PRINTED:	03/26/2019	
FORM APH	PROVED	

OMB NO. 0938-039

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G508 B. WING 02/26/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE. IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE W 0000 Bldg. 00 This visit was for the investigation of Complaint W 0000 #IN00286338. This visit resulted in an Immediate Jeopardy. Complaint #IN00286338: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W159, W164, W186, W189, W249, and W407. Unrelated deficiencies cited. Dates of Survey: February 20, 21, 22, 25, and 26, 2019. Facility Number: 001022 Provider Number: 15G508 AIM Number: 100245140 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/7/19. W 0102 483.410 GOVERNING BODY AND MANAGEMENT Bldg. 00 The facility must ensure that specific governing body and management requirements are met. Each home is assigned a nurse Based on observation, record review and W 0102 03/28/2019 interview, the facility failed to meet the Condition to oversee the monitoring and of Participation: Governing Body for 3 of 3 oversight of each individual's sampled clients (A, B, and C), plus 5 additional medical needs including clients (D, E, F, G, and H). The governing body documentation of the neglected to implement its written policy and interventions and progress of procedures to prevent neglect of client C in any injuries or illness. Each regards to an identified pressure ulcer, and to nurse is responsible for implement its POC (Plan of Correction) for clients assessing and following up any

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any define cystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONST	RUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	OING	00	COM	PLETED
		15G508	B. WING			02/2	6/2019
	PROVIDER OR SUPPLIE	D	SI	TREET ADD	RESS, CITY, STATE, ZIP COD	,	
				475 N 17			
NORMA	L LIFE OF INDIAN	Ą		ERRE HA	UTE, IN 47805		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	.10			DATE
		G, and H in regard to community			edical issue identified		
	participation.				aintaining documentat		
				-	pecific chronic and acu		
		ly failed to exercise general			eeds on an ongoing ba		
		operating direction over the		-	ntil the issue is resolve		
	-	he facility met the Condition of			ach nurse is responsib		
	-	nt Protections for 1 of 3 sample			ast a weekly visit to th		
	clients (C). The governing body neglecte implement its written policy and procedu prevent neglect of client C in regards to a				monitor health issues	s and	
					ocumentation that is	The	
	identified pressure	e			aintained in the home.		
	identified pressure	uicei.			urse is responsible for		
	The governing hod	ly failed to exercise general			ompleting a monthly p	rogress	
					ote and a quarterly ssessment for each inc	lividual	
	policy, budget and operating direction over the facility to ensure the facility met the Condition o Participation: Health Care Services for 1 of 3					lividual	
		-			ssigned. Il of the nurses will rec	oivo	
	-	). The governing body failed to			-training on their	eive	
	- · ·	eived timely nursing			esponsibilities to monit	tor and	
		ention, staff training, and			omplete documentation		
		ing the identification of the			pecific chronic and act		
	repeated pressure u				eeds on an ongoing ba		
					ntil the issue is resolve		
	Findings include:				ealth services Director		
	e				sponsible to insure th		
	1. The governing b	ody failed to implement their			aining is completed an		
		ires to address recurrent issues			ocumented in the empl		
		articipation addressed in prior			aining file.		
		n (POC) in 2018, neglected to			lient C HRP for skin in	tegrity	
		licy and procedures to ensure			as been reviewed and i		
	· ·	mely nursing assessment,			ace.		
		training, and monitoring			he facility adheres to th	he	
	following the ident	tification of the repeated			gulations to provide m		
	pressure ulcer occu	irrence, neglected to prevent		tre	eatment, assessments	and	
	Verbal Aggression	(VA) and Physical Aggression		la	bs as needed to ensur	e	
		rds clients, and failed to		cl	ient's optimal health.		
	provide client A w	ith supervision to prevent		C	lient C receives weekly	/	
	elopement,failed to	preport an allegation of staff to		tre	eatment and assessme	ents	
		g clients B and E, an allegation		pr	rovided by Union Hosp	oital	
		A involving clients A and B,		w	ound Care Center and	will	
	and two of client C	"s Injuries of Unknown Origin		co	ontinue until the press	ure	

	R MEDICARE & MEDI					1B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	
		15G508	B. WING		02/26	/2019
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COD		
	L LIFE OF INDIAN	٨	-	I 17TH ST E HAUTE, IN 47805		
-	-			- TAUTE, IN 47805		1
X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIVE	ON	(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	TAG			DATE
		Developmental Disabilities		ulcer is cleared.		
		within 24 hours of the alleged		All staff in the home will		
		thoroughly investigate multiple		receive training on Client		
		cal and verbal aggression		HRP, proper repositioning	-	
		, B, D, E, F, G, and unnamed		when to reposition, when		
	-	on of PA by staff towards		call the nurse, meeting of		
		nd client C's IUO in July 2018		medical needs, and When	ı to	
		, failed to report the results of		Order Medical Supplies.		
	-	s of staff to client Verbal		Health Services Director	will	
		and Physical Aggression (PA)		train Facility Nurse on Nu	-	
		B, and E to the administrator		Assessments, When to de	D	
		days of the alleged events,		Nursing Assessments,		
		aff demonstrated competency in		Understanding of Job		
	tracking clients A	and C's Sleep Flow Chart (SFC),		Responsibilities, When to	) Train	
	client A's Location	n Tracking Five Minute Checks		Staff, and Meeting of Clie	nts'	
	(LTFMC), failed	to ensure staff completed client		Medical Needs.		
	C's Reposition Tra	acking Form (RTF), and failed to		Health Service Director w	rill -	
	ensure staff in the	home were trained regarding		audit each clients chart a	t least	
	clients A and C pr	ior to working with them in the		quarterly to ensure ongoi	ng	
	home, failed to ad	dress client C's need for an		HRP adherence, appropri	ate	
	accurate pain asse	ssment, failed to implement		completion of Nursing		
	client A's door ala	rm protocol, and client C's		Assessments, and Meetin	ng of	
	Health Risk Plan	(HRP) for repositioning after a		Clients' Medical Needs.		
	diagnosed pressur	e ulcer, and failed to ensure		The Residential Manager	and	
	client C received	timely nursing assessment,		all DSPs will receive train	ing	
	intervention, staff	training, and monitoring		on the clients right to rec	eive	
	following the iden	tification of the repeated		an active habilitation prog	gram	
	pressure ulcer occ	urrence. Please see W104.		and the right to access ar	nd	
	_			participate in community		
	2. The governing	body failed to systemically		activities.		
	ensure client C ree	ceived timely nursing		The Residential Manager	will	
	assessment, interv	rention, staff training, and		develop a schedule of		
		ring the identification of the		proposed community act	ivities	
		ulcer occurrence. The		based on individual		
		stemically failed to report to		preferences and choices.	The	
		velopmental Disabilities Services		Residential Manager will		
		ly investigate, and implement		daily to ensure activities		
		ve action to prevent the neglect		completed. The Resident		1
		nued pressure ulcer. Please see		Manager will ensure all		
	W122.	nava pressure ureer. I rease see		individuals residing in the	-	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		COM	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		4475	i address, city, state, zip c N 17TH ST E HAUTE, IN 47805	OD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLETIC DATE	
	3. The governing b of Participation: H governing body fa timely nursing asso training, and moni identification of th occurrence. Please	body failed meet the Condition ealth Care Services. The iled to ensure client C received essment, intervention, staff toring following the e repeated pressure ulcer		facility have an oppor participate in commun activities. The Area Supervisor responsible for provid training. Additional tra- will be provided immed in instances where sta observed not to be made expectations. The Res Manager will provide Supervisor with a mod activity calendar and inform the Area Super any changes or conce attending the activitie Area Supervisors and home audit forms hav updated to include a p inspection of the com- participation schedule logs. These will be co- and submitted to the Manager for review of weekly basis. The Pro Manager will review th submitted audit and in corrections and sched follow up visit where deficiencies are noted deficiencies will be act follow up visit where deficiencies will be act following the agency' progressive disciplina policy. Administrative observ- have been implement home daily, seven day and will remain in plat the team determines in appropriate to decrea	nity will be ding this aining ediately aff are eeting the sidential the Area nthly will rvisor of erns with s. I QIDP's re been physical munity e and mpleted Program he mplement dule d. Repeat ddressed s ary action rvations ed in the ys a week ce until it is		

	R MEDICARE & MEDIC	1		CONSTRUCTION		<b>IB NO. 0938-039</b> SURVEY
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	<u>00</u>	COMP	LETED 6/2019
	PROVIDER OR SUPPLIE		4475	t address, city, state, zip cod N 17TH ST RE HAUTE, IN 47805		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
				number of observations will ensure all correction implemented per ResCa policy and regulations. Ongoing weekly and mo observations and review continue with the QIDP a Area Supervisor over the location. Observations a completed by various st various times, including morning, evening and weekend visits.	ns are re nthly v will and e are aff at	
W 0104 Bldg. 00	policy, budget, ar the facility. Based on observati interview for 3 of 3 plus 5 additional cl governing body fai budget and operati failing to implement address recurrent is participation addree Correction (POC) is their policy and pro- received timely nur- staff training, and r identification of the occurrence, neglec Aggression (VA) a by staff towards cl client A with super failed to report an a involving clients B	DY dy must exercise general d operating direction over on, record review, and a sampled clients (A, B, and C), ients (D, E, F, G, and H), the led to exercise general policy, ng direction over the facility by at their policy and procedures to sues with community ssed in prior Plans of n 2018, neglected to implement ocedures to ensure client C rsing assessment, intervention, monitoring following the e repeated pressure ulcer ted to prevent Verbal nd Physical Aggression (PA) ents, and failed to provide vision to prevent elopement, and E, an allegation of staff to g clients A and B, and two of	W 0104	The facility will ensure the specific governing body management requirement met. The Governing Body exercise general policy a operating direction over facility and will impleme written policy and procest to ensure all individuals supported are free from neglect, exploitation and mistreatment. The facility has developed will consistently impleme written policies that defind prohibit abuse, neglect, exploitation and mistreatment and the obligation and responsibility of reporting violations; the process for the specific operation operation operation operation operation and the process of the specific operation o	and nts are ly will and the nt dures abuse, d abuse, d ed and ent its ne and tment	03/28/2019

TERS FO	R MEDICARE & MEDI	CAID SERVICES				IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C			SURVEY
ND PLAN	OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPI	
		15G508	B. WING		02/26	/2019
JAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COD		
	L LIFE OF INDIAN			I 17TH ST E HAUTE, IN 47805		
X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	DN BE	(X5)
REFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	TAG			DATE
		pmental Disabilities Services		follow-up to any such		
		hours of the alleged incidents,		allegations reported. All		
	-	ly investigate multiple incidents erbal aggression between clients		employees receive trainin	-	
				this policy upon hire and	at	
		and unnamed clients, an		least annually thereafter.		
	e	by staff towards clients A and B,		All staff, including the		
		) in July 2018 and October 2018,		Residential Manager and		
	-	e results of two investigations of		support roles will comple		
		bal Aggression (VA) and		competency-based trainin	-	
		on (PA) towards clients A, B,		the facilities ANEM policy		
		nistrator within 5 business days		an emphasis on defining	and	
	-	nts, failed to ensure staff		recognizing neglect.		
		petency in tracking clients A				
	-	w Chart (SFC), client A's		The Residential Manager		
		g Five Minute Checks (LTFMC),		all DSPs will receive train	-	
		aff completed client C's		on the clients right to rec		
		ng Form (RTF), and failed to		an active habilitation prog	-	
		home were trained regarding		and the right to access ar	nd	
	-	tior to working with them in the		participate in community		
		dress client C's need for an		activities.		
	· ·	ssment, failed to implement		The Residential Manager	will	
		rm protocol, and client C's		develop a schedule of		
		(HRP) for repositioning after a		proposed community act	vities	
		e ulcer, and failed to ensure		based on individual		
		timely nursing assessment,		preferences and choices.		
		training, and monitoring		Residential Manager will		
		tification of the repeated		daily to ensure activities a		
	pressure ulcer occ	purrence.		completed. The Resident	ial	
				Manager will ensure all		
	Findings include:			individuals residing in the		
				facility have an opportuni	ty to	
		terviewed on 2/20/19 at 4:25 PM.		participate in community		
		We don't get to go out very		activities.		
	-	nt to go to church." Client E		The Area Supervisor will		
		told staff on the weekends that		responsible for providing	this	
	-	church. Client E stated, "I don't		training. Additional training	ng	
	know why I can't	go."		will be provided immediat	ely	
				in instances where staff a	re	
	Client G was inter	rviewed on 2/20/19 at 4:30 PM.		observed not to be meeting	ng the	
	Client G stated "	Yes, I want to go to church. I		expectations. The Reside	ntial	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIPLE CONS	TRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	ETED
		15G508	B. WIN	G		02/26/	2019
NAME OF		D	- T	STREET ADI	DRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE			4475 N 17			
NORMA	L LIFE OF INDIAN	4		TERRE H	AUTE, IN 47805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t G provided a Sunday bulletin		N	lanager will provide the Are	a	
	for a church she at	tended in October 2018. Client		S	Supervisor with a monthly		
	G indicated that w	as the last time she had visited		a	ctivity calendar and will		
	church. Client G st	ated, "This is the church I want		ir	nform the Area Supervisor o	of	
	to go to. I like it th	ere. I asked [Home Manager		a	ny changes or concerns wit	th	
	(HM) #1] about go	oing. She told me that I can't go		a	ttending the activities.		
	to church because	she doesn't go either."			Area Supervisors and QIDP's	S	
				h	ome audit forms have been	l	
	Community Partic	ipation Logs (CPLs) were		u	pdated to include a physica	al	
		19 at 11:55 AM. The review			nspection of the community		
	indicated the follo				articipation schedule and		
		5		-	ogs. These will be complete	d	
	- Client A's CPL d	ated November 2018 did not			nd submitted to the Program		
	indicate client A h	ad gone on any outings during			lanager for review on a		
	the month.				veekly basis. The Program		
					lanager will review the		
	Client A's CPL dat	ted January 2019 indicated client			ubmitted audit and impleme	ont	
		e outing on $1/26/19$ .			orrections and schedule	5111	
	Tt had gone on one	outing on 1/20/17.		-	ollow up visit where		
	Client A's CPL dat	ted February 2019 indicated			leficiencies are noted. Repe	at	
		on two outings on 2/19/19 and			leficiencies will be addresse		
	2/20/19.	on two outnigs on 2/19/19 and		-		a	
	2/20/19.				ollowing the agency's		
	Client Die CDL d	ted Neverther 2018 did act			rogressive disciplinary acti	on	
		ated November 2018 did not			olicy.		
		ad gone on any outings during			ach home is assigned a nu		
	the month.				o oversee the monitoring an		
	Climit D's CDL 1	- 1 I			versight of each individual'	5	
		ed January 2019 indicated client			nedical needs including		
	B nad gone on one	outing on 1/16/19.			ocumentation of the		
					nterventions and progress of		
		ed February 2019 did not			ny injuries or illness. Each		
		ad gone on any outings during			urse is responsible for		
	the month.				ssessing and following up a	any	
					nedical issue identified and		
		ated November 2018 did not			naintaining documentation of	of	
		ad gone on any outings during			pecific chronic and acute		
	the month.				eeds on an ongoing basis o	or	
				u	ntil the issue is resolved.		
		ted December 2018 indicated		E	ach nurse is responsible fo	or at	
	client D had gone on one outing on $12/7/18$ .			le	east a weekly visit to the ho	me	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	· ,	E SURVEY PLETED	
		15G508	B. WING	<u></u>		02/26/2019	
NAME OF	AME OF PROVIDER OR SUPPLIER			et address, city, state, zip c 5 N 17TH ST	OD		
NORMA	L LIFE OF INDIAN	Ą		RE HAUTE, IN 47805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	<u>`</u>	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE PPROPRIATE	COMPLETION DATE	
				to monitor health issu			
		ted January 2019 did not indicate on any outings during the		documentation that is maintained in the hom			
	month.	on any outings during the		nurse is responsible f			
				completing a monthly			
	Client D's CPL dat	ted February 2019 did not		note and a quarterly			
		ad gone on any outings during		assessment for each i	individual		
	the month.			assigned.			
	Client Ele CDL d	ated November 2018 indicated		All of the nurses will r	eceive		
		on three outings on $11/5/18$ ,		re-training on their responsibilities to mo	nitor and		
	11/18/18, and 11/2	-		complete documentat			
	11,10,10, <b>unu</b> 11, <b>-</b>			specific chronic and a			
	Client E's CPL dat	ed December 2018 indicated		needs on an ongoing			
	client E had gone on three outings on 12/4/18,			until the issue is reso	lved. The		
	12/6/18, and 12/21	/18.		Health services Direct			
				responsible to insure			
		ed January 2019 did not indicate		training is completed			
	month.	on any outings during the		documented in the en training file.	ipioyees		
	montin.			Client C HRP for skin	integrity		
	Client E's CPL dat	ed February 2019 did not		has been reviewed an			
		ad gone on any outings during		place.			
	the month.			The facility adheres to	o the		
				regulations to provide	e medical		
		ated November 2018 did not		treatment, assessmen			
	the month.	ad gone on any outings during		labs as needed to ens			
	the month.			client's optimal health Client C receives wee			
	Client F's CPL dat	ed December 2018 indicated		treatment and assess	-		
		on three outings on $12/7/18$ ,		provided by Union Ho			
	12/15/18, and 12/2	-		Wound Care Center a	-		
				continue until the pres	ssure		
		ed January 2019 did not indicate		ulcer is cleared.			
	•	on any outings during the		All staff in the home w			
	month.			receive training on Cli			
	Client F's CPL dat	ed February 2019 did not		HRP, proper repositio when to reposition, w	-		
		ad gone on any outings during		call the nurse, meeting			
	the month.	one on any outings turing		medical needs, and W	-	1	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	00	_	PLETED 6/2019
		156506	<u> </u>		_	5/2019
NAME OF	PROVIDER OR SUPPLI	ER		f address, city, state, zip ( N 17TH ST	COD	
NORMA	L LIFE OF INDIAN	IA	TERR	RE HAUTE, IN 47805		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIO
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				Order Medical Suppli	es.	
		dated November 2018 indicated		Health Services Direct	ctor will	
	-	on three outings on $11/3/18$ ,		train Facility Nurse o	n Nursing	
	11/4/18, and 11/6	/18.		Assessments, When	to do	
				Nursing Assessment	s,	
	Client G's CPL da	ated January 2019 indicated client		Understanding of Jol	b	
	G had gone on the	ree outings on 1/19/19, 1/21/19,		Responsibilities, When	en to Train	
	and 1/26/19.			Staff, and Meeting of	Clients'	
				Medical Needs.		
	Client G's CPL da	ated February 2019 indicated		Health Service Direct	or will	
	client G had gone	on one outing on $2/17/19$ .		audit each clients ch	art at least	
				quarterly to ensure o	ngoing	
	- Client H's CPL	dated November 2018 indicated		HRP adherence, appr	ropriate	
	client H had gone	on two outings on 11/11/18 and		completion of Nursin	g	
	11/13/18.			Assessments, and M	eeting of	
				Clients' Medical Need	ds.	
	Client H's CPL da	ated December 2018 indicated		Administrative obser	vations	
	client H had gone	on two outings on $12/3/18$ and		have been implement	ted in the	
	12/7/18.			home daily, seven da	iys a week	
				and will remain in pla	ice until	
	Client H's CPL da	ated January 2019 did not indicate		the team determines	it is	
	client H had gone	on any outings during the		appropriate to decrea	ase the	
	month.			number of observation	ons. This	
				will ensure all correc	tions are	
	Client H's CPL da	ated February 2019 indicated		implemented per Res	Care	
	client H had gone	on two outings on 2/5/19 and		policy and regulation		
	2/6/19.			Ongoing weekly and		
				observations and rev	iew will	
	On 2/26/19 at 1:3	0 PM, the facility's 8/17/18 Plan of		continue with the QI		
	Correction (POC)	indicated, "All staff at the		Area Supervisor over	r the	
		eive training on client's right to		location. Observatio		
		bilitation program and the right to		completed by various		
		pate in community activities.		various times, includ		
	· ·	sor (AS) will be responsible for		morning, evening an	-	
	· ·	ining. Additional training will be		weekend visits.		
		ately in instances where staffs				
	-	not to be meeting the				
		Site Supervisor will provide the				
	-	y activity calendar and will				
		any changes or concerns with				
		,	1			1

