STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G591	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	411 N PINE BRAZIL, IN 47834

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00398647. Complaint #IN00398647: Substantiated, A Federal and state deficiency related to the allegation is cited at W186. Unrelated deficiencies cited. Dates of Survey: 3/17, 3/20, 3/21, 3/22, 3/23 and 3/24/2023. Facility Number: 001105 Provider Number: 15G591 AIMS Number: 100245580 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 3/30/23.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home remained in good repair. Findings include: On 3/20/23 from 4:04 PM to 6:35 PM, an	W 0104	**The facility will ensure that specific governing body and management requirements are met. The Governing Body will exercise general policy, budget, and operating direction over the facility in regard to home maintenance. Cosmetic maintenance needs are tasked with priority behind**	04/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Newton	Q. I. D. P. Manager	04/13/2023

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	observation was conducted at the group home. During the observation, the following issues were noted affecting clients A, B, C, D, E, F, G and H: 1) Landscaping timbers were laying in the front yard in various areas and directions. 2) The front yard had various sizes of broken tree branches covering the yard. 3) The front yard had a patio swing tipped over and leaning on the house. 4) There was 1 navy blue cushion on the railing of the porch. Two other cushions were on broken chairs on the front porch. 5) There was a bed frame in one corner of the porch. 6) There was a broken end table in the other corner of the porch. 7) The porch had chipped green paint in areas. 8) The north side bathroom did not have a toilet seat. 9) Areas on the wall above the chair rail on the north side living room wall were white and there were areas missing paint. 10) There was an area of missing flooring in the living room measuring 3 inches by 7 inches. 11) Three of the four bedroom doors had areas of paint missing and streaks of brown and black substances. 12) A drawer was missing from kitchen cabinets near the kitchen sink. 13) There was a missing privacy fence panel in the back yard. 14) There were 2 small gray bags of trash behind a fence panel leaning against the fence. Various pop cans were under small gray bags. 15) There were 3 tiki torches on the ground in front of a patio swing. An interview was conducted on 3/20/23 at 4:13 PM with DSP (Direct Support Professional) #4.		**those involving client safety and larger projects involving the appearance of the home.** **A seat was acquired for the northside bathroom toilet and installed the date the observation was made by the surveyor.** **The three inch by seven inch area of missing flooring in the living room was repaired on 3/28/23.** **Maintenance requests have been submitted to address unfinished maintenance needs in the home including the missing drawer in the kitchen cabinetry, chipped paint on the porch, missing paint on the wall above the chair rail on the north side living room, bedroom doors with areas of paint missing, and the missing panel of privacy fence.** **A cleaning crew was dispatched to address the tiki torches, landscaping timbers and broken tree branches in the front yard, patio swing tipped over in the front yard, bed frame, end table, cushions, and broken chairs on the porch.** **The bags of trash behind the privacy fence, and pop cans were disposed of.** **Area Supervisor an all staff in the home will receive retraining on completing maintenance requests at the**	

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	DSP #4 stated, "we are in process of obtaining bids from companies to replace the flooring." DSP #4 indicated the home was old and settling and this was why there were maintenance issues. An interview was conducted on 3/20/23 at 6:16 PM with DSP #1. DSP #1 indicated maintenance requests were completed when repairs were needed. DSP #1 stated, "maintenance requests were now done on-line." DSP #1 indicated they were never sure when the repairs would be completed. An interview was conducted on 3/22/23 at 3:08 PM with the QIDP-M (Qualified Intellectual Disabilities Professional- Manager). The QIDP-M stated, "maintenance needs are completed best to the agencies ability, life safety issues are a priority over cosmetic." The QIDP-M stated, "cleaning of the home should be priority." 9-3-1(a)		**time needs arise and following up to ensure completion. 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.**	
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 additional clients (D, E, F and H), the facility failed to ensure thorough investigations were completed. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) incident reports and investigations were reviewed on 3/20/23 at 10:00 AM. The review indicated the following: 1) A 6/8/22 BDDS incident report indicated,	W 0154	**Timeliness and thoroughness of Investigations remains an ongoing issue. All trained investigators will be trained on the operations revised investigative process so as to ensure five day completion for investigations. The facility will have evidence that all Client to Client Aggression incidents are thoroughly investigated and reported to BDDS per reporting**	04/23/2023

