planned ignoring when [client #2] approaches the cat unless she is observed to exhibit aggressive behavior. Staff will verbally prompt [client #2] to be gentle when touching the cat and verbally prompt peers to not interject themselves into correcting [client #2's] behavior regarding the cat."</p> <p>The review indicated DSP #3 was the only direct care staff interviewed for the investigation of client to client abuse involving clients #2 and #4.</p> <p>DSP #4 was interviewed on 10/30/23 at 6:20 pm. DSP #4 stated "we only have 3 staff total right now, we are pretty much always single staffed." DSP #4 stated "I'm not even sure who comes in tonight, we have no night shift staff right now and there is no one scheduled. People will be pulled from other homes and will come in to work this home with no training." DSP #4 stated the clients' behaviors included "aggression toward other clients and staff". DSP #4 indicated one staff was</p>			

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

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FORM APPROVED

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	<p>not enough to follow each client's plans. DSP #4 stated "I just try to get between them when they're fighting and redirect them."</p> <p>DSP #5 was interviewed on 10/31/23 at 9:30 am. DSP #5 stated "we're short staffed right now, we always work single staffed."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/2/23 at 9:30 am. The QIDP indicated she was responsible for completing client to client investigations. The QIDP stated "there was one staff on duty" for each of the client to client incidents reviewed. The QIDP stated "it can be difficult for one staff to pass meds, cook meals and deal with client behaviors."</p> <p>The Quality Assurance Coordinator (QAC) was interviewed on 11/2/23 at 10:00 am. The QAC stated "there was only 1 staff in the home" at the time of the reported client to client incidents. The QAM stated "one staff was not effective in providing care for the clients."</p> <p>This deficiency was cited on 9/7/23. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>			