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE attending the activities. AS and QIDPs (Qualified Intellectual Disabilities Professional) will be conducting audits of the CPLs during their weekly and monthly site visits to ensure the promotion of community outings are taking place at all service locations." Area Supervisor (AS) #1 was interviewed on 2/22/19 at 11:00 AM. AS #1 indicated POCs should be implemented as written. AS #1 indicated she is unsure why the POC was not implemented. AS #1 indicated the CPL documents outings into the community clients A, B, D, E, F, G, and H make each day. AS #1 indicated outings for clients in the home should be weekly at minimum. AS #1 indicated she was unsure why clients A, B, D, E, F, G, and H were not going on more frequent outings. AS #1 indicated all staff are responsible for ensuring clients have community outings regularly. AS #1 stated, "I'm aware community outings have been a problem at this home for a long time. I know they were cited at the annual in July 2018. We should have fixed it then." 2. The governing body neglected to implement their policy and procedures to ensure client C received timely nursing assessment, intervention, staff training, and monitoring following the identification of the repeated pressure ulcer occurrence, neglected to prevent Verbal Aggression (VA) and Physical Aggression (PA) by staff towards clients, and failed to provide client A with supervision to prevent elopement. The facility systemically failed to report the Bureau of Developmental Disabilities Services (BDDS), thoroughly investigate, and implement sufficient corrective action to prevent the neglect of client C's continued pressure ulcer. Please see W149. ZRF511 Facility ID: 001022 Page 10 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	Сом 02/2	'e survey pleted <b>6/2019</b>
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST HAUTE, IN 47805	)D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE	(X5) COMPLETIO DATE
	<ul> <li>allegation of staff</li> <li>and E, an allegation</li> <li>clients A and B, and Unknown Origin</li> <li>Disabilities Service</li> <li>the alleged incide</li> <li>4. The governing</li> <li>investigate multipe</li> <li>verbal aggression</li> <li>and unnamed cliee</li> <li>towards clients A</li> <li>2018 and October</li> <li>5. The governing</li> <li>of two investigation</li> <li>Aggression (VA)</li> <li>towards clients A</li> <li>within 5 business</li> <li>Please see W156.</li> <li>6. The governing</li> <li>demonstrated com</li> <li>and C's Sleep Flow</li> <li>Location Tracking</li> <li>failed to ensure staff in the</li> <li>clients A and C pu</li> <li>home. Please see</li> <li>7. The governing</li> <li>need for an accuration</li> <li>W210.</li> <li>8. The governing</li> <li>A's door alarm pro-</li> </ul>	body failed to report an to client VA involving clients B on of staff to client PA involving nd two of client C's Injuries of to the Bureau of Developmental ces (BDDS) within 24 hours of nts. Please see W153. body failed to thoroughly le incidents of physical and between clients A, B, D, E, F, G, nts, an allegation of PA by staff and B, and client C's IUO in July 2018. Please see W154. body failed to report the results ons of staff to client Verbal and Physical Aggression (PA) , B, and E to the administrator days of the alleged events. body failed to ensure staff petency in tracking clients A w Chart (SFC), client A's g Five Minute Checks (LTFMC), aff completed client C's ng Form (RTF), and failed to home were trained regarding tor to working with them in the W189. body failed to address client C's the pain assessment. Please see				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLIE		4475	T ADDRESS, CITY, STATE, ZIP COD N 17TH ST RE HAUTE, IN 47805	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
W 0122 Bidg. 00	received timely nu staff training, and identification of th occurrence. Please This federal tag re 9-3-1(a) <b>483.420</b> <b>CLIENT PROTE</b> The facility must protections requi Based on observat interview, the faci of Participation: C sampled clients (C systemically ensur nursing assessmen and monitoring fo repeated pressure is systemically failed Developmental Di thoroughly investi corrective action th C's continued press This noncomplian Jeopardy. The Imm on 2/22/19 at 12:1 was notified of the at 12:11 PM. The 10/18/18 when cli- second pressure ul previously healed systemically ensur	body failed to ensure client C rrsing assessment, intervention, monitoring following the repeated pressure ulcer e see W331. lates to complaint #IN00286338. CTIONS ensure that specific client rements are met. ion, record review, and lity failed to meet the Condition lient Protections for 1 of 3 c). The facility failed to re client C received timely t, intervention, staff training, llowing the identification of the ulcer occurrence. The facility I to report to the Bureau of sabilities Services (BDDS), gate, and implement sufficient o prevent the neglect of client	W 0122	The facility has developed an will consistently implement it written policies that define an prohibit abuse, neglect, exploitation and mistreatment and the obligation and responsibility of reporting violations; the process for reporting and appropriate follow-up to any such allegations reported. All employees receive training o this policy upon hire and at least annually thereafter. Each home is assigned a nur to oversee the medical aspect of each person according to their needs. Client C HRP for skin integritt has been reviewed and is in place. Client C receives weekly treatment and assessments provided by Union Hospital	ts nd nt se sts

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G508	B. WING		02/26/2019
NAME OF	PROVIDER OR SUPPLIE	R.	STREE	ET ADDRESS, CITY, STATE, ZIP	COD
				N 17TH ST	
NORMA	L LIFE OF INDIAN	A	IER	RE HAUTE, IN 47805	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RRECTION (X5
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	SHOULD BE COMPLE'
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	llowing the identification of the		Wound Care Center a	
		ulcer occurrence. In addition,		continue until the pre	essure
		ically failed to report to BDDS,		ulcer is cleared.	
		gate, and implement sufficient		The facility adheres t	
		o prevent the neglect of client		regulations to provid	
	C's continued pres	sure ulcer.		treatment, assessme	
	TTI 0 11: 1			labs as needed to en	
		tted a plan of action to remove		client's optimal healt	
		pardy on 2/23/19 at 5:19 PM by		All staff in the home	
		r (ED) #1. The facility's 2/23/19		receive training on C	
		of Immediate Jeopardy indicated		HRP, proper reposition	-
	the following:			when to reposition, v	
	"Client C hea a a	tonding wooldy annointmont		call the nurse, meetin	-
		tanding weekly appointment und care center. Documentation		medical needs to inc	
		center is specific to the		dressing of wounds a appropriate use of m	
	-	includes the physician's		supplies, and When t	
	-	t, measurement, and required		Medical Supplies.	
	-	eview of the documentation		Health Services Dire	ctor will
	-	ntions provided by the wound		train Facility Nurse o	
		effective and the pressure ulcer		Assessments, When	-
		. The nurse will attend the next		Nursing Assessment	
	-	client C and staff to ensure all		Understanding of Jo	
	~ ~	outcomes are available and		Responsibilities, Wh	
	provided."			Staff, and Meeting of	
	<sup>^</sup>			Medical Needs.	
	- "The director of	nursing will complete training		Health Service Direct	tor will
		providing timely nursing		audit each client cha	rt at least
	assessment, interv	entions, staff training and		quarterly to ensure o	ngoing
	monitoring regard	ing their responsibilities to		HRP adherence, app	
	provided (sic) nur	sing services to all individuals		completion of Nursin	Ig
	supported. Trainin	g will be complete by 2/25/19."		Assessments, Meetir	ng of
				Clients' Medical Need	ds, and
	- "All required car	e supplies have been obtained		adherence to Physic	ian's
	and are present in	the home."		Orders.	
				All staff, including th	e
	- "Staff addressing	g client C's rotation and		Residential Manager	and
		dule, tracking and dressing care		support roles will co	mplete
	has been initiated	in the home throughout the		competency-based to	raining on
	weekend and will	be complete by 2/25/19."		the facilities ANEM p	olicy with

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE an emphasis on prevention of - "The nursing team will maintain a presence in the abuse, neglect, and home twice daily to ensure the training is effective mistreatment. and proper care is provided to client C." The agency has current policies and procedures that - "The operations team, comprised of the program prohibit the mistreatment, manager, quality assurance manager, QIDP neglect and abuse of the (Qualified Intellectual Disabilities Professional), individuals served as well as nurse manager, and registered nurse, as well as policies that specifically area supervisors will maintain a daily presence in address the reporting of and the home." completion of investigations of client abuse, neglect, "- Administrative monitoring in the home exploitation and mistreatment. includes, but is not limited to staff/client observations and documentation review." The facility will have evidence that all allegations of abuse. - "The operations team is conducting daily neglect and mistreatment are conference calls to develop and ensure thoroughly investigated and implementation of solutions for identified needs." reported to BDDS per reporting guidelines. Based on observation, record review, and The Leadership Team will interview, it was determined the facility's plan for complete a review of these removal of Immediate Jeopardy dated 2/23/19 had policies to ensure that they are been effective to remove the Immediate Jeopardy. current and continue to meet The Immediate Jeopardy was removed on 2/26/19 the needs and safety of the at 12:00 PM. ED #1 was notified of the Immediate individuals served. All staff Jeopardy removal on 2/26/19 at 12:00 PM. receive training on these policies upon hire and Observations were done at the home on 2/25/19annually thereafter. The from 3:07 PM to 5:00 PM. Client C was present in training includes a review and the home during observations with staff #1, Home competency of the process for Manager (HM) #1, AS #1, and staff #9 reporting and investigating any supervising. Upon arrival to the home, client C incidents on client on client was in her bedroom. Client C was laying in her bed aggression. with a pillow under her left hip. She was tilted to All staff, including Supervisors, the right ride. Client C was not wearing depends, QA, Nursing and QIDPs will but her bed was dry. At 3:09 PM, the wall of client receive retraining on agencies C's bedroom had "[Client C's] Wound Care" Abuse, Neglect, Exploitation posted. It was dated 2/22/19. The dresser in client and Mistreatment, Incident C's room had a plastic tote. The tote housed Management and Reporting

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZRF511 Facility

Facility ID: 001022

If continuation sheet

Page 14 of 167

03/26/2019

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	R MEDICARE & MEDI						MB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>00</b>			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		PLETED	
		15G508	B. WI	NG		02/2	6/2019	
NAME OF	PROVIDER OR SUPPLIE	R		STREET AD	DDRESS, CITY, STATE, ZIP COD			
				4475 N 1				
NORMA	L LIFE OF INDIAN	A		TERRE H	HAUTE, IN 47805			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE OPRIATE	COMPLETI	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	supplies for client	C's wound care. The supplies			and Investigation policie	s.		
	included: Normal	saline tubes, Hypafix (reinforced			The Area Supervisor/QID	P is		
	adhesive bandages	s), Medihoney (wound care			responsible for initiating	and		
	ointment), circular	r sponges, and gauze. At 3:11			completing initial investi	gation		
	PM, staff #1 enter	ed client C's bedroom. Staff #1			of client to client aggres	sion.		
	removed the pillow	w from client C's left side and			The Quality Assurance			
	moved it to her rig	ht side. Client C was now tilted			Manager is responsible f	or		
	-	PM, AS #1 walked into client			ensuring that these incid			
	C's bedroom and c	checked on her. As #1 did not			allegations of abuse, neg			
	readjust client C. A	At 4:06 PM, AS #1 walked into			and mistreatment are rep	-		
	5	n and checked on her. AS #1 did			to BDDS, thoroughly			
		C. At 4:30 PM, staff #1 walked			investigated, and follow-	up is		
	-	room to prepare her for dinner.			completed within the	up io		
		client C's wound. The wound			established timelines.			
		Hypafix, and had a foam			Area Supervisor, Reside	ntial		
		th. Staff #1 applied an adult			Manager and QIDP will b			
		arment to client C. At 4:33 PM,			trained to ensure all corr			
	-	sist staff #1 to move client C into			measures are implement			
		lient C was lifted and placed into			following an IDT and/or	eu		
		pillow was on the left side of the			investigation. This will in	ncludo		
		52 PM, AS #1 adjusted client C in			obtaining all necessary	liciuue		
		ne used the protective pad under			consents and authorizat	one for		
		to the right. At 4:55 PM, AS #1			such corrective measure			
		n her wheelchair again. She				•••		
		e pad under client C to tilt her to			Administrative observati			
	the left.	e pad under cheft C to the her to			have been implemented			
	uie ieit.				home daily, seven days a			
	Observations war	done at the home on $2/26/10$			and will remain in place			
		e done at the home on 2/26/19			the team determines it is			
		8:45 AM. Client C was present in			appropriate to decrease			
		bservations with staff #1 and			number of observations.			
	· ·	ervising. Upon arrival to the			will ensure all correction			
		s in her wheelchair sitting in the			implemented per ResCar	е		
		:06 AM, AS #1 adjusted client C			policy and regulations.			
		She used the protective pad			Ongoing weekly and mo	-		
		ilt her to the left. AS #1 asked			observations and review			
		e timer on the oven. AS #1			continue with the QIDP a			
		ng a timer to help us remember			Area Supervisor over the			
		s] position every 15 minutes. I			location. Observations a			
		"At 7:22 AM, the timer sounded			completed by various sta	aff at		
	from the stove AS	S #1 adjusted client C in her			various times, including		1	