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	"[Client H] was hit in the right leg with a chair thrown by a peer. [Client H] has a 1 cm (centimeter) by 1 cm red area." The review did not indicate documentation of an investigation regarding peer to peer aggression. 2) An 8/10/22 BDDS incident report indicated, "[Client H] was hit by a peer at RDS (Residential Day Services). No injuries." The review did not indicate documentation of an investigation regarding peer to peer aggression. 3) An 11/8/22 BDDS incident report indicated, "[Client E] was hit by a peer at RDS no injury." The review did not indicate documentation of an investigation regarding peer to peer aggression. 4) A 1/2/23 BDDS incident report indicated, "[Client A] had a 3" (inch) by 3" abrasion on his lower right side. [Client H] reported he accidentally dropped [client A] while helping staff with lifting. DSP (Direct Support Professional) has been placed off duty pending allegations of having a peer assist with transfer." The investigation interview of DSP #6 dated 1/5/23 indicated, "When I'm on shift, [client A] is normally in good spirits without issues. I did ask [client H] to help get [client A] up and walk with him because I cannot due to having bad knees. I let AS (Area Supervisor) know that I need help when I work at (sic) with lifting things because of my knees. I have been asked to provide a doctor's note indicating that I have this type of restriction but I can't afford a doctor or insurance to provide this. [DSP #1] and AS (Area Supervisor) told me I could call another home but they also said [client		**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 reported and investigated. The QIDP is responsible for initiating and completing initial investigation of Client to Client Aggression incidents. The Quality Assurance Manager is responsible for ensuring that these incidents of Client to Client Aggression are thoroughly investigated, and follow-up is completed within the established timelines.**	

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	H] was big help around the house, so I didn't think it would be a big deal to ask [client H] to help me out. I don't remember [client A] ever falling down or seeing any bruising on his side." The investigation interview of AS dated 1/5/23 indicated, "[DSP #6] did mention she felt like she couldn't do lifting in the home because of her knees. I asked her to provide a doctor's note with restrictions and her response to me was she didn't need a doctor's note because she knew what she could and couldn't do. She did not mention having any restrictions during her hiring process. I tried to double staff the house when possible while she was on shift even without her having a note." The 1/6/23 investigation summary indicated,"It is substantiated DSP #6 violated policy by neglecting to assist [client A] in the home and requesting [client H] help lift [client A] out of bed." The 1/6/23 investigation summary indicated "staff termination for failure to follow [client A's] HRP (High Risk Plan) and failure to report incident of [client A] falling." The investigation was not thorough due to not identifying one staff working at the group home as insufficient to meet the needs of the clients. An interview was conducted on 3/24/23 at 3:38 PM with the QAM (Quality Assurance Manager). The QAM stated, "The ratio of staff to clients is 2:8 (2 staff to 8 clients)." The QAM stated, "We try to meet the ratio when we can." 5) A 1/7/23 incident report indicated, "[Client H] was hit on the left hand by a peer at RDS, no			

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	injury." The review did not indicate documentation of an investigation regarding peer to peer aggression. 6) A 1/10/23 incident report indicated, "[Client D] hit [client F] in between the shoulder blades, no injuries noted" The review did not indicate documentation of an investigation regarding peer to peer aggression. An interview was conducted on 3/17/23 at 10:14 AM with the QIDP-M (Qualified Intellectual Disabilities Professional- Manager). The QIDP-M indicated peer to peer aggression should have been investigated. An email was received on 3/22/23 at 12:59 PM stated, " investigations requested, we do not have." An interview was conducted on 3/24/23 at 3:38 PM with the QAM (Quality Assurance Manager). The QAM stated, "Any peer to peer aggression should be investigated every time." 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 additional client (H), the facility failed to implement corrective action to address DSP (Direct Support Professional) #1 failing to follow Safe Driving procedures by transporting client H in her personal vehicle rather than a company owned vehicle. Findings include:	W 0157	**The agency's Safe Driving Policy does not include requirement of staff to drive consumers in agency owned vehicles in lieu of their personal vehicles.** **The investigation provided to the surveyor was a draft copy and had not been replaced by**	04/23/2023