NTERS FO	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. E	AULTIPLE CO BUILDING VING	DNSTRUCTION 00	CO	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIEI			STREET A 4475 N TERRE	D			
	1		TERRE HAUTE, IN 47805					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	CTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
	wheelchair. She use client C to tilt her to over to the oven an the timer sounded f adjusted client C in protective pad unde Staff #2 then walke the timer. At 7:54 stove. Staff #2 adju She used the protect her to the right. Sta oven and reset the f sounded from the s in her wheelchair. S under client C to til walked over to the 8:25 AM, the timer adjusted client C in protective pad unde right. AS #1 then w reset the timer. At 8 from the stove. AS wheelchair. She use client C to tilt her to over to the oven an Client C's Wound C 2/22/19 was review WCP indicated the "Gather your equip "Wash your hands."	ed the protective pad under o the right. AS #1 then walked d reset the timer. At 7:38 AM, rom the stove. Staff #2 her wheelchair. She used the er client C to tilt her to the left. d over to the oven and reset AM, the timer sounded from the sted client C in her wheelchair. tive pad under client C to tilt ff #2 then walked over to the imer. At 8:08 AM, the timer tove. Staff #1 adjusted client C She used the protective pad t her to the left. Staff #1 then oven and reset the timer. At sounded from the stove. AS #1 her wheelchair. She used the er client C to tilt her to the 'alked over to the oven and 8:40 AM, the timer sounded #1 adjusted client C in her ed the protective pad under to the left. AS #1 then walked d reset the timer. Care Protocol (WCP) dated red on 2/25/19 at 3:09 PM. The following: ment."			morning, evening and weekend visits.			
	"Open packages ne	eded for the dressing change."						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE C A. BUILDING B. WING	00	COM 02/2	te survey 1pleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP I 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	Do not scrub or u	ine and cleanse the open area. se excessive force. Pat dry with o not use a cotton ball."				
		y to the wound bed with a clean ad cover with a foam dressing e gauze sponge."				
	"Cover the whole waterproof tape."	dressing with Hypafix				
	"Twice daily: App	bly antifungal around dressing."				
	"Report to the nur wound has a chan	se if supplies are needed or the ge."				
	Staff #1 stated, "[ #1] came to the he	viewed on 2/25/19 at 3:14 PM. Health Services Manager (HSM) ouse and did reposition training aining. She taught us to change				
	Staff #2 indicated care of client C. S and having the su we can take care of #2 indicated staffi too. Staff #2 state	viewed on 2/26/19 at 7:42 AM. HSM #1 had trained her on the taff #2 stated, "With the training pplies in the house now, I think of [client C] the right way." Staff ing the home has been better d, "We actually have people the clients are awake and need e day."				
	#1 indicated HSM the weekend and of the home. AS #1 wound care. AS # I've seen the wound	ewed on 2/25/19 at 7:48 AM. AS I #1 had come to the home over done the training for the staff in indicated she was trained on the 1 stated, "That's the first time nd. I was a little surprised by it." nen [HSM #1] was here, she				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE trained all the staff on wound care and repositioning of [client C]." AS #1 indicated the staff were using a timer to prompt them to change client C's position. AS #1 indicated the timer appeared to be working. AS #1 stated, "The staff feel a lot more comfortable caring for [client C] after having the needed supplies and training." Even though the facility's corrective actions removed the Immediate Jeopardy on 2/26/19, the facility remained out of compliance at a Condition level (Client Protections) in that the facility showed a pattern which failed to systemically ensure client C received timely nursing assessment, intervention, staff training, and monitoring following the identification of the repeated pressure ulcer occurrence. The facility systemically failed to report to the Bureau of Developmental Disabilities Services (BDDS), thoroughly investigate, and implement sufficient corrective action to prevent the neglect of client C's continued pressure ulcer. Findings include: 1. The facility failed to promote community outings for clients A, B, D, E, F, G, and H. Please see W136. 2. The facility neglected to implement their policy and procedures to ensure client C received timely nursing assessment, intervention, staff training, and monitoring following the identification of the repeated pressure ulcer occurrence, neglected to prevent Verbal Aggression (VA) and Physical Aggression (PA) by staff towards clients, and failed to provide client A with supervision to prevent elopement. Please see W149. 3. The facility failed to report an allegation of staff ZRF511 Event ID: Facility ID: 001022 Page 18 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to client VA involving clients B and E, an allegation of staff to client PA involving clients A and B, and two of client C's Injuries of Unknown Origin to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours of the alleged incidents. Please see W153. 4. The facility failed to thoroughly investigate multiple incidents of physical and verbal aggression between clients A, B, D, E, F, G, and unnamed clients, an allegation of PA by staff towards clients A and B, and client C's IUO in July 2018 and October 2018. Please see W154. 5. The facility failed to report the results of two investigations of staff to client Verbal Aggression (VA) and Physical Aggression (PA) towards clients A, B, and E to the administrator within 5 business days of the alleged events. Please see W156. This federal tag relates to complaint #IN00286338. 9-3-2(a) W 0136 483.420(a)(11) PROTECTION OF CLIENTS RIGHTS Bldg. 00 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on record review and interview for 2 of 3 W 0136 The Residential Manager and 03/28/2019 sample clients (A and B), plus 5 additional clients all DSPs will receive training (D, E, F, G, and H), the facility failed to promote on the clients right to receive community outings for clients A, B, D, E, F, G, and an active habilitation program H. and the right to access and participate in community Findings include: activities. The Residential Manager will ZRF511 Event ID: Facility ID: 001022 Page 19 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 02/26/2019
					02,20,2010
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD I 17TH ST	
NORMA	L LIFE OF INDIAN	4		E HAUTE, IN 47805	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		viewed on 2/20/19 at 4:25 PM.		develop a schedule of	
		/e don't get to out out very		proposed community activiti	es
		t to go to church." Client E		based on individual	
		old staff on the weekends that		preferences and choices. The	
		church. Client E stated, "I don't		Residential Manager will che	СК
	know why I can't g	30.		daily to ensure activities are	
	Client C was inter	viewed on 2/20/19 at 4:30 PM.		completed. The Residential Manager will ensure all	
		Yes, I want to go to church. I		individuals residing in the	
		t G provided a Sunday bulletin		facility have an opportunity t	•
		tended in October 2018. Client		participate in community	0
		as the last time she had visited		activities.	
		tated, "This is the church I want		The Area Supervisor will be	
		ere. I asked [Home Manager		responsible for providing this	
	-	bing. She told me that I can't go		training. Additional training	5
		she doesn't go either."		will be provided immediately	
				in instances where staff are	
	Community Partic	ipation Logs (CPLs) were		observed not to be meeting t	he
		19 at 11:55 AM. The review		expectations. The Residentia	
	indicated the follow			Manager will provide the Are	
		e		Supervisor with a monthly	-
	1. Client A's CPL	dated November 2018 did not		activity calendar and will	
	indicate client A ha	ad gone on any outings during		inform the Area Supervisor o	f
	the month.			any changes or concerns wit	
				attending the activities.	
	Client A's CPL dat	ted January 2019 indicated client		Area Supervisors and QIDP's	;
	A had gone on one	e outing on 1/26/19.		home audit forms have been	
				updated to include a physica	I
		ted February 2019 indicated		inspection of the community	
	client A had gone	on two outings on 2/19/19 and		participation schedule and	
	2/20/19.			logs. These will be completed	d
				and submitted to the Program	n
		dated November 2018 did not		Manager for review on a	
		ad gone on any outings during		weekly basis. The Program	
	the month.			Manager will review the	
				submitted audit and impleme	ent
		ed January 2019 indicated client		corrections and schedule	
	B had gone on one	outing on 1/16/19.		follow up visit where	
				deficiencies are noted. Repea	
	Client B's CPL dat	ed February 2019 did not	1	deficiencies will be addresse	d

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	î î	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G508	A. BUILDING <u>00</u> B. WING		COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		4475	T ADDRESS, CITY, STATE, ZIP N 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
	<ul> <li>the month.</li> <li>3. Client D's CPL of indicate client D hat the month.</li> <li>Client D's CPL dat client D had gone of Client D's CPL dat client D had gone of month.</li> <li>Client D's CPL dat indicate client D hat gone of month.</li> <li>4. Client E's CPL of the month.</li> </ul>	ad gone on any outings during dated November 2018 did not ad gone on any outings during ted December 2018 indicated on one outing on 12/7/18. ted January 2019 did not indicate on any outings during the ted February 2019 did not ad gone on any outings during dated November 2018 indicated on three outings on 11/5/18,			nary action ervations need in the lays a week lace until s it is ease the ions. This ctions are esCare ns. d monthly eview will IDP and er the ons are us staff at ding	
	Client E's CPL dat client E had gone of 12/6/18, and 12/21 Client E's CPL dat client E had gone of month. Client E's CPL dat indicate client E hat the month. 5. Client F's CPL of indicate client F hat the month. Client F's CPL dat	ed December 2018 indicated on three outings on 12/4/18,		various times, including morning, evening and weekend visits.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 02/26	e survey pleted 5/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
	<ul> <li>client F had gone month.</li> <li>Client F's CPL daindicate client F he month.</li> <li>6. Client G's CPL client G had gone 11/4/18, and 11/6</li> <li>Client G's CPL da G had gone on the and 1/26/19.</li> <li>Client G's CPL da client G had gone</li> <li>7. Client H's CPL da client H had gone 11/13/18.</li> <li>Client H's CPL da client H had gone 12/7/18.</li> <li>Client H's CPL da client H F had go month.</li> </ul>	ted January 2019 did not indicate on any outings during the ted February 2019 did not ad gone on any outings during dated November 2018 indicated on three outings on 11/3/18,					
	2/6/19. Area Supervisor ( 2/22/19 at 11:00 /	AS) #1 was interviewed on AM. AS #1 indicated the CPL s into the community clients A,					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP COD I 17TH ST E HAUTE, IN 47805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	indicated outings fa be weekly at minin unsure why clients not going on more indicated all staff a	H make each day. AS #1 or clients in the home should num. AS #1 indicated she was A, B, D, E, F, G, and H were frequent outings. AS #1 re responsible for ensuring unity outings regularly.			
W 0149	483.420(d)(1)	ENT OF CLIENTS			
Bldg. 00	The facility must of written policies are mistreatment, neg Based on observation interview for 2 of 3 2 additional clients facility neglected to procedures to ensure nursing assessment and monitoring fol repeated pressure or prevent Verbal Agg Aggression (PA) by failed to provide cliprevent elopement. to report the Burea Services (BDDS), implement sufficient the neglect of client Findings include: 1. Observations we from 4:12 PM to 5 laying in bed. Client required staff assiss care. Staff #1 remote	develop and implement and procedures that prohibit glect or abuse of the client. on, record review, and a sampled clients (A and B), plus (E and Former Client (FC)), the o implement their policy and re client C received timely c, intervention, staff training, lowing the identification of the alcer occurrence, neglected to gression (VA) and Physical y staff towards clients, and ient A with supervision to The facility systemically failed u of Developmental Disabilities thoroughly investigate, and nt corrective action to prevent t C's continued pressure ulcer.	W 0149	Each home is assigned a nur to oversee the monitoring an oversight of each individual's medical needs including documentation of the interventions and progress of any injuries or illness. Each nurse is responsible for assessing and following up a medical issue identified and maintaining documentation of specific chronic and acute needs on an ongoing basis of until the issue is resolved. Each nurse is responsible fo least a weekly visit to the hor to monitor health issues and documentation that is maintained in the home. The nurse is responsible for completing a monthly progree note and a quarterly assessment for each individu assigned. All of the nurses will receive	d s s s s s s s s s s s s s s s s s s s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **ZRF511** Facility ID: **001022** 

If continuation sheet Page 23 of 167

TERS FO	R MEDICARE & MEDIO	CAID SERVICES			OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED
		15G508	B. WING		02/26	/2019
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
				I 17TH ST		
NORMA	L LIFE OF INDIAN	4	TERRE	E HAUTE, IN 47805		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	NATE	DATE
	snugly attached. St	aff #1 and Home Manager		re-training on their		
		ent C to her right side. Staff #1		responsibilities to monito	r and	
		ressing from client C's left lower		complete documentation		
		sing consisted of a non stick		specific chronic and acute		
		nches. The non stick pad was		needs on an ongoing basi		
		a 3 inch by 4 inch reinforced		until the issue is resolved		
		There was no foam present on		Health services Director w		
	-	he dressing covering client C's		responsible to insure that		
	-	had a 2 CM (Centimeter) round		training is completed and		
		en area did not have drainage.		documented in the employ	/ees	
	· ·	ng the open area was red for 2		training file.	,	
		the site. Staff #1 did not clean		Client C HRP for skin integ	arity	
		ving the old dressing. Staff #1		has been reviewed and is		
		essing by adding a quarter sized		place.		
		intment (skin protectant) to a		Client C receives weekly		
		f #1 stated, "This non stick pad		treatment and assessmen	te	
	-	posed to help with healing		provided by Union Hospita		
		re. We used to use Medihoney		Wound Care Center and w		
		ounds), but they changed it. We		continue until the pressur		
		more." Staff #1 then put the		ulcer is cleared.	6	
		non stick pad with A&D		The facility adheres to the		
	· · ·	nt C's open area. Staff #1 took		regulations to provide me		
		d adhesive bandage) and				
				treatment, assessments a	na	
	the new dressing s	here was no foam present on		labs as needed to ensure		
	the new dressing s	tan #1 appned.		client's optimal health. All staff in the home will		
	Observations were	done at the home on $2/21/19$			<b>^</b>	
				receive training on Client		
		28 AM. Upon arrival to the		HRP, proper repositioning		
		#3 were supervising the		when to reposition, when	10	
		A, client C was sitting upright in		call the nurse, meeting of	4-	
		90 degree angle. Client C's		medical needs, and When	το	
		the wheelchair. At 7:27 AM,		Order Medical Supplies.		
		sitting upright in her		Health Services Director v		
		degree angle. Client C's bottom		train Facility Nurse on Nur	-	
		eelchair. Staff #2 and #3 did not		Assessments, When to do	)	
	-	At 7:37 AM, client C		Nursing Assessments,		
		pright in her wheelchair at a 90		Understanding of Job		
		nt C's bottom was flat on the		Responsibilities, When to		
		2 and #3 did not reposition		Staff, and Meeting of Clier	its'	
	L client C At 7.42	AM, client C continued sitting		Medical Needs.		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **ZRF511** Facility ID: **001022** 

If continuation sheet

Page 24 of 167

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
NORMA	L LIFE OF INDIAN	A		E HAUTE, IN 47805		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE CC	(X5) DMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		elchair at a 90 degree angle. was flat on the wheelchair. Staff		Health Service Director will audit each clients chart at le	aat	
		reposition client C. At 7:47 AM,		quarterly to ensure ongoing		
		er to client C's wheelchair and		HRP adherence, appropriate		
		er at the dining room table. Staff		completion of Nursing	,	
		C's breakfast. Staff #2 began		Assessments, and Meeting	of	
		o eat her breakfast. Staff #2 did		Clients' Medical Needs.		
	-	nt C. At 7:55 AM, client C was		The facility will ensure that		
	-	er wheelchair at a 90 degree		specific governing body and	4	
		ottom was flat on the		management requirements		
	-	<sup>2</sup> 2 continued to assist client C		met. The Governing Body w		
		#2 did not reposition client C. At		exercise general policy and		
	-	was sitting upright in her		operating direction over the		
		degree angle. Client C's bottom		facility and will implement		
		eelchair. Staff #2 continued to		written policy and procedure	06	
		dining. Staff #2 did not		to ensure all individuals	55	
		. At 8:13 AM, client C was		supported are free from abu		
	-	er wheelchair at a 90 degree		neglect, exploitation and	30,	
		ottom was flat on the		mistreatment.		
	-	<sup>4</sup> 3 assisted client C by utilizing		The facility has developed a	nd	
		go to the office for her morning		will consistently implement		
		at 8:18 AM, staff #3 adjusted		written policies that define a		
	-	elchair. Staff #3 pulled on the		prohibit abuse, neglect,		
		er client C in order to shift her		exploitation and mistreatme	nt	
		8:33 AM, client C was sitting		and the obligation and		
	-	elchair with her hips slightly		responsibility of reporting		
		aff #3 was next to client C. Staff		violations; the process for		
		client C's medications. At 8:38		reporting and appropriate		
		ted client C in her wheelchair.		follow-up to any such		
		the protective pad under client		allegations reported. All		
	_	her hips to the right. At 8:48		employees receive training	on	
		ed to assist with morning		this policy upon hire and at		
	-	M, client C was sitting upright		least annually thereafter.		
		with her hips tilted to the right.		All staff, including the		
		IM #1 did not reposition client		Residential Manager and		
		lient C was sitting upright in her		support roles will complete		
		er hips tilted to the right. Staff		competency-based training	on	
		did not reposition client C. At		the facilities ANEM policy w		
		was sitting upright in her		an emphasis on defining an		
		er hips tilted to the right. Staff		recognizing abuse and	-	

	R MEDICARE & MEDI					-	MB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>00</b>			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		OMPLETED	
		15G508	B. WI	NG		02/2	6/2019	
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD			
					17TH ST			
NORMA	L LIFE OF INDIAN	A		TERRE	HAUTE, IN 47805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		COMPLETI	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY		DATE	
	#2, #3, and HM #1	did not reposition client C.			mistreatment.			
					Self-Advocacy meetings with the set of the s	II		
	Observations were	e done on 2/22/19 from 7:00 AM			occur with all individuals in	ı the		
	to 9:14 AM. Upon	arrival, staff #2 was the only			home to promote an open			
	staff working in th	e home. Staff #2 was in the			forum to voice concerns.			
	bathroom assisting	g client F with her shower. At			The facility will provide			
	7:03 AM, client C			sufficient staff to manage a	nd			
	hospital bed with an air mattress. Client C was				supervise clients in accord	ance		
	laying on her back, with a pillow under each hip.				with their individualized pla	in.		
	She did not have a	n adult brief on. Client C was			The home has recently			
	laying in her bowe	el movement. The bowel			experienced turnover that	nas		
	movement was pre-	esent from her mid back to her			initiated extra recruiting an	d		
	ankles, and had sp	read the width of her body on			training efforts to meet the			
		aying on. The protective pad			needs of the individuals in	the		
	under client C was	saturated, and had soaked			home.			
		ets underneath. At 7:05 AM,			The Area Supervisor and/o	r		
	staff #3 arrived for	her shift. Staff #3 stated to			Residential Manager is			
		n late." At 7:08 AM, the cabinet			responsible for ensuring th	at		
		C's bed had medical supplies			there is sufficient staff in the	ie		
		had disposable gloves, wipes,			home always. The Area			
	• •	tment, and collagen non stick			Supervisor is responsible t	0		
	pads. The cabinet	did not have supplies to clean			review and approve the			
	the open area, or a	ny padding to use in dressing			staffing schedule weekly to	)		
	-	changes. At 7:16 AM, staff #2 went into client C's			ensure that adequate staffs	are		
		er for the day. Staff #2 stated,			assigned. The staffing sch	dule		
		blow out." Staff #2 called to			has been reviewed for the			
		er to bring a bowl of soapy			home and the Area Superv			
		l more wipes. At 7:24 AM, staff			will monitor that adequate	staff		
	· ·	esent in client C's room assisting			are assigned daily.			
	-	of client C after her bowel			Area Supervisor will train			
		2 stated, "With this wound, we			Residential Manager on Jo			
		nds on her." Client C's wound			Responsibilities, and ensu	-		
		here was not a dressing on the			adequate staffing in the ho			
		d, "The wound is supposed to			The facility has policies an			
	be covered at all times. I guess the bandage fell				procedures in place to train	1		
		unable to locate the bandage in			employees who work with			
		ff #2 stated, "It's (the wound)			clients on skills and			
	~ ~	we any open air time at all."			competencies directed tow	ards		
		ntinued to clean client C using			clients' health needs and			
	wet wines At 7.3/	AM, while staff #2 and #3			programming objectives.		1	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP COI N 17TH ST E HAUTE, IN 47805	D	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C continued to clean when her buttocks "I think she's in pa says 'ow' and we c normally just has u a temperature them #2 indicated she w assessment for clie #3 rolled client C t	<sup>C</sup> STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION client C, client C said, "ow" were cleaned. Staff #2 stated, in, but I really don't know. She an call the nurse. The nurse is take temperatures. If she has we give her medication." Staff as unaware if there was a pain ent C. At 7:36 AM, staff #2 and to her right side again. Staff #2	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) The Area Supervisor wi retrained on ensuring a are thoroughly consum specific trained to inclu health needs, ISP, BSP objectives, and HRC ap Rights Restrictions. All staff will be retrained implementation and	ULD BE PROPRIATE COMPLE DATI III be III staff ler Ide their pproved d on the	
	clean bowel move to pat over the wor to staff #3, "She's I leave and go star the room. Staff #3 care to client C as #3 prepared to app wound. Staff #3 di applying a new dro	towel she had been using the ment off of client C and used it and. At 7:39 AM, staff #2 said pretty much done. Are you ok if t breakfast?" Staff #2 then left remained to provide continued she got ready for the day. Staff ly a new dressing to client C's d not clean the site prior to essing. Staff #3 prepared a new g a quarter sized amount of		monitoring of door alar the home. All staff will receive competency-based con specific training to inclu- their health needs, HRF BSP and objectives. All clients have the pote be affected by this define Consumer specific train reviewing client needs	isumer ude P, ISP, ential to ciency. ning and	
	A&D ointment to put the prepared co A&D ointment on took Hypafix and foam present on th At 7:55 AM, staff wheelchair. Client wheelchair at a 90	a non stick pad. Staff #3 then ollagen non stick pad with to client C's open area. Staff #3 covered the site. There was no e new dressing staff #3 applied. #3 placed client C into her C was now sitting upright in her degree angle. Client C's bottom eelchair. At 8:10 AM, client C		a prominent componen agencies all staff month meetings. The facility will have ev that all allegations of all neglect and mistreatme thoroughly investigated reported to BDDS per re guidelines.	it of the hly ridence buse, ent are d and	
	degree angle. Cliet wheelchair. Staff # client C. At 8:25 A upright in her whe Client C's bottom #2 and #3 did not staff #3 adjusted c #3 pulled on the pr order to shift her h	in her wheelchair at a 90 at C's bottom was flat on the 2 and #3 did not reposition M, client C continued to sit elchair at a 90 degree angle. was flat on the wheelchair. Staff reposition client C. At 8:31 AM, lient C in her wheelchair. Staff rotective pad under client C in ips to the right. At 8:34 AM, er to client C's wheelchair and		The agency has current policies and procedure prohibit the mistreatme neglect and abuse of the individuals served as w policies that specificall address the reporting of completion of investiga client to client abuse or incidents. The Leadership Team w	s that ent, ne vell as y of and attions of	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	DNSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	CON	MPLETED
		15G508	B. WING			02/	26/2019
		D		STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE				17TH ST		
NORMA	L LIFE OF INDIAN	Ą		TERRE	E HAUTE, IN 47805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	Ń	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	<sup>BE</sup> RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		er at the dining room table. Staff			complete a review of these	)	
		C's breakfast. Staff #3 did not			policies to ensure that the	y are	
	reposition client C			current and continue to m	eet		
	#3 began assisting			the needs and safety of th	e		
	8:46 AM, staff #3			individuals served. All sta	f		
	eat her breakfast. S	Staff #3 did not reposition client			receive training on these		
		aff #1 arrived to the home for her			policies upon hire and		
	shift. At 9:01 AM,			annually thereafter. The			
	client C to eat her			training includes a review	and		
	did not reposition	client C. At 9:14 AM, client C			competency of the proces	s for	
	continued to sit tilt	ted to the right in her			reporting and investigating	g any	
	wheelchair. Staff #	1, #2 and #3 did not reposition			incidents on client on clien	nt	
	client C.				aggression.		
					All staff, including Superv	isors.	
	Home Manager (H	IM) #1 was interviewed on			QA, Nursing and QIDPs with		
		1. HM #1 stated, "This is the			receive retraining on agen		
		taken anyone to the wound			Abuse, Neglect, Exploitati		
	-	an't believe it's not healed yet."			and Mistreatment, Inciden		
		he had re-educated staff about			Management and Reportin		
		. HM #1 stated, "I keep trying to			and Investigation policies.	-	
	-	to change her position more,			The Area Supervisor/QIDP		
		depends, and keep the bandage			responsible for initiating a		
	-	ated the home only had A&D			completing initial investig		
	-	ne for client C's pressure ulcer.			of client to client aggressi		
		e used to have Medihoney				011.	
		out, and now I think the nurse is			The Quality Assurance		
		bre. We haven't had it for a long			Manager is responsible fo		
		ed. "I just don't know why the			ensuring that these incide		
		ng to heal. I feel like we're			allegations of abuse, negl		
	-	-			and mistreatment are repo	rtea	
	doing everytning v	ve can for [client C]."			to BDDS, thoroughly		
	St. (C 112	· · · · · · · · · · · · · · · · · · ·			investigated, and follow-u	D IS	
		viewed on 2/21/19 at 8:17 AM,			completed within the		
		7:40 AM. Staff #3 indicated she			established timelines.		
		nd sometimes will work			Administrative observatio	-	
	-	stated, "The nurse is here			have been implemented in		
		k. She comes in to watch staff			home daily, seven days a		
		ses and check on [client C's]			and will remain in place u	ntil	
	catheter." Staff #3	indicated she was unaware of			the team determines it is		
	the last time the nu	rse had visited the home and			appropriate to decrease th	е	
	looked at client C's	s wound. When asked if the			number of observations.	This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING	00	_	PLETED	
		15G508	B. WING		02/26/2019		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP	COD		
NORMA	L LIFE OF INDIAN	Δ		N 17TH ST E HAUTE, IN 47805			
-	-						
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
		her on the protocol of changing		will ensure all correc			
	-	, staff #3 stated, "Have you		implemented per Res			
		ame telephone? One person		policy and regulation			
	~	mething, then the next person		Ongoing weekly and	-		
	· ·	on something and so on. My		observations and rev			
	-	ike that." Staff #3 indicated		continue with the QI			
		d her in regards to changing		Area Supervisor over	r the		
	-	on her wound. Staff #3 stated,		location.			
	-	essing in the morning and at					
	-	tted, "I know we're supposed to					
		hange the dressing. We just					
	-	aner in the home. We haven't					
		Staff #3 indicated the home has					
		to add to the dressing for client					
		taff #3 indicated client C has to					
		requently. Staff #3 stated,					
		s in bed, she has to change					
	· ·	ur. When she's in her					
		s to shift positions every fifteen					
		indicated client C is unable to					
		y herself. Staff #3 stated,					
		etely relies upon staff to help her					
		Staff #3 stated, "I started here					
		ent C] had a bed sore on her					
		bottom. I feel bad for her. She					
	shouldn't have to h	have all these sores."					
	Staff #2 was interv	viewed on 2/21/19 at 8:55 AM,					
		7:48 AM. Staff $#2$ indicated she					
		home for several years. Staff #2					
		new nurse has started, I've only					
		ree times." Staff #2 indicated					
		rained by the nurse. Staff #2					
		rained by watching other staff,					
		risk plan the nurse made for					
		re." Staff #2 stated, "No one has					
		e what to do. I just try to do what					
		aff #2 indicated she changes the					
		days, or when the dressing is					
		dicated the home used to have a					
	soneu stun 2 m						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE cleaner to use on client C's wound. Staff #2 stated, "We don't have it anymore. I don't know why." Staff #2 indicated client C has a cream to put on the area. Staff #2 stated, "We have used a few different things. Right now, all we have is A&D ointment." Staff #2 indicated client C has to be repositioned multiple times. Staff #2 stated, "We have to change [client C's] position every 15 minutes when she is in her wheelchair, and every two hours when she is in her bed." Staff #2 indicated client C should only be out of bed for meals. Staff #2 stated, "The wound care center ordered [client C] to be on bed rest. She's not supposed to be out of bed unless she is eating." Staff #1 was interviewed on 2/21/19 at 5:16 PM, and on 2/22/19 at 9:03 AM. Staff #1 indicated she had worked in the home for several years. Staff #1 indicated she works the day shift, and takes client C to many of her wound care center appointments. Staff #1 stated, "I paid attention at the wound care visits and learned how they wanted the dressing changes done. I've tried to teach the other staff how to do it. The nurse has never been in to show us how to care for the area. We call the nurse when we need her, but that's about it." Staff #1 indicated the nurse had never attended a wound care center visit. Staff #1 stated, "She's never come during the day and assessed the wound either. I actually don't know if she's ever seen it." Staff #1 indicated the wound should be cleaned each time the dressing is changed. Staff #1 stated, "We used to have squirt bottles with saline in them. We don't have those anymore. I just use a wet wipe now. It's better than nothing." Staff #1 indicated the home had stocked a foam bandage at one time. Staff #1 stated, "We had some, but they're gone. We haven't had them in a while. I know the wound care center told us we could even use a makeup sponge as a foam padding ZRF511 Facility ID: 001022 Page 30 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE because they were cheaper. We've never had those either." Staff #1 indicated client C's wound has been present for 16 weeks. Staff #1 stated, "This is the longest we've ever dealt with a bed sore. [Client C's] had a staphylococcus infection (bacterial infection) at the sore. She's also had a yeast infection on the skin surrounding the sore. It's just really bad all around." Staff #1 indicated client C required staff assistance for all position changes. Staff #1 stated, "[Client C] cannot change positions on her own. Staff has to help her. We have to move her every hour when she is in bed, and every fifteen minutes when she's in her wheelchair." Staff #1 indicated client C has been on bed rest since Fall 2018. Staff #1 stated, "It's just really sad. She can't go anywhere because of this bedsore." Client C's record was reviewed on 2/21/19 at 12:10 PM. The review indicated the following: - Client C's Individual Support Plan (ISP) dated 3/2/18 indicated client C's diagnoses included, but were not limited to, Profound Intellectual and Developmental Disability, Cerebral Palsy (congenital disorder of movement), Quadriparesis (weakness in all four limbs), and Incontinent of Bowel and Bladder. The ISP also indicated the following: "She (client C) is verbal, but on a limited basis. She requires supervision around the clock for assistance with everyday life skills and activities in the community and group home.... unable to provide basic health, safety, and nutritional needs without continuous supervision, training, and staff support...". - Client C's Individual Nursing Notes (INN) dated 7/24/18 were written by Licensed Practical Nurse ZRF511 Event ID: Facility ID: 001022 Page 31 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (LPN) #3. The INN indicated, "Saw [client C]. No complaints voiced and no signs or symptoms of distress noted. [Client C] went to convenient care for a rash on her left hip. Diagnosis was contact dermatitis. New order for hydrocortisone (steroid cream) twice daily until healed." The INN did not indicate LPN #3 had performed a physical assessment on client C's skin integrity issue. The INN did not indicate LPN #3 had personally trained staff regarding the care of the site. - Client C's Medical Consult Report (MCR) dated 7/25/18 indicated client C had been seen by a physician. The reason for the visit was listed as, "Pain on left hip." The physician's notes indicated, "Contact dermatitis on left hip. Hydrocortisone. Apply twice daily until healed." - Client C's MCR dated 7/26/18 indicated client C had been seen a physician. The reason for the visit was not listed. The physician's notes indicated, "Talk to PCP (Primary Care Physician) regarding rash on left flank. Patient (client C) is not to wear depends. Hold day service for now. Keep in bed, reposition every two hours. Maybe only up for short time for meals and appointments. Return appointment needed." - Client C's INN dated 7/26/18 was written by LPN #3. The INN indicated, "No depends. Keep at home from day program for now. Keep in bed and reposition every two hours. [Client C] may be up for short time for medications and appointment." The INN did not indicate LPN #3 had performed a physical assessment on client C's skin integrity issue. The INN did not indicate LPN #3 had personally trained staff regarding the care of the site. - Client C's Wound Care Center Instructions ZRF511 Facility ID: 001022 Page 32 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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03/26/2019

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FORM APPROVED						

OMB NO. 0938-039

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508		ULTIPLE CON JILDING ING	struction 00		(X3) DATE COMPI <b>02/26</b>	LETED
	PROVIDER OR SUPPLIEI			4475 N 1	DRESS, CITY, STAT 7TH ST IAUTE, IN 4780	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIA (IENCY)	TE	(X5) COMPLETION DATE
	(WCCI) from her 7 following:	/26/18 visit indicated the						
	"Weeks in treatmer	nt: 0."						
	"Wound: Left Glut	eal (buttocks) fold."						
	excessive drainage. and water. Remove plastic bag and plac wound with Norma clean dressing usin or cotton balls. Do force. Pat dry using cotton balls Appl bed. Foam adhesive "Gel mattress overl "If patient (client C repositioned every "Turn and repositio "Patient is not to w service for now and	ay (on bed)." ) is in chair , she needs to be						
	#3. The INN indica care. Continue curr indicate LPN #3 ha assessment on clier indicate LPN #3 ha regarding the care of	ted 7/31/18 was written by LPN ted, "[Client C] saw wound ent dressing." The INN did not d performed a physical tt C's wound. The INN did not d personally trained staff of the site. ted 8/1/18 was written by LPN						
	#3. The INN indica	ted, "Wound center called ushe (wound cleaner) spray to						
M CMS-2567(0	02-99) Previous Versions Ol	bsolete Event ID:	ZRF511	Facility ID	001022	If continuation s	heet Pa	ge 33 of 167