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	The facility's BDDS (Bureau of Developmental Disabilities Services) incident reports and investigations were reviewed on 3/20/23 at 10:00 AM. The review indicated the following: A 1/20/23 BDDS incident report indicated,"[Client H] was being transported in the personal vehicle of DSP #1. Another motorist did not yield for a flashing red light and pulled out in front of DSP #1's vehicle causing impact." The 1/26/23 investigation indicated, "Substantiated [DSP #1] failed to follow Safe Driving procedure by transporting [client H] in her personal vehicle rather than a company owned vehicle." An interview was conducted on 3/22/23 at 3:09 PM with the QIDP-M (Qualified Intellectual Disabilities Professional -Manager). The QIDP-M stated, "Group home staff are to use the van to transport individuals." The QIDP-M indicated this was addressed in our new hire orientation. An interview was conducted on 3/23/23 at 12:51 PM with the HR (Human Resources) Generalist. The HR Generalist indicated there was not any corrective action, disciplinary action or retraining for DSP #1 regarding the use of her personal vehicle to transport individuals. 9-3-2(a)		**the final copy which indicated it was unsubstantiated staff had violated the agency Safe Driving Policy. The draft copy has since been replaced with the corrected copy.**	
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.			

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	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. Based on observation, record review, and interview for 3 of 3 sample clients (A, B and C), and 5 additional clients (D, E, F, G and H), the facility failed to provide a sufficient number of staff to address the clients' needs. Findings include: An observation was conducted at the group home on 3/20/23 from 4:04 PM through 6:35 PM. At 4:04 PM DSP (Direct Support Professional) #4 indicated she was the only staff in the home with client A. DSP #1 indicated the rest of the individuals were on their way home from RDS (Residential Day Services) with DSP #1. At 4:14 PM DSP #4 indicated DSP #1 would be the only staff working the evening shift. DSP #4 stated, "I try to work overtime and help fill the evening shift, but I can not work tonight." At 4:25 PM DSP #1 arrived at the home with clients (B, C, D, E, F, G and H). At 4:30 PM DSP #4 left the home leaving DSP #1 the only staff for the evening with clients A, B, C, D, E, F, G and H. At 4:35 PM DSP #1 went into the office to prepare to administer 4:00 PM medications. At 4:37 PM DSP #1 prompted client C into the office for his medications. DSP #1 closed the office door. At 4:45 PM DSP #1 prompted client E into the office for his medications. DSP #1 closed the office door. At 4:49 PM DSP #1 prompted client B into the office for his medications. DSP #1 closed the office door. At 5:00 PM client A sat in the recliner watching cartoons in the living room on the south side of the home. On the north side living room of the home clients E, F and G were watching a	W 0186	**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.** **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.** **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 train the Area Supervisor on Job Responsibilities ensuring adequate staffing in the home.** **Administrative observations have been implemented in the**	04/23/2023

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	television show. DSP #1 at 5:15 PM prompted client H to assist with setting the table for dinner. Client H set the table then went to his bedroom. At 5:20 PM DSP #1 assisted client G with gathering his supplies for his evening hygiene routine. DSP #1 was went back into the kitchen and washed her hands. At 5:30 PM DSP #1 prompted client C to help prepare garlic bread and corn for dinner. DSP #1 noted dinner was in the oven and would be done shortly. At 5:45 DSP #1 assisted client A to the rest room. While in the restroom, the door was closed. At 6:02 PM DSP #1 assisted client E to the restroom. DSP #1 and client E were in the restroom for 5 minutes with the door closed. The facility's BDDS (Bureau of Developmental Disabilities Services) incident reports and investigations were reviewed on 3/20/23 at 10:00 AM. The review indicated the following: A 1/2/23 BDDS incident report and investigation indicated, "[Client A] had a 3" by 3" abrasion on his lower right side. [Client H] reported he accidentally dropped [client A] while helping staff with lifting. DSP #6 has been placed off duty pending allegations of having a peer assist with transfer." The investigation interview of DSP #6 dated 1/5/23 indicated, "When I'm on shift, [client A] is normally in good spirits without issues. I did ask [client H] to help get [client A] up and walk with him because I can not due to having bad knees. I let AS (Area Supervisor) know that I need help when I work at (sic) with lifting things because of my knees. I have been asked to provide a doctor's note indicating that I have this type of restriction but I can't afford a doctor or insurance to provide this. [DSP #1] and AS told me I could call another		**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.**	