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		Cor 02/	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475	et address, city, stati N 17TH ST RE HAUTE, IN 47805			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAI (EACH CORRECTIVE A CROSS-REFERENCED DEFICII	TO THE APPROPRIATE	(X5) COMPLETIC DATE	
	(antibiotic) was st time." The INN d performed a phys wound. The INN personally trained site.	before dressing change. Keflex arted as a preventative at this id not indicate LPN #3 had ical assessment on client C's did not indicate LPN #3 had staff regarding the care of the					
	#3. The INN indic center. Continue of not indicate LPN assessment on clio	lated 8/7/18 was written by LPN eated, "Also saw wound care purrent treatment." The INN did #3 had performed a physical ent C's wound. The INN did not had personally trained staff of the site.					
	<ul><li>#3. The INN india complaints or sign noted at this time.</li><li>#3 had performed C's wound. The IN</li></ul>	lated 8/8/18 was written by LPN eated, "Saw [client C]. No as or symptoms of distress " The INN did not indicate LPN a physical assessment on client NN did not indicate LPN #3 had staff regarding the care of the					
	#3. The INN indic complaints voiced indicate LPN #3 h assessment on clie	lated 8/13/18 was written by LPN eated, "Saw [client C]. No I at this time." The INN did not ad performed a physical ent C's wound. The INN did not ad personally trained staff of the site.					
	#3. The INN indic	lated 8/16/18 was written by LPN eated, "[Client C] seen at the xt appointment 8/23/18."					
	#3. The INN indic	lated 8/17/18 was written by LPN cated, "Saw [client C]. No as or symptoms of distress					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	UILDING 'ING	DNSTRUCTION 00	02	ATE SURVEY OMPLETED 2/26/2019
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	noted. Wound lool indicate LPN #3 c assessment and do of her assessment indicate LPN #3 h regarding the care - Client C's WCCI Home Manager (F appointment. The "Weeks in treatme "Wound: Left Glu "Gel mattress over "If patient (client G repositioned every "Turn and repositi "Patient if wearing not tight or rubbin - Client C's INN d #3. The INN indic from the wound ca activities and turn - Client C's INN d #3. The INN indic	ks good." The INN did not ompleted a thorough nursing cumented a visual description of the wound. The INN did not ad personally trained staff of the site. from her 8/23/18 visit indicated IM) #1 accompanied her to the WCCI indicated the following: ent: 4." teal (buttocks) fold. Healed. " clay (on bed)." C) is in chair , she needs to be fifteen minutes." on every two hours (in bed)." g depends (sic) to make sure it is g." ated 8/23/18 was written by LPN ated, "[Client C] was discharged are center. She can resume every two hours." ated 8/29/18 was written by LPN ated, "Saw [client C]. No is or symptoms of distress				
	- Client C's INN d LPN #2. The INN at the house Has and area on buttoe	ated 10/10/18 was written by indicated, "Saw client (client C) irritated area below ribcage, ks, where leg and buttocks join. Manager (HM) #1] to keep area				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLII L LIFE OF INDIAN		4475 1	<sup>°</sup> Address, city, state, zip N 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	much as possible.	to make sure to stay off as Has appointment with wound 3. Will continue to monitor."				
		from her 10/18/18 visit indicated nied her to the appointment. The he following:				
	"Weeks in treatme	ent: 0."				
	"Wound: Left Glu	teal fold."				
	excessive drainage and water. Remove plastic bag and pla wound with Norm clean dressing usi or cotton balls. Do force. Pat dry usin cotton balls App bed as directed. C Secure in place. M sponge. Cover with "Gel mattress ove	C) is in chair , she needs to be				
	repositioned every	on every two hours (in bed)."				
	it must be applied Patient should not	f if possible. Leave off in bed. If , please make sure it is loose. go to day service for a few e off back, and turned				
		ated 10/19/18 was written by indicated, "Client (client C) was				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST HAUTE, IN 47805	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
	orders received." had performed a p wound. The INN personally trained site. - Client C's WCC	e center on 10/18/18. New The INN did not indicate LPN #2 obysical assessment on client C's did not indicate LPN #2 had staff regarding the care of the I from her 10/25/18 visit indicated nied her to the appointment. The				
	WCCI indicated i wound. The instru	instructions to care for the actions were the same provided intment for this wound on				
	LPN #2. The INN orders received." had performed a p wound. The INN	lated 10/26/18 was written by indicated, "Wound center new The INN did not indicate LPN #2 obysical assessment on client C's did not indicate LPN #2 had staff regarding the care of the				
	#2. The INN india house. Resting in The INN did not i physical assessme INN did not indic	lated 11/1/18 was written by LPN cated, "Saw client (client C) at the bed. Voices no complaints." ndicate LPN #2 had performed a ent on client C's wound. The ate LPN #2 had personally ding the care of the site.				
	Staff #1 accompa WCCI indicated i wound. The instru	I from her 11/1/18 visit indicated nied her to the appointment. The nstructions to care for the actions were the same provided intment for this wound on				
	#2. The INN indic	lated 11/2/18 was written by LPN cated, "Client (client C) was seen n 11/1/18. New orders received."				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	'EMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	The INN did not i physical assessme INN did not indic trained staff regar - Client C's Nursin	ndicate LPN #2 had performed a ent on client C's wound. The ate LPN #2 had personally ding the care of the site. ng Quarterly Assessment (NQA) completed by LPN #2. The				
	NQA indicated th					
	"Skin:" "Open areas: No.'					
	wound center wee glute. Foley cathe draining clear yell normal. No signs - Client C's INN c #2. The INN indic Service (RDS). C Voices no compla LPN #2 had perfo client C's wound.	mary: Client has been going to kly for area on back and right ter has been changed and low urine. G-Tube site looks or symptoms of infection." lated 11/8/18 was written by LPN cated, "Saw client at ResCare Day olor good. Respirations easy. ints." The INN did not indicate rmed a physical assessment on The INN did not indicate LPN #2 ined staff regarding the care of				
	HM #1 accompan WCCI indicated in wound. The instru- at the initial appoi 10/18/18. The WC had been cultured	I from her 11/8/18 visit indicated ied her to the appointment. The instructions to care for the actions were the same provided intment for this wound on CCI indicated client C's wound for bacteria. The culture ind was positive for a acteria infection).				
		lated 11/9/18 was written by LPN ated, "Client (client C) was seen				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	received." The IN performed a phys wound. The INN personally trained site. - Client C's WCC staff #1 accompar WCCI indicated i wound. The instru- at the initial apport 10/18/18. - Client C's WCC staff #1 accompar WCCI indicated i wound. The basic provided at the in on 10/18/18. The	ter on 11/8/18. New orders N did not indicate LPN #2 had ical assessment on client C's did not indicate LPN #2 had staff regarding the care of the I from her 11/15/18 visit indicated hied her to the appointment. The instructions to care for the actions were the same provided intment for this wound on I from her 11/21/18 visit indicated hied her to the appointment. The instructions to care for the instructions to care for the instructions to care for the instructions were the same itial appointment for this wound instructions included, "Need to ders on the wound."				
	LPN #2. The INN seen at wound car orders". The IN performed a phys wound. The INN	lated 11/21/18 was written by indicated, "Client (client C) was e center on 11/15/18. No new N did not indicate LPN #2 had ical assessment on client C's did not indicate LPN #2 had staff regarding the care of the				
	LPN #2. The INN resting in bed (sic easy and non-labo The INN did not i physical assessme INN did not indic	lated 11/26/18 was written by indicated, "Saw client at the ) Color good. Respirations ored Denies any complaints." ndicate LPN #2 had performed a ent on client C's wound. The ate LPN #2 had personally ding the care of the site.				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	DDRESS, CITY, STATE, ZIP COI 17TH ST HAUTE, IN 47805	D	
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY ( - Client C's INN of LPN #2. The INN seen at wound can	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION lated 11/28/18 was written by findicated, "Client (client C) was be center on 11/21/18. Orders N did not indicate LPN #2 had	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	performed a phys wound. The INN	ical assessment on client C's did not indicate LPN #2 had staff regarding the care of the				
	staff #1 accompan WCCI indicated i wound. The instru- at the initial appo 10/18/18. The ass wound care cente on palpation. Stag	I from her 11/29/18 visit indicated nied her to the appointment. The instructions to care for the actions were the same provided intment for this wound on essment of the wound by the r nurse indicated, "Tenderness ge 3 pressure ulcer. 4 CM (Centimeters) by 1.4 CM				
	LPN #2. The INN seen at wound can orders received." had performed a p wound. The INN	lated 11/30/18 was written by indicated, "Client (client C) was e center on 11/29/18. New The INN did not indicate LPN #2 obysical assessment on client C's did not indicate LPN #2 had staff regarding the care of the				
	dated 12/4/18 ind (RDS): Only cam restWants to ge only to be in her of shower, and for o	isciplinary Team (IDT) meeting icated, "ResCare Day Service e six days last quarter due to bed tout of bed. Has restrictions shair to eat, receive medications, ne hour after she eats then to lay octors orders from the wound				
		I from her 12/6/18 visit indicated ied her to the appointment. The				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLIE L LIFE OF INDIAN			4475 N	ADDRESS, CITY, STATE, ZII 17TH ST HAUTE, IN 47805	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
	WCCI indicated in wound. The instru	nstructions to care for the ctions were the same provided ntment for this wound on					
	#2. The INN indic at wound care cen The INN did not in physical assessme INN did not indica	ated 12/7/18 was written by LPN ated, "Client (client C) was seen ter on 12/6/18. No new orders." ndicate LPN #2 had performed a nt on client C's wound. The ate LPN #2 had personally ding the care of the site.					
	LPN #2. The INN at the Christmas p distress." The INN performed a physi wound. The INN o	ated 12/12/18 was written by indicated, "Saw client (client C) arty. Appears to be in no I did not indicate LPN #2 had cal assessment on client C's did not indicate LPN #2 had staff regarding the care of the					
	staff #1 accompan WCCI indicated in wound. The instru	from her 12/13/18 visit indicated ied her to the appointment. The astructions to care for the ctions were the same provided ntment for this wound on					
	HM #1 accompan WCCI indicated in wound. The instru	from her 12/27/18 visit indicated ied her to the appointment. The instructions to care for the ctions were the same provided intment for this wound on					
	LPN #2. The INN seen at wound car	ated 12/27/18 was written by indicated, "Client (client C) was e center on 12/13/18." The INN PN #2 had performed a physical					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site. - Client C's INN dated 12/28/18 was written by LPN #2. The INN indicated, "Saw client (client C). Color good. Respirations easy and non-labored. Lungs clear, abdomen soft, bowel sounds in four quadrants. G-Tube (nutritional stomach feeding tube) site clean dry and intact, No signs or symptoms of infection. Foley catheter patent and draining clear, yellow urine." The INN did not indicate LPN #2 had performed a physical assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site. - Client C's INN dated 1/3/19 was written by LPN #2. The INN indicated, "Client (client C) was seen at wound care center. No new orders." The INN did not indicate LPN #2 had performed a physical assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site. - Client C's INN dated 1/4/19 at 10:45 AM was written by LPN #2. The INN indicated, "Saw client (client C) sitting up in wheelchair. Color good. Respirations easy and non-labored. L ung fields clear, abdomen soft and non-tender. Bowel sounds in four quadrants. Foley catheter patent and draining clear, yellow urine. Denies any complaints of discomfort." The INN did not indicate LPN #2 had performed a physical assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site. - Client C's Event ID: ZRF511 Facility ID: 001022 Page 42 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	CO	ATE SURVEY MPLETED /26/2019
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			4475	ET ADDRESS, CITY, STATE, ZI N 17TH ST RE HAUTE, IN 47805	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TI DEFICIENCY	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
	indicate the stat the appointment instructions to a instructions we initial appointment 10/18/18. The a the wound care "Tenderness or ulcer. Measures 0.2 CM."- Clie 10:00 AM was INN indicated, wound care cer received." The #2 had perform client C's wound LPN #2 had per regarding the c INN dated 1/11 by LPN #2. Th (client C). Colo and non-labore abdomen soft a sounds in four patent and drain Denies any con INN did not ind performed a ph C's wound. The #2 had persona	r 1/10/19 visit did not ff who accompanied her to at. The WCCI indicated care for the wound. The re the same provided at the nent for this wound on assessment of the wound by center nurse indicated, a palpation. Stage 3 pressure ments: 2 CM by 1.9 CM by nt C's INN dated 1/11/19 at written by LPN #2. The "Client (client C) was seen at at out on 1/10/19. New orders INN did not indicate LPN and a physical assessment on ad. The INN did not indicate rsonally trained staff are of the site Client C's /19 at 7:30 PM was written e INN indicated, "Saw client or good. Respirations easy d. Lung fields clear, nd non-tender. Bowel quadrants. Foley catheter ning clear, yellow urine. mplaints of discomfort." The dicate LPN #2 had ysical assessment on client e INN did not indicate LPN lly trained staff regarding the - Client C's WCCI from her				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LDBE	(X5) COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION dicated staff #1 accompanied	1.	AG	DEFICIENCE		DATE
		intment. The WCCI					
		ictions to care for the wound.					
		s were the same provided at					
		intment for this wound on					
		ent C's INN dated 1/18/19					
		LPN #1. The INN indicated,					
		enter visit today. No changes					
		turn 1/24/19 at 11:00 AM."					
		ot indicate LPN #1 had					
		ysical assessment on client					
		e INN did not indicate LPN					
		lly trained staff regarding the					
		- Client C's WCCI from her					
		dicated HM #1 accompanied					
		intment. The WCCI					
		ctions to care for the wound.					
	The instruction	s were the same provided at					
		intment for this wound on					
	10/18/18 Clie	ent C's Reposition Tracking					
	Form (RTF) da	ted 2/1/19 did not indicate					
	client C was re	positioned from 12:00 AM to					
	8:00 AM Clie	ent C's RTF dated 2/3/19					
	indicated client	C was in her wheelchair from					
	7:00 AM to 3:0	0 PM when she was placed					
	in her bed on h	er left side Client C's RTF					
	dated 2/5/19 di	d not indicate client C was					
	repositioned fro	om 6:00 AM to 8:00 AM,					
	and from 4:00	PM to 11:00 PM Client					
	C's Health Risk	Plan (HRP) dated 2/5/19					
	indicated client	C had a risk plan created for					
	Skin Breakdow	n. The HRP was created by					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRF511 Facility ID: 001022

If continuation sheet Page 44 of 167

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	5
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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST E HAUTE, IN 47805	D	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
	indicated the fe Breakdown.""" Redness, irritat from open area at the base of t G-Tube site."" instructs staff t give [client C] scheduled as w a shower, inco catheter is out. irritation or op change, turn, o record and rep any abnormal f C] every two h pressure to the up in her whee every fifteen m notified as inst assessment by an appointmen (As Soon As P start (sic) on th occurs.""Staff center appoint the nurse of fir responsible: D (staff), home m (AS), and nurs	s Manager (HSM). The HRP ollowing:"Risk for Skin Triggers to notify the nurse: tion, open areas, bleeding as on buttocks, coccyx (bone he spine), hips, or around Call 911 if [client C's] nurse o do so.""Actions:""Staff will a shower or bath as "ash and dry thoroughly after ntinence of feces, or urine if ""Staff will assess for redness, en areas with each depends r G-Tube feeding.""Staff will ort to the nurse immediately findings.""Staff will turn [client ours while in bed to release buttocks and hips and while lchair she will be repositioned ninutes.""The doctor will be ructed by the nurse after the Home Manager to make t with the wound clinic ASAP ossible) to have treatment the area if breakdown will transport to the wound nents as schedule and inform adings via consult form.""Staff irect support professionals nanager, Area Supervisor e."- Client C's RTF dated indicate client C was				

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	•
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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	Client C's WCC indicated staff appointment. T instructions to instructions we initial appointm 10/18/18. The anti-fungal creat assessment of the center nurse inter- palpation. Stag Measurements: CM."- Client C written by LPN "New order from anti-fungal creat apply foam dreat indicate LPN # assessment on the did not indicate trained staff reg Client C's RTF client C was re 8:00 AM Client indicated client 7:00 AM to 1:00 in her bed on h Hospital Disch 2/16/19 indicate	om 7:00 AM to 1:00 PM CI from her 2/7/19 visit #1 accompanied her to the he WCCI indicated care for the wound. The basic re the same provided at the nent for this wound on nstructions included, "Apply am to peri-wound skin." The he wound by the wound care dicated, "Tenderness on e 3 pressure ulcer. 2 CM by 1.6 CM by 0.2 "s INN dated 2/7/19 was I #1. The INN indicated, m wound clinic to apply am, collagen to wound bed, ssing". The INN did not 1 had performed a physical client C's wound. The INN e LPN #1 had personally garding the care of the site dated 2/8/19 did not indicate positioned from 12:00 AM to ont C's RTF dated 2/10/19 C was up in her chair from 00 PM when she was placed er right side Client C's arge Instructions dated ed the following:"Admission: harge: 2/16/19."Diagnosis: Tract Infection). Stage 3				

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	admission."- C did not indicate from 12:00 AM documentation schedule for 2/ RTF dated 2/18 changed position PM. The docum repositioning s blank Client C written by LPN "Visited with [ in lazy boy chat draining clear y with split dress The INN did no performed a ph C's wound. The #1 had personal care of the site 2/19/19 did not positions from documentation schedule for 2/ RTF dated 2/20 was repositioned scheduled Cl did not indicate from 12:00 AM placed in her w	left buttocks, present upon lient C's RTF dated 2/16/19 e client C changed positions 4 to 11:00 PM. The for client C's repositioning 16/19 was blank Client C's 8/19 did not indicate client C ons from 12:00 AM to 11:00 mentation for client C's chedule for 2/18/19 was C's INN dated 2/18/19 was V#1. The INN indicated, client C] this morning. Sitting ir. Foley catheter in place yellow urine. G-Tube in place ing. Clean, dry, and intact". ot indicate LPN #1 had tysical assessment on client e INN did not indicate LPN lly trained staff regarding the c. Client C's RTF dated t indicate client C changed 12:00 AM to 11:00 PM. The for client C's repositioning 19/19 was blank Client C's 0/19 did not indicate client C ed at 11:00 PM, as ient C's RTF dated 2/21/19 e client C was repositioned it to 7:00 Am when she was theelchair for breakfast dated 2/22/19 did not				

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/	te survey Mpleted 26/2019
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	12:00 AM to 1 for client C's re 2/22/19 was bla Developmental reports, Incider Investigations v 2:30 PM. The r BDDS report, I pressure ulcer of wound care cer 2018. The revia report, IR, or in ulcer client C v at the wound ca 2018 The faci Facility Survey dated 2/20/19 v 11:00 AM. The #2, #3, #4, #5, working in the Client Specific indicate staff #, trained on clier the home. Clier C Training did #6 had been tra regarding her m providing care (AS) #1 was in 11:00 AM. AS	C changed positions from 1:00 PM. The documentation positioning schedule for ank Bureau of Disabilities Services (BDDS) at Reports (IRs), and were reviewed on 2/20/19 at eview did not indicate a R, or investigation for the client C was treated for at the atter in July 2018 and August ew did not indicate a BDDS avestigation for the pressure vas currently being treated for are center since October lity's Community Residential for Worksheet (CRFSW) vas reviewed on 2/21/19 at c CRFSW indicated staff #1, #6, and #7 were staff home. Client C's undated Training (CST) did not 5, #6, and #7 had been at C prior to providing care in at C's undated Care of Client not indicate staff #4, #5, and ined on client C's care hedical needs prior to in the home. Area Supervisor terviewed on 2/22/19 at #1 indicated staff should be of clients prior to working in				

AND PLAN OF CORRECTION IDENTIFICA		x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE ( A. BUILDING B. WING	00	CO 02	ate survey mpleted /26/2019
	PROVIDER OR SUPPLI		4475	T ADDRESS, CITY, STATE, ZIP N 17TH ST RE HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	responsible for to working." A responsible for staff on client's positioning cha in entirety for t [Qualified Intel Professional (Q #1 was intervie AM. LPN #1 ir nurse for client just started at R But, I've been i since January." the home week LPN #1 stated, look at [client Q Foley catheter a at the staff shift (Medication AQ staff about how remind them to she did not revi regarding client when she was w indicated client ulcer. LPN #1 s	<sup>41</sup> stated, "[HM #1] is ensuring staff is trained prior S #1 indicated the nurse was providing medical training to needs. AS #1 stated, "The nge forms should be filled out he [LPN #1], [HM #1], and lectual Disabilities PIDP) #1] to review." LPN wed on 2/22/19 at 11:00 adicated she is the primary C's home. LPN #1 stated, "I escCare a few months ago. n charge of [client C's] home LPN #1 indicated she was in ly providing care for client C. "When I go into the home, I C's] wound. I also check her and her G-Tube site. I look t notes and review the MARs dministration Record). I ask [client C] is doing and turn her." LPN #1 indicated ew any documentation t C's repositioning schedule visiting the home. LPN #1 C has a stage 3 pressure stated, "Yes, a stage 3 s serious. It requires a great attion to heal it." LPN #1 C has had a pressure ulcer in a stated, "I know she's had				

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FORM APPROVED							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP C 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	She just can't s That's why she LPN #1 indicat should be follo indicated client bed every two should be chan minutes. LPN # out of bed unle medications. S #1 indicated sta dressing daily, LPN #1 stated, it with normal foam Band-Aid think they have haven't been th #1 indicated cl care center wea stated, "I know appointment be but I think that stated, "I've ne center visit wit could go." LPN the wound care LPN #1 stated, verify the orde them." LPN #1	a ulcer) on and off for years. eem to keep her skin intact. has a skin integrity protocol." ted the skin integrity protocol wed as written. LPN #1 t C should be repositioned in hours, and her position ged in her chair every fifteen #1 stated, "She shouldn't be ss she's eating or getting he's on strict bed rest." LPN aff should be changing the and as needed if it is soiled. "They're supposed to clean saline, then put collagen and a d on it." LPN #1 stated, "I e the supplies they need. I ere in a while to check." LPN ient C went to the wound ekly for treatment. LPN #1 she's missed one ecause the roads were bad, 's all she's missed." LPN #1 ver been to a wound care h [client C]. I didn't know I W#1 indicated she contacted e center once to verify orders. "Other than the one time to rs, I haven't spoken with indicated the orders from the neter should be followed. LPN e trained staff on nursing				

OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES	
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 02/26/2019	
	NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 17TH ST E HAUTE, IN 47805		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
		r client C. LPN #1 stated, "I aff on the wound care and				
		s. The staff seemed to				
	2	hat to do. I watched one of				
	•	a dressing once." LPN #1				
		ne only time I've only seen				
		t was sometime in January."				
		"I don't have any				
		of assessments on her				
		ever done a full assessment				
		vestigations were reviewed				
		30 PM. The review				
		llowing:Investigative				
	Summary (IS) d	ated 9/12/18 indicated, "On				
	9/7/18, [clients]	B and E] were attending				
	[day service pro	wider]. While there, staff				
	overheard [clien	ts B and E] say that [female				
	name] wakes the	em up in the middle of the				
	night and yell (s	sic) and scream (sic) at them.				
	[Staff #2] worke	ed the overnight on 9/6/18				
	and is the only r	name close to [female name].				
	[AS #1] informe	ed [Executive Director (ED)				
	#1]. An investig	ation was initiated."The IS				
	was completed	by Quality Assurance				
	Manager (QAM	1) #1 on 9/12/18. The IS				
	indicated the fol	llowing:Client B was				
	interviewed for	the investigation by QAM #1				
	on 9/10/18 and	9/12/18. The interview				
	indicated, "[Clie	ent B] refused to speak or				
	_	nent on 9/12/18. On				
	-	B] stated that [staff #2] does				
	-					
	not yell or screa	m at her. When asked if she				

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

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	VILDING NG	DNSTRUCTION 00	COI 02/	te survey Mpleted 26/2019
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST E HAUTE, IN 47805	)D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH( CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
	why, she stated reference to how the day, she stat yell at her".C: the investigatio The interview if good staff, but so and [client B's] stated she (staff wake them up. does this. [Clien overnight staff When asked if ] this way all the she said, 'yes.' W anyone about th When asked wh [staff #2] yells don't know' [O telling the truth the investigatio The interview i that she has not [clients B and F middle of the n sometimes she [client B] wake screaming at stat does speak in a hear her over how	she stated, 'no.' When asked , 'No. I do not like her.' In w [staff #2] wakes her up for ted that [staff #2] does not lient E was interviewed for n by QAM #1 on 9/10/18. ndicated, " [Staff #2] is a she yells she (sic) (client E) names loudly. She (client E) E#2) does yell at them to She stated no other staff nt E] stated she wants a new saying, 'I want a new girl' [staff #2] has awakened her time she has worked there, When asked if she told his before she said, 'No.' ny she did not tell anyone at her before now she said, 'I Client E] stated she was ."Staff #2 was interviewed for n by QAM #1 on 9/12/18. ndicated, "[Staff #2] stated yelled or screamed at E] during her shift or in the ight [Staff #2] stated that has to have a louder tone if s up in a behavior or aff or clients. She states she louder tone so [client B] can er own yelling and will usually it after. [Staff #2] stated again				

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AND PLAN OF CORRECTION IDENTIFICAT 15G508		x1) provider/supplier/clia identification number 15G508	î î		00	(X3) DATE SURVEY COMPLETED 02/26/2019		
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE	]	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
		t yell or scream during on:""It is unsubstantiated that						
		ed ResCare policy."The						
	-	l not indicate a peer review						
	-	The investigation did not						
		safeguards listed to ensure						
		me were protected from						
	-	staff. BDDS reports were						
		0/19 at 2:30 PM. The						
		ndicate a BDDS report						
		leged staff to clients B and E						
	-	visor (AS) #1 was						
		2/22/19 at 11:00 AM. AS						
	-	ling at clients is not						
	-	#1 stated, "[Staff #2] has						
		rk in the home with the						
		indicated since staff #2 has						
	returned to the h	nome to work there has not						
	been any addition	onal oversight. AS #1 stated,						
	"I guess we sho	uld be watching her too so						
	we make sure th	at abuse is not part of the						
	culture in the ho	ome." AS #1 indicated the						
	ANE policy sho	uld be followed by all						
	staff.3. The faci	lity's BDDS (Bureau of						
	Developmental	Disabilities Services) reports						
	and investigatio	ns were reviewed on 2/20/19						
	at 2:30 PM. The	review indicated the						
	following:BDD	S report dated 9/17/18						
	indicated, "[Stat	ff #1] was placed off duty						
	pending allegati	ons of ANE (Abuse,						
	Neglect, and Ex	ploitation).""Plan to Resolve:						
	-	(FC)] appears to be in good						

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<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>
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STATEME AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		A. BUILDING <u>00</u> B. WING				COMPLETED 02/26/2019	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	(X5) COMPLET DATE	TIO
IAU		tigation will be initiated."IS		IAU			DATE	
		ummary) dated 9/24/18 was						
	· •	AM #1. The IS indicated						
		ntroduction: On 9/17/18,						
	-	AS #1] that prior to dinner						
		ff #1] came into her						
		at her. Then slammed her						
		FC] could not identify what						
	-	id. She (FC) stated that						
		ave heard what [staff #1]						
		formed [ED #1]. An						
		as initiated."FC was						
	-	the investigation by QAM #1						
		9/24/18. The interview						
		stated [staff #1] told her						
		ing her bowling on 9/13/18,						
		as supposed to take them.						
		to her bedroom. She (FC)						
		came into her bedroom and						
	1	g to the fact that she does not						
		ammed her door. [FC]						
		FC) had just told [staff #9]						
		es not like [staff #1] and						
	. ,	taff #1] this. She (FC)						
		was in the home and heard						
	[staff #1] yell at	her. On 9/13/18, [FC] told						
		taff #1] yelled at her [FC]						
		13/18 she (FC) and [staff						
	#1] did not spea	k. She (FC) stated that she						
		ff #1] a hug and they did not						
		e another or say they were						
		about anything that happened						

OMB NO. 0938-039

ENTERS FOR MEDICARE & MEDICAID SERVICES	
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		A. BUILDING <u>00</u> B. WING			02/	COMPLETED 02/26/2019	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805			
(X4) ID PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE	(X5) COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ff #8 was interviewed for the					
		y QAM #1 on 9/13/18. The					
		ated, "On 9/13/18, [FC] told					
		s upset because [staff #1]					
		ing to take her bowling					
	,	Staff #8). [FC] told her that					
	[staff #1], 'screa	staff #1], 'screamed really bad' at her then					
	slammed the door [Staff #8] stated on						
	9/13/18 there w	as a house meeting in the					
	morning so she	was at the home, but she did					
	not see [FC and	l staff #1] interact."AS #1					
	was interviewe	d for the investigation by					
	QAM #1 on 9/1	8/18. The interview					
	indicated, "[FC	] told her the initial allegation					
	on 9/17/18 that	[staff #1] came into her					
	bedroom, yelle	d at her, and slammed her					
	bedroom door s	shut. On 9/18/18, [FC] told					
	[AS #1] that [st	aff #1] did not yell at her but					
	raised her voice	e at her and she was not sure					
	what she said b	ecause she had her					
	headphones on	[FC] stated that she					
	understood that	if she had her headphones					
		e would have to speak					
	louder to get he	er to hear them."Staff #9 was					
	-	the investigation by QAM #1					
		date. The interview					
		ff #9] stated before [staff #1]					
	_	home, [FC] kept saying she					
	-	ff #1]. When [staff #1]					
		riveway, [FC] said she was					
		dphones on and going to her					
		n [staff #1] walked in she					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE C A. BUILDING B. WING	00	COM 02/2	re survey ipleted 26/2019
	PROVIDER OR SUPPLIE		4475 N	TADDRESS, CITY, STATE, ZIP CON 17TH ST E HAUTE, IN 47805	DD	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION and [staff #9] told her she	TAG			DATE
		oom [Staff #9] stated she				
	does not recall	[staff #1] going to [FC's]				
	bedroom [FC]	] did not tell [staff #9] that				
	[staff #1] yelled	l at her."HM #1 was				
	interviewed for	the investigation by QAM #1				
	on 9/21/18. The	e interview indicated, "She				
	(HM #1) stated	on 9/13/18, she did not				
	hear [staff #1 and	nd FC] speak to one				
	another."Staff#	1 was interviewed for the				
	investigation by	A QAM #1 on 9/20/18. The				
	interview indica	ated, "On 9/12/18 [FC]				
	came home and	stated to her that she				
	wanted [staff #8	8] to take them bowling on				
	9/13/18. [Staff ;	#1] stated she told [FC] that				
	she was taking	them bowling. [FC] said,				
	'No, [staff #8] i	s.' She told [FC] that she can				
	not say who is t	aking her bowling. [FC] then				
	went to her bed	room [Staff #1] knocked				
		om door and said, '[FC], I				
	know you're ma	ad at me, but I still love you.				
	-	ow.' [FC] was laying on her				
		looking at her laptop with				
	-	on. [Staff #1] stated she				
		[FC] had the headphones				
		l not turn around, look at				
	· •	her. [Staff #1] stated that				
		loor an left [Staff #1]				
		8 she worked the morning				
		in and [FC] gave her a hug				
		orry I was mad at you.' She				
	told [FC], 'It's o	k. It's done and over				

CENTERS FOR M	AEDICARE &	MEDICAID	SERVICES
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 02/26		
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP COD 17TH ST HAUTE, IN 47805		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	that [staff #1] y Peer Review (I dated 9/25/18. "Recommenda professionalism duty with pay if meet with [FC] investigation a house."Area So interviewed on #1 indicated ye acceptable. AS continued to w clients." AS #1 members and F interaction betw house meeting odd because [F AS #1 indicate to the home to additional over we should be y sure that abuse the home."4. T Developmenta and investigati at 2:30 PM. The following:BDI indicated, "[Sta duty pending a	lusion:""It is unsubstantiated violated ResCare policy."The PR) for the investigation was The review indicated, tions: Retrain [staff #1] on an and boundaries. Return to for scheduled shifts. AS to to discuss outcome of and [staff #1] being in the apervisor (AS) #1 was 2/22/19 at 11:00 AM. AS elling at clients is not #1 stated, "[Staff #1] has ork in the home with the indicated multiple staff FC indicated there was no ween FC and staff #1 at the AS #1 stated, "That seems C] is a very social person." d since staff #1 has returned work there has not been any rsight. AS #1 stated, "I guess vatching her too so we make is not part of the culture in he facility's BDDS (Bureau of 1 Disabilities Services) reports ons were reviewed on 2/20/19 he review indicated the DS report dated 2/11/19 aff #7 and #6] were placed off llegations of ANE for physical o Resolve: Both individuals				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	Cor 02/	te survey Mpleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	health. An inver (Investigative S completed by C Coordinator (Q indicated the fo 2/11/19, [staff is she had been to and #7] held [c B] to hit her. [S off duty. [AS # Director) #1]. A initiated."Home interviewed for on 2/14/19. The #1] stated that 2/6/19 that [sta incident in ques #3] she and [sta on 2/3/19 and a [HM #1] stated [AS #1] on 2/6, for the investig The interview if [HM #1] did re [client B] hit [c but [HM #1] stated and [client B] just of then spoke with informed [AS #	B) appear to be in good stigation has been initiated."IS Summary) dated 2/20/19 was Quality Assurance AC) #1 on 2/20/19. The IS ollowing:"Introduction: On #3] informed [AS #1] that old by [staff #6] that [staff #6 lient A] and allowed [client Staff #6 and #7] were placed 1] informed [ED (Executive An investigation was e Manager (HM) #1 was the investigation by QAC #1 e interview indicated, "[HM [staff #3] reported to her on ff #6] had told her about the stion [Staff #6] told [staff aff #7] held [client A] down illowed [client B] to hit her. she then reported this to /19."AS #1 was interviewed ation by QAC #1 on 2/15/19. ndicated, "[AS #1] stated that port to her on 2/6/19 that elient A] while in a restraint, ated she was unsure if staff allowed this to happen or used the opportunity. [AS #1] in [staff #3] on 2/11/19, who #1] that [staff #6 and #7] had couraged [client B] to hit				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		A. BUILDING B. WING	00	02/	MPLETED 26/2019	
	PROVIDER OR SUPPL		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	placed both sta informed [ED for the investig The interview she was workin [staff #6]. On the that she and [staff #6]. On the that she and [staff #3] coul [client B] hit [of reported that [staff #3] coul [client B] hit [of reported that [staff #3] coul [client B] hit [of reported that [staff #7] If and #7] speakin derogatory ma #6] has referred and [staff #7] If A] during her If appropriate reconstruct that she felt boo acted in ways to behaviors. [Staff 2/6/19."Client investigation boo interview indice did restrain her asked to descrift each staff held legs around boo	e they restrained her. [AS #1] off off duty at this time and #1]."Staff #3 was interviewed gation by QAC #1 on 2/15/19. indicated, "[Staff #3] stated ing in the home on 2/5/19 with this day, [staff #6] told her taff #7] held [client A] down lient B] to hit her on 2/3/19. d not give specifics as to how client A] or where. [Staff #3] staff #6] did not tell her this Staff #3] also stated during her she has overheard [staff #6 ing about [client A] in a nner. [Staff #3] states [staff d to [client A] as ' trash' has argued back with [client behaviors instead of using lirection. [Staff #3] stated th [staff #6 and #7] have that increase [client A's] off #3] reported that was said Staff and provention and wrapped th of her legs. [Client A] was estrained her in any other way,				

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>
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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/	te survey Mpleted <b>26/2019</b>
	PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	[client B] did h held. [Client A because she wa no when asked her. However, [staff #6] called said she was fa stated that [stat spoke to her in interviewed for on 2/20/19. Th B] reported that back. [Client B remember if sta restraint. [Client staff yell or use asked if she hat did not hit [client that she did no questions asked for the investig The interview a that she and [stat in a two person day in question elope from the [client B] a few #7] stated that had [client A] a	'no.' [Client A] reported that in her while she was being ] stated that [client B] hit her as mad. [Client A] answered if anyone told [client B] to hit [client A] did report that d her the 'N' word and also at on this day. [Client A] ff #6] was the only staff who this way."Client B was r the investigation by QAC #1 e interview indicated, "[Client at [client A] hit her in the b] stated she did not aff held [client A] in a at B] stated she did not hear e inappropriate words. When d hit [client A], she stated she ent A]. [Client B] kept saying t remember anything to most d."Staff #7 was interviewed gation by QAC #1 on 2/15/19. indicated, "[Staff #7] states faff #6] had placed [client A] n standing hold twice on the a due to [client A] trying to home. [Client A] had also hit v times (on that day). [Staff during one of the times they restrained, [client B] did hit neither she (staff #7) or [staff B] to do this. After [client B]				

OMB NO. 0938-039

ENTERS FOR MEDICARE & MEDICAID SERVICES	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE A. BUILDING B. WING	A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			4475	STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)		(X5) IPLETIO DATE	
1	the restraint to v	ey released [client A] from verbally redirect [client B]. that she never yelled or						
	She (staff #7) tr	toward either individual. ied to verbally redirect						
1	music and calm	to her room and listen to down. She (staff #7) called client A] would not listen to						
1	redirection [S	taff #7] expressed wanting I to a different location."Staff						
		wed for the investigation by 9/19. The interview						
:	she (staff #6) ve	he day in question (2/3/19), erbally redirected [client A]						
	B] when they st	een her (client A) and [client arted fighting. [HM #1] nt A] while she calmed						
	down. After [H]	M #1] left, [client A] started dly through the home trying						
		<ul><li>#7] told [staff #6] they</li><li>[client A] in a restraint.</li></ul>						
1	remembering ex	she had difficulty eactly how to do a two						
	The first time, s	restraint from her training. he (staff #7) and [staff #6] e forgot to wrap her legs						
	around [client A	Which allowed her to still [Client B] became upset that						
	[client A] was k	icking staff, so [client B] hit f #6 and #7] then released						
		irect [client B]. They placed estraint once more since she						
	[client A]. [Staf [client A] to red	f #6 and #7] then released irect [client B]. They placed estraint once more since she	ZRF511 Faci	lity ID: 001022	If continuation sheet	a Page	61	

	CATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER       A. BUILDING       00         15G508       B. WING		00	(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	[HM #1] was the arrived at the be outside to speal both holds were was never held states she has n towards [client she may have ra- behaviors on 2/ such as, 'You ca- leave, you will more trouble.' [ reluctant to com because other s to her that [HM (staff #6) and [s terminated."The D, E, F, G, and regarding the al- reported on 2/1 findings:""Revi- showed [staff # only two staff w question"."Tw pulled and revia 2/3/19. One rep had engaged in with [client A] B]. A second re-	to run through the home. hen contacted and she ome and took [client A] c with her. [Staff #6] states e standing holds. [Client A] on the ground. [Staff #6] ever used derogatory terms A]. She (staff #6) reports aised her voice during the 3/19, but she only said things an't leave [client A]. If you go to jail and get in even Staff #6] stated she was he in and be interviewed taff in the home had reported taff in the home had reported taff in the home had reported taff if in the home had reported taff if in the nome had reported taff if in the home had reported taff if if the home had reported taff if t				