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	home but they also said [client H] was big help around the house, so I didn't think it would be a big deal to ask [client H] to help me out. I don't remember [client A] ever falling down or seeing any bruising on his side." The investigation interview of AS dated 1/5/23 indicated, "[DSP #6] did mention she felt like she couldn't do lifting in the home because of her knees. I asked her to provide a doctor's note with restrictions and her response to me was she didn't need a doctor's note because she knew what she could and couldn't do. She did not mention having any restrictions during her hiring process. I tried to double staff the house when possible while she was on shift even without her having a note." The 1/6/23 investigation summary indicated,"It is substantiated [DSP #6] violated policy by neglecting to assist [client A] in the home and requesting [client H] help lift [client A] out of bed." 1) Client A's record review was completed on 3/22/23 at 1:15 PM. Client A's HRP dated 10/6/22 addressing falls indicated, "Staff are to walk with [client A] when not seated, holding the gait belt." Client A's HRP for Choking and Aspiration Pneumonia due to reflux, g-tube (Gastrostomy Tube) feeding indicated, "Staff will always monitor [client A] and encourage him to refrain from eating or drinking by mouth." 2) Client B's record review was completed on 3/22/23 at 1:30 PM. Client B's ISP (Individualized Support Plan) dated 1/27/23 indicated, "At this time, [client B] requires supervision and verbal prompts to complete his ADLs (Activities of Daily Living). He is currently in good health, but is			

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	unable to provide for his basic health, safety, and nutritional needs without supervision, training and staff support." 3) Client C's record review was completed on 3/22/23 at 12:30 PM. Client C's BSP (Behavior Support Plan) dated 10/5/22 addressing elopement indicated, "If [client C] attempts to leave the premises, staff is to follow [client C]." Client C's ISP dated 10/5/22 indicated, "[Client C] requires prompting to complete his ADLs." [Client C] is in good health, but is unable to provide for his basic health, safety, and nutritional needs without continuous training, supervision and staff support." Client C's dining plan dated 6/2/22 indicated "Regular diet w/ (with) ground meats. Staff should encourage [client C] to eat slowly and chew his food thoroughly." An interview was conducted on 3/20/23 at 4:10 PM with DSP #4. DSP #4 indicated it was not easy to be single staffed with all 8 clients. DSP #4 stated, "one individual we have to assist with a gait belt, there are 2 individuals with walkers and 1 in a wheelchair. Sometimes it is hard to provide supervision." An interview was conducted on 3/22/23 at 3:08 PM with the QIDP-M (Qualified Intellectual Disabilities Professional- Manager). The QIDP-M indicated the individuals needs could be met easier when there was adequate staffing. An interview was conducted on 3/24/23 at 3:38 PM with the QAM (Quality Assurance Manager). The QAM stated, "The ratio of staff to clients is 2:8 (2 staff to 8 clients)." The QAM stated, "We try to meet the ratio when we can." This federal tag relates to complaint #IN00398647.			

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	9-3-3(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure a high risk plan was implemented as written. Findings include: An observation was conducted at the group home on 3/20/23 from 4:04 PM through 6:35 PM. At 4:49 PM client B was prompted to come into the office for medication administration. Client B was given a small glass of water to drink with his medications. At 6:25 PM client B was sitting at the table. The pitcher was passed to him containing tea. Client B poured himself a glass of tea. Client B's record review was conducted on 3/22/23 at 1:30 PM. Client B's Diabetes HRP (High Risk Plan) dated 10/6/22 indicated, "[Client B] - encourage at least 8 ounces of water with EACH med pass & (and) meal." Client B was not prompted to drink 8 ounces of water with medication pass. Client B was not prompted to drink water with his meal. An interview was conducted on 3/21/23 at 3:15	W 0249	**Client B's HRP has been amended to indicate staff should prompt client to drink fluids with medications and at meal times.** **Facility Nurse will train all staff on the amended HRP for Client B.**	04/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G591	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	411 N PINE BRAZIL, IN 47834

(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
	PM with the LPN (Licensed Practical Nurse) for the group home. The LPN stated, "if the HRP indicates he is to have water at meals, he should be encouraged to drink water." An interview was conducted on 3/22/23 at 3:08 PM with the QIDP-M (Qualified Intellectual Disabilities Professional- Manager). The QIDP-M stated,"the HRP should be followed as written." The QIDP-M indicated the staff failed to implement client B's diabetes HRP. 9-3-4(a)			