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICE</b>	ES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	Col 02/	ate survey Mpleted 26/2019
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	report complet [client B] hittin restrained.""No incident report incident report In addition, wh (clients A and staff (staff #6 a progress notes not have anyth [HM #1] had c tracking for [cl unsubstantiated ResCare policy unsubstantiated ResCare policy Peer Review (I reviewed the fi BDDS report. retrained on Y Safe).""All sta reporting, docu Neglect, and E #3] will receive to report timely receive correct and not comple [staff #6 and # (IR) dated 2/4/ in front room v	kit the home. This incident ed by staff does not mention ng her (client A) while she was either staff completed the s on [clients A and B]. All s were written by [HM #1]. en books for the individuals B) were reviewed, neither and #7) had written any for this day. [Client B] did ing documented behaviorally. ompleted all the behavior ient A].""Conclusion:""It is d that [staff #7] violated 7 for physical aggression.""It is d that [staff #6] violated 7 for physical aggression."The PR) dated 2/21/19 indicated it ndings from the 2/11/19 "Recommendations:""All staff SIS (You're Safe. I'm ff retrained on incident umentation, and ANE (Abuse, xploitation Policy).""[Staff e corrective action for failure y.""[Staff #6 and #7] to ive action for failure to report eting documentation.""Return 7] to duty."- Incident Report 19 indicated, "[Client A] was vatching out, waiting for [staff ne (staff #6) arrived, [client A]				

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/	te survey Mpleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST HAUTE, IN 47805	D	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH( CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
	proceeded into followed, walk slapped her fac picking up any destroy TV. Sh game cabinet, I DVDs, and cab threw the top a Then opened u all over TV con clothes, and of taken to [hospi for evaluation. transferred to r hospital."Clien 2/20/19 at 1:20 the following:- Hospital Psych dated 2/5/19 in admits to havir why, she said b angry,' but cou reasons She ( angry at staff a staff was callin she claims she she does not w home, and she to having assau group home"	go again.' As she (staff #6) the back room, [client A] ed up to her (staff #6), and e. Afterward she started thing to throw and further e knocked down the freezer, both tables, [gaming] console, ble box. Then broke table and t the office door repeatedly. p a paint bottle and poured it unter, laundry basket with fice door. [Client A] was tal ER (Emergency Room)] She (client A) is going to be neuropsychiatries t A's record was reviewed on PM. The review indicated Client A's Neuropsychiatric iatric Evaluation (NHPE) dicated, "Patient (client A) ag behaviorsWhen I ask her because, 'They make me ld not give any specific client A) admits to being t the group home. She states g her derogatory names, and was being bullied. She says ant to return to that group seems oriented She admits altive ideas towards staff at the .Area Supervisor (AS) #1 d on 2/22/19 at 11:00 AM.				

CENTERS FO	R MEDICARE	& MEDICAID	SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	terminated sind (administration corporate offic terminating her to the home to indicated she w held client A d hit her. AS #1 the incident rep AS #1 indicate interviewed in investigation. A allegedly happ interview for th 2/14/19. Some interviewed un AS #1 indicate includes interv witnesses. AS why clients C, interviewed as #1 indicated th attacking staff investigation. A would seem [cl attacked [staff happened." AS has returned to not been any ac stated, "I guess	[Staff #6] has been be the investigation. We b) sent the investigation to our e, and they recommended c. [Staff #7] has been returned work though." AS #1 vas unsure if staff #6 and #7 own and allowed client B to stated, "The staff didn't fill out borts or behavior tracking." d witnesses should be a timely manner for the AS #1 indicated, "The incident ened on 2/3/19. The first he investigation was on witnesses weren't even til 2/20/19. That's too late." d a thorough investigation iews with all potential #1 indicated she was unsure D, E, F, G, and H were not part of the investigation. AS e IR involving client A #6 made her question the AS #1 stated, "I can see how it then A] retaliated and #6 for something that had #1 indicated since staff #7 the home to work there has diditional oversight. AS #1 we should be watching her e sure that abuse is not part				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C IDENTIFICATION NUMBER A. BUILDING 15G508 B. WING		<u>00</u>		<ul> <li>(3) DATE SURVEY</li> <li>COMPLETED</li> <li>02/26/2019</li> </ul>	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST E HAUTE, IN 47805	DD		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
	BDDS (Bureau Disabilities Ser investigations y 2:30 PM. The r following:- BD indicated, "(Or A] was upset of group home. [O began walking the road. Staff redirected her t [client A] refus [Client A] refus [Client A] was driver to a loca transported hor sight for appro- returning home behaviors. She knocked pictur then called 911 with [client A] [Client A] agai into the yard af and was able to inside the home line of sight wh calmed down a activity.""Plan to be in good h follow her BSF	n the home."5. The facility's of Developmental vices) reports and were reviewed on 2/20/19 at review indicated the DS report dated 2/4/19 a 2/3/19 at 4:35 PM) [Client ver not wanting to live in a Client A] exited the home and to the stop sign at the end of followed and verbally to return inside the home, but eed. HM and QIDP notified. taken by a good samaritan 1 fire station. Staff arrived and me. [Client A] was out line of ximately 45 minutes. Upon e, [client A] had continued threw fire extinguishers and es off of the wall [Client A] . [City] police arrived, spoke , and left without incident. n left the home and walked ther police left. HM followed overbally redirect to return e. [Client A] was not out of hile in the front yard. [Client A] nd resumed normal to Resolve: [Client A] appears ealth. Staff will continue to P. [Client A] does not any alone time allotted in her					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		00	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLII L LIFE OF INDIAN			4475 N	ADDRESS, CITY, STATE, ZIP COD I 17TH ST E HAUTE, IN 47805		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL NR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
W 0153 Bldg. 00	The facility must mistreatment, ne injuries of unkno immediately to th officials in accord established proc Based on record re allegations of abu Injuries of Unkno failed to report an involving clients I client PA involvir client C's Injuries Bureau of Develo (BDDS) within 24 Findings include: 1. Client C's recor 12:10 PM. The re - Client C's Woun (WCCI) from her following: "Weeks in treatmed "Wound: Left Glu BDDS reports we PM. The review d client C's wound s 7/26/18.	IENT OF CLIENTS ensure that all allegations of eglect or abuse, as well as wn source, are reported he administrator or to other dance with State law through edures. eview and interview for 4 of 14 se, neglect, mistreatment, and wn Origin reviewed, the facility allegation of staff to client VA 3 and E, an allegation of staff to og clients A and B, and two of of Unknown Origin to the pmental Disabilities Services thours of the alleged incidents. d was reviewed on 2/21/19 at view indicated the following: d Care Center Instructions 7/26/18 visit indicated the	w	0153	The facility will have evidence that all allegations of abuse, neglect and mistreatment are thoroughly investigated and reported to BDDS per report guidelines. The agency has current policies and procedures that prohibit the mistreatment, neglect and abuse of the individuals served as well as policies that specifically address the reporting of and completion of investigations client to client abuse or incidents. The Leadership Team will complete a review of these policies to ensure that they current and continue to meet the needs and safety of the individuals served. All staff receive training on these policies upon hire and annually thereafter. The training includes a review and competency of the process reporting and investigating a incidents on client on client aggression. All staff, including Supervise	, re l ting t s s d s of are et	03/28/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA     X2) MULTIPLE CONSTRUCTION       IDENTIFICATION NUMBER     A. BUILDING       15G508     B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019			
	NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
NORMA (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION         - Client C's WCCI from her 10/18/18 visit indicated         Staff #1 accompanied her to the appointment. The         WCCI indicated the following:         "Weeks in treatment: 0."         "Wound: Left Gluteal fold."         BDDS reports were reviewed on 2/20/19 at 2:30         PM. The review did not indicate a report regarding client C's wound she sought treatment for on 10/18/18.         3. Investigations were reviewed on 2/20/19 at 2:30         PM. The review indicated the following:         Investigative Summary (IS) dated 9/12/18         indicated, "On 9/7/18, [clients B and E] were attending [day service provider]. While there, staff overheard [clients B and E] say that [female name] wakes them up in the middle of the night		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPP DEFICIENCY) QA, Nursing and QIDPs will receive retraining on agence Abuse, Neglect, Exploitation and Mistreatment, Incident Management and Reporting and Investigation policies. The Area Supervisor/QIDP responsible for initiating an completing initial investiga of client to client aggression The Quality Assurance Manager is responsible for ensuring that these incider allegations of abuse, negle and mistreatment are report to BDDS, thoroughly investigated, and follow-up completed within the established timelines. Administrative observation have been implemented in home daily, seven days a w	E COMPLETIO DATE DATE DATE			
	<ul> <li>and yell (sic) and scream (sic) at them. [Staff #2] worked the overnight on 9/6/18 and is the only name close to [female name]. [Area Supervisor (AS) #1] informed [Executive Director (ED) #1]. An investigation was initiated."</li> <li>BDDS reports were reviewed on 2/20/19 at 2:30 PM. The review did not indicate a BDDS report regarding the alleged staff to clients B and E VA.</li> <li>4. BDDS report dated 2/11/19 indicated, "[Staff #7 and #6] were placed off duty pending allegations of ANE (Abuse, Neglect, and Exploitation) for physical abuse."</li> <li>"Plan to Resolve: Both individuals (clients A and B) appear to be in good health. An investigation has been initiated."</li> </ul>			and will remain in place un the team determines it is appropriate to decrease the number of observations. T will ensure all corrections a implemented per ResCare policy and regulations. Ongoing weekly and month observations and review w continue with the QIDP and Area Supervisor over the location.	e ihis are ill			

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G508	TION NUMBER A. BUILDING <u>00</u> B. WING		x3) date survey completed 02/26/2019
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP COD 17TH ST E HAUTE, IN 47805	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E (X5) COMPLETION DATE
		ndicated the following:			
	[AS #1] that she I [staff #6 and #7] I [client B] to hit he	n 2/11/19, [staff #3] informed had been told by [staff #6] that held [client A] and allowed er. [Staff #6 and #7] were placed informed [ED #1]. An initiated."			
	investigation by C (QAC) #1 on 2/14 "[HM #1] stated t 2/6/19 that [staff incident in questi and [staff #7] hele allowed [client B	(HM) #1 was interviewed for the Quality Assurance Coordinator 4/19. The interview indicated, hat [staff #3] reported to her on #6] had told her about the on [Staff #6] told [staff #3] she d [client A] down on 2/3/19 and to hit her. [HM #1] stated she to [AS #1] on 2/6/19."			
	2/11/19, and adm 2/11/19, and the H IS indicated the in	listed an incident date of inistrative knowledge date of BDDS report date of $2/11/19$ . The neident date was $2/3/19$ , and the owledge date was $2/6/19$ .			
	AS #1 indicated a exploitation, and	iewed on 2/22/19 at 11:00 AM. Ill incidents of abuse, neglect, injuries of unknown origin d to BDDS within 24 hours of owledge.			
	9-3-2(a)				
W 0154 Bldg. 00	The facility must alleged violation	IENT OF CLIENTS have evidence that all s are thoroughly investigated.			
	incidents of client	eview and interview for 12 of 14 to client aggression, staff to gression (VA) and Physical	W 0154	The facility will have evidence that all allegations of abuse, neglect and mistreatment are	03/28/201

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Aggression (PA), and Injuries of Unknown Origin thoroughly investigated and (IUO) reviewed, the facility failed to thoroughly reported to BDDS per reporting investigate multiple incidents of physical and guidelines. verbal aggression between clients A, B, D, E, F, G, The agency has current and unnamed clients, an allegation of PA by staff policies and procedures that towards clients A and B, and client C's IUO in July prohibit the mistreatment, 2018 and October 2018 neglect and abuse of the individuals served as well as Findings include: policies that specifically address the reporting of and 1. Client C's record was reviewed on 2/21/19 at completion of investigations of 12:10 PM. The review indicated the following: client to client abuse or incidents. - Client C's Wound Care Center Instructions The Leadership Team will (WCCI) from her 7/26/18 visit indicated the complete a review of these following: policies to ensure that they are current and continue to meet "Weeks in treatment: 0." the needs and safety of the individuals served. All staff "Wound: Left Gluteal (buttocks) fold." receive training on these policies upon hire and Investigations were reviewed on 2/20/19 at 2:30 annually thereafter. The PM. The review did not indicate an investigation training includes a review and regarding client C's wound she sought treatment competency of the process for for on 7/26/18. reporting and investigating any incidents on client on client 2. Client C's record was reviewed on 2/21/19 at aggression. 12:10 PM. The review indicated the following: The Residential Manager, Area Supervisor, Nursing, QIDP and - Client C's WCCI from her 10/18/18 visit indicated trained investigators will Staff #1 accompanied her to the appointment. The complete re-training on the WCCI indicated the following: facility policies and procedures regarding their responsibilities "Weeks in treatment: 0." to ensure that all incidents as defined by the policy are "Wound: Left Gluteal fold." reported and investigated immediately. The QIDP is Investigations were reviewed on 2/20/19 at 2:30 responsible for initiating and PM. The review did not indicate an investigation completing initial investigation regarding client C's wound she sought treatment of client to client aggression.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z

ZRF511 Facility

Facility ID: 001022

If continuation sheet P

Page 70 of 167

03/26/2019

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE for on 10/18/18. The Quality Assurance Manager is responsible for 3. Bureau of Developmental Disabilities Services ensuring that these incidents of (BDDS) reports were reviewed on 2/20/19 at 2:30 allegations of abuse, neglect PM. The review indicated the following: and mistreatment are thoroughly investigated, and BDDS report dated 11/14/18 indicated, "[Client B] follow-up is completed within displayed aggressive behaviors after being the established timelines. redirected about using too much sugar at breakfast. [Client B] hit [client D] twice. [Client B] then went into the living room and hit [client F] in the head twice...". "Plan to Resolve: All individuals appear to be in good health. Staff will continue to follow [client B's] BSP (Behavior Support Plan). Staff will continue to monitor and report any changes to their health. A C2C (Client to Client) investigation will be initiated." Investigations were reviewed on 2/20/19 at 2:30 PM. The review did not indicate an investigation regarding clients B, D, and F's PA reported on 11/14/18. 4. BDDS report dated 11/20/18 indicated, "[Clients B and G] had an argument while doing the dishes. [Client B] hit [client G] with an open hand on her right arm... Staff observed a quarter sized red mark on [client G's] upper right arm. Nurse notified." "Plan to Resolve: All individuals appear to be in good health. Staff will continue to follow [client B's] BSP. Staff will continue to monitor and report any changes to their health. A C2C investigation will be initiated." Investigations were reviewed on 2/20/19 at 2:30 PM. The review did not indicate an investigation regarding clients B and G's PA reported on ZRF511 Event ID: Facility ID: 001022 Page 71 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G508       15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019			
	PROVIDER OR SUPPLIE L LIFE OF INDIAN		44	75 N 1	DDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREJ TA	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	UOUI D RE	СО	(X5) MPLETIC DATE
	<ul> <li>riding in the van, [client G] talking. at her".</li> <li>"Plan to Resolve: observed on [client to monitor and rep Staff will continue C2C investigations were PM. The review d regarding clients F 12/2/18.</li> <li>6. BDDS report da B and D] got into eating other peopl exhibited target be D] in the head twi twice. [Client B] the arm and hit [client C] the twice in the arm a</li> <li>"Plan to Resolve: good health. Staff B's] BSP Staff w report any change investigations were PM. The review d</li> </ul>	re reviewed on 2/20/19 at 2:30 id not indicate an investigation B and G's PA reported on ated 12/8/18 indicated, "[Clients an argument over [client B] e's food at dinner. [Client B] ehaviors of PA by hitting [client ce and then also in (sic) the arm hen hit [client E] twice in the hen walked into the living room twice in the arm and [client E] gain". All individuals appear to be in will continue to follow [client vill continue to monitor and s to their health. A C2C						
	7. BDDS report da	ated 12/10/18 indicated, "[Client						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	A. BUILD B. WING	DING	STRUCTION 00	CO 02	(X3) DATE SURVEY COMPLETED 02/26/2019	
	NAME OF PROVIDER OR SUPPLIER			475 N 1	DRESS, CITY, STATE, ZI 7TH ST IAUTE, IN 47805	P COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	PRE	D PROVIDER'S PLAN OF CORRECTIO EFIX (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROP AG DEFICIENCY)		N SHOULD BE	(X5) COMPLETIC DATE	
	would not be com	being informed her mother ing for a visit. [Client B] ] several times in the left arm".						
	good health. Staff B's] BSP Staff v	Both individuals appear to be in will continue to follow [client vill continue to monitor and s to their health. A C2C be initiated."						
	PM. The review d	re reviewed on 2/20/19 at 2:30 id not indicate an investigation A and B's PA reported on						
	staff asked [client upset and displaye physical aggression	ated 12/22/18 indicated, "When B] to take a shower, she became ed targeted behaviors of on. [Client B] hit [client E] and pack. Staff separated them and m".						
	apparent injuries. and report any cha	[Clients B and E] have no Staff will continue to monitor anges to their health. Staff will [client B's] BSP. A C2C be initiated."						
	PM. The review d	re reviewed on 2/20/19 at 2:30 id not indicate an investigation 3 and E's PA reported on						
	A] became upset of when trying to cal target behaviors of B] and knocking h yelling at her, and	ated 1/20/19 indicated, "[Client over the phone not working 1 her mother. [Client A] exhibited f PA be walking over to [client her coloring pages to the floor, then smacking her several times ht and left arms".						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE L LIFE OF INDIAN		4475	T ADDRESS, CITY, STATE, ZIP N 17TH ST RE HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	<ul> <li>good health. Staff</li> <li>A's] BSP. Staff wi</li> <li>any changes to the</li> <li>will be initiated."</li> <li>Investigations wer</li> <li>PM. The review d</li> <li>regarding clients A</li> <li>1/20/19.</li> <li>10. BDDS report of</li> <li>prior incident, [Cl</li> <li>other clients in the</li> <li>A] picked up a cup</li> <li>individual at the ta</li> <li>observed. [Client A]</li> <li>[Client A] threw th</li> <li>causing the TV to</li> <li>[Client A] calmed</li> <li>activity."</li> <li>"Plan to Resolve:</li> <li>health. Staff will of</li> <li>will continue to m</li> <li>to their health. A G</li> <li>initiated."</li> <li>Investigations wer</li> <li>PM. The review d</li> </ul>	Both individuals appear to be in will continue to follow [client Il continue to monitor and report in health. A C2C investigation er reviewed on 2/20/18 at 2:30 id not indicate an investigation A and B's PA reported on lated 2/4/19 indicated, "Without ient A] became (sic) yelling at bhome while at breakfast. [Client o and threw it toward another able. No damage or injury A] threw the fire extinguisher. he remote control at the TV break. Staff verbally redirected. down and resumed normal [Client A] appears to be in good continue to follow her BSP Staff onitor and report any changes C2C investigation will be				
	reported on 2/4/19 11. BDDS report of A] became upset a	and unnamed clients PA 2. dated 2/4/19 indicated, "[Client after [client B] yelled at her for the phone. [Clients A and B]				
	punched [client B]	vith on another [Client A]   in her right upper arm and n her right knee".				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST E HAUTE, IN 47805	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CO (FACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	good health. Staff A's] BSP Staff w report any changes investigation will l The Client to Clien (CCAI) dated 2/8/ between clients A CCAI was comple Disabilities Profes not indicate a plan or any recommend implement. The re CCAI was left blan 12. BDDS report of #7 and #6] were pl allegations of ANI Exploitation) for p "Plan to Resolve: I B) appear to be in has been initiated." IS dated 2/20/19 in interviewed for the Investigation did m G, and H were inter staff to client PA r Area Supervisor ( <i>A</i> 2/22/19 at 11:00 A of verbal and phys clients, and injurie investigation must future incidents. A	nt Aggression Investigation 19 investigated the incident and B reported on 2/4/19. The ted by Qualified Intellectual sional (QIDP) #1. The CCAI did to prevent future occurrences ations of safeguards to commendation section on the nk. lated 2/11/19 indicated, "[Staff aced off duty pending E (Abuse, Neglect, and hysical abuse." Both individuals (clients A and good health. An investigation					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G508	A. BUILD B. WING		02/2	PLETED 6/2019
	PROVIDER OR SUPPLIE		44	TREET ADDRESS, CITY, STATE, ZIP C 475 N 17TH ST ERRE HAUTE, IN 47805	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	II PRE TA	PROVIDER'S PLAN OF COR	IOULD BE	(X5) COMPLETION DATE
TAG W 0156 Bldg. 00	investigations. AS investigation inclu witnesses. AS #1 ii clients C, D, E, F, part of the investig 9-3-2(a) 483.420(d)(4) STAFF TREATM The results of all reported to the a representative or accordance with days of the incide Based on record re allegations of abus reviewed, the facili two investigations Aggression (VA) a towards clients A, within 5 business Findings include: The facility's BDE Disabilities Servic were reviewed on indicated the follo 1. Investigative Su indicated, "On 9/7 attending [day ser-	<ul> <li>#1 indicated a thorough des interviews with all potential ndicated she was unsure why G, and H were not interviewed as gation.</li> <li>ENT OF CLIENTS investigations must be dministrator or designated</li> <li>to other officials in State law within five working ent.</li> <li>eview and interview for 2 of 14 se, neglect, and mistreatment ity failed to report the results of of staff to client Verbal and Physical Aggression (PA) B, and E to the administrator days of the alleged events.</li> <li>DS (Bureau of Developmental es) reports and investigations 2/20/19 at 2:30 PM. The review</li> </ul>	W 0150		w of all ments and hered by trained l, and to the /her sonable st within ors will be sy to sions of ons. The ons will	03/28/201
	and yell and screar overnight on 9/6/1 [female name]. [A	a up in the middle of the night m at them. [Staff #2] worked the 8 and is the only name close to rea Supervisor (AS) #1] informed or (ED) #1]. An investigation was		manager to ensure the completed within five days. The QA departr begin tracking all initi incidents requiring investigation through	working nent will al	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE completion to ensure all are The review did not indicate a BDDS report completed within the specified regarding the alleged staff to clients B and E VA. timeframe. The agency has The IS indicated the investigation was completed implemented an electronic by Quality Assurance Manager (QAM) #1 on tracking systems and calendar 9/12/18. The IS did not indicate an administrator reminders to ensure the reviewed the results of the investigation regarding administrator is able to the alleged staff to client VA. implement corrective actions if the allegation is substantiated. 2. BDDS report dated 2/11/19 indicated, "[Staff #7 and #6] were placed off duty pending allegations of ANE (Abuse, Neglect, and Exploitation) for physical abuse." "Plan to Resolve: Both individuals (clients A and B) appear to be in good health. An investigation has been initiated." IS dated 2/20/19 indicated the following: - "Introduction: On 2/11/19, [staff #3] informed [AS #1] that she had been told by [staff #6] that [staff #6 and #7] held [client A] and allowed [client B] to hit her. [Staff #6 and #7] were placed off duty. [AS #1] informed [ED #1]. An investigation was initiated." - Home Manager (HM) #1 was interviewed for the investigation by Quality Assurance Coordinator (QAC) #1 on 2/14/19. The interview indicated, "[HM #1] stated that [staff #3] reported to her on 2/6/9 that [staff #6] had told her about the incident in question... [Staff #6] told [staff #3] she and [staff #7] held [client A] down on 2/3/19 and allowed [client B] to hit her. [HM #1] stated she then reported this to [AS #1] on 2/6/19." The BDDS report listed an incident date of 2/11/19, and administrative knowledge date of 2/11/19, and the BDDS report date of 2/11/19. The ZRF511 Event ID: Facility ID: 001022 Page 77 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	CONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		4475	et address, city, state, zip cod N 17TH ST RE HAUTE, IN 47805		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
W 0159 Bldg. 00	administrative know The Peer Review ( reviewed the findin report. Area Supervisor ( <i>A</i> 2/22/19 at 11:00 A investigations shote business days of the indicated she was to not completed in the 9-3-2(a) 483.430(a) QIDP Each client's active be integrated, co a qualified intelle Based on observate interview for 2 of 2 QIDP (Qualified In Professional) failed professional service identified behavior client C's need for failed to implement Plan (BSP) in regate Health Risk Plan ( diagnosed pressured Findings include: 1. The QIDP failed	cident date was 2/3/19, and the wledge date was 2/6/19. PR) dated 2/21/19 indicated it has from the 2/11/19 BDDS AS) #1 was interviewed on M. AS #1 indicated all hd be completed within five he alleged event. AS #1 unsure why the reviews were he required five business days. we treatment program must ordinated and monitored by ctual disability professional. ion, record review and B sample clients (A and C), the htellectual Disabilities d to ensure client A had es to address client A's al needs, failed to address an accurate pain assessment, it client A's Behavior Support rds to door alarms, and client C's HRP) for repositioning after a e ulcer.	W 0159	Agency contracts with Sprin Health Behavioral Health an Integrated Care to provide professional behavioral management services to client's identified as needin additional and professional behavioral management services. Client A is enrolled with Spri Health Behavioral Health an Integrated Care as of 9.10.1 and has a Behavior Management Specialist, wh sees her routinely and has developed a Behavior Supp Plan implemented on 10.27. and updated on 1.4.19. All QIDP's and Area	g ring id 8 ich ort	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2. The QIDP failed to address client C's need for Supervisors will be educated an accurate pain assessment. Please see W210. on our contract with this professional behavioral 3. The QIDP failed to implement client A's BSP in management company and regards to door alarms, and client C's HRP for how to implement their repositioning after a diagnosed pressure ulcer. services for any individual Please see W249. requiring additional and professional behavioral This federal tag relates to complaint #IN00286338. management services. The Program Manager will ensure 9-3-3(a) professional services are considered by the IDT and obtained as needed based on analysis of documentation, incident reports, support plans, referral packets and voiced concerns. The Area Supervisor, QIDP, **Residential Manager and Staff** will be re-trained on client A's BSP. To ensure training is effective the administrative team will complete observations in the home, staff will complete competency-based training, and QA/Program Staff will review home documentation and incident reports to ensure policies and procedures were followed. Health Services Director will train the Facility Nurse on Nursing Assessments, and when to do them. Health Services will train all staff on Pain Assessments, when to do them and when to call the nurse. Health Services Director will ZRF511 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 001022 Page 79 of 167 If continuation sheet

03/26/2019

	MEDICARE & MEDI		(X2) MULTIPLE C			B NO. 0938-03
	r OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019	
	ROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP COD N 17TH ST E HAUTE, IN 47805	•	
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				audit each clients chart at le	ast	
				quarterly to ensure ongoing HRP adherence, appropriate		
				completion of Pain Assessments, and Meeting of Clients' Medical Needs.	of	
				The facility has policies and procedures in place to train		
				employees who work with clients on skills and		
				competencies directed towa clients' health needs and	rds	
				programming objectives. The Area Supervisor will be retrained on ensuring all sta	ff	
				are thoroughly consumer specific trained to include th		
				health needs, ISP, BSP, objectives, and HRC approve	ed	
				Rights Restrictions. All staff will be retrained on	the	
				implementation and monitoring of door alarms ir the home.	ı	
				All staff will receive competency-based consume	er	
				specific training to include their health needs, HRP, ISP		
				BSP and objectives. All clients have the potential be affected by this deficienc		
				Consumer specific training a reviewing client needs rema	and	
				a prominent component of the agencies all staff monthly montings	he	
				meetings. Administrative observations have been implemented in th		
				home daily, seven days a we and will remain in place unti	ek	

	R MEDICARE & MEDIO		-			MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE C A. BUILDING B. WING	00	COME	e survey pleted 5/2019
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP COD N 17TH ST E HAUTE, IN 47805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
				the team determines it is appropriate to decrease the number of observations. will ensure all corrections implemented per ResCare policy and regulations. Ongoing weekly and monto observations and review of continue with the QIDP and Area Supervisor over the location.	This are thly will	
W 0164 Bldg. 00	Each client must program services active treatment f client's individual Based on record re sampled clients (A client A had profes client A's identified Findings include: Client A's record w PM. - Client A's record w PM. - Client A's Order (ONCNT) was dat corporation]. The 0 two occasions, [cli toy doll in school a A] too (sic) tried to #10 in order to ent On Monday, 9/10/ playground, went of the arm and did no to break free." The	PROGRAM SERVICES receive the professional meeded to implement the program defined by each program plan. view and interview for 1 of 3 ), the facility failed to ensure ssional services to address d behavioral needs. vas reviewed on 2/20/19 at 1:20 of No Contact and No Trespass ed 9/12/18 from [school DNCNT indicated, "On at least ent A] has tried to enroll her at [elementary school]. [Client o enter the school through door er the family daycare program. 18, (client A) entered the school up to a student, grabbed her by t let go. The student was able ONCNT indicated client A was ess to all [school corporation]	W 0164	Agency contracts with Sp Health Behavioral Health a Integrated Care to provide professional behavioral management services to client's identified as need additional and profession behavioral management services. Client A is enrolled with S Health Behavioral Health a Integrated Care as of 9.10 and has a Behavior Management Specialist, w sees her routinely and has developed a behavior sup plan implemented on 10.2 and updated on 1.4.19. All QIDP's and Area Supervis will be educated on our contract with this profess behavioral management	and and al pring and .18 which s port 7.18 cors	03/28/2019

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI		00	, í	PLETED
	of condensit	15G508	B. WIN				6/2019
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
JAME OF	PROVIDER OR SUPPLIE	R			17TH ST		
NORMA	L LIFE OF INDIAN	A		TERRE	E HAUTE, IN 47805		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	Ň	(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	property.				company and how to		
					implement their services for	or	
	- Client A's Behav	ior Baseline Tracking (BBT)			any individual requiring		
	dated 9/4/18 indica	ated, "Not listening, throwing			additional and professiona	ıl	
	chairs, cussing, thr				behavioral management		
	, ,	C			services. The Program		
	- Client A's BBT d	ated 9/6/18 indicated, "Not			Manager will ensure		
		o run away. Crying. Yelling.			professional services are		
		Hitting staff. She was put in a hold (physical			considered by the IDT and		
	-	restraint by staff)."			obtained as needed based		
					analysis of documentation	•••	
	- Client A's BBT d	ated 9/7/18 indicated, "[Client			incident reports, support p		
		ned client) came in the building			referral packets and voice		
		open hand slapped peer. Had			concerns.	u	
	to be put in hold."	j open nand stapped peer. Had					
	to be put in noid.				The Area Supervisor, QIDF		
					Residential Manager and S		
		ated 9/14/18 indicated, "started			will be re-trained on client	A′S	
		her dolls. Flipping everyone off.			BSP.		
	Screaming '[Exple	tive] ResCare'."			To ensure training is effec		
					the administrative team wi		
		S (Bureau of Developmental			complete observations in t	the	
		es) reports and investigations			home, staff will complete		
		2/20/19 at 2:30 PM. The review			competency-based training	g,	
	indicated the follow	wing:			and QA/Program Staff will		
					review home documentation		
	· ·	ted 9/17/18 indicated, "During a			and incident reports to ens		
	-	] through (sic) a fire			policies and procedures w	ere	
	• ·	ient at Former Home (CFH)] as			followed.		
		h the kitchen. Staff intervened			Administrative observation	าร	
	-	ent A]. Staff removed the fire			have been implemented in	the	
	extinguisher from	the area and put it in the office			home daily, seven days a v	week	
	Staff observed a tw	vo inch black and blue bruise			and will remain in place ur	ntil	
	on her (CFH's) right	ht side (on her upper thigh).			the team determines it is		
	Nurse notified."				appropriate to decrease th	е	
					number of observations.		
	2. BDDS report da	ted 9/18/18 indicated, "[Client			will ensure all corrections		
	· ·	ted behaviors of PA (Physical			implemented per ResCare	-	
		nt A and CFH] were arguing,			policy and regulations.		
		yelling to [client A] inside the			Ongoing weekly and mont	hlv	
		rabbed the fire extinguisher and			observations and review w	-	
		raceou and the examplified and					

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	MEDICARE & MEDIC OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	r í	UILDING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 02/26/2019	
	OVIDER OR SUPPLIEF			4475 N	ADDRESS, CITY, STATE, ZIP C 17TH ST E HAUTE, IN 47805	OD		
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	attempted to throw preventing contact. arrived and separate informed the police charges. The police transported [client A was arrested for Ba and kicking the win notified. On 9/18/18 court and will be he 9/20/18." "Plan to Resolve: [C health. No apparent [CFH or client A]. I communication wit updates are (sic) ob medications to the j there. Behavior man contracted to assist (Behavior Support 1	LSC IDENTIFYING INFORMATION         it at [CFH]. Staff intervened         911 was contacted. The police         ed [client A and CFH]. [CFH]         that she wanted to press         handcuffed, arrested, and         A] to [county jail]. [Client A]         ttery resulting in bodily injury         dows in the police car. Nurse         8 at 8:30 AM, [client A] had         ed until her next court date on         CFH] appears to be in good         injuries were observed on         ResCare will remain in         h [county jail] and provide         tained. Staff provided her         ail to provide during her time         hagement services have been         with [client A's] BSP         Plan) and targeted behaviors.		TAG	continue with the QID Area Supervisor over location.		DATE	
Behavior C 9/18/18 inc A's BSP or developing targeted bel 3. BDDS re A] was rele recognizand psychiatric Staff transp evaluation. (Emergency referral to a	Client A's record re Behavior Consultar 9/18/18 incident to A's BSP or provide developing staff int targeted behavior no 3. BDDS report dat A] was released fro recognizance and w psychiatric evaluati Staff transported he evaluation. He then (Emergency Room) referral to an inpation	view did not indicate a tt (BC) was contacted after the provide assistance with client consultation regarding erventions for client A's						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	CONSTRUCTION 00	COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI		4475	T ADDRESS, CITY, STATE, ZIP N 17TH ST RE HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROFIDENCE PROVIDENCE PROVIDENCE PROFILE OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION CONTRACTOR OF CONTRACT OF CONTRACT.		(X5) COMPLETIC DATE
	scheduled appoint increase Abilify (a (Milligrams) to 15 (seizures) from 50 with [psychiatrist] "Plan to Resolve: health and no app ResCare will rema A's] mother while working with BDI home. Staff will c her health." - Client A's Interd dated 12/3/18 indi the transition from group home]. The elopement, inappr physical aggressio steps with [client questioned (IDT r dolls and team ren her mom's house be successful in h - Client A's BBT of A] threw glass at Smashed items. P herself. Threw a f away. Flipped off [expletives]' multi - Client A's Medio 12/13/18 indicated for a follow up vis	[Client A] appears to be in good arent injuries were observed. ain in communication with [client she is visiting. ResCare is DS to transition her to another ontinue to report any changes to isciplinary Team (IDT) meeting cated the meeting was called for a [group home #1] to [current IDT indicated, "BSP for opriate social behaviors, and on Reviewed all escalating A] if she gets upset [Client A] nembers) about having baby ninded her that her dolls are at . She (client A) is determined to				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE - Client A's MCR dated 1/3/19 indicated client A had seen [therapist] for a follow up visit. The MCR indicated, "[Client A] is now settled into a group home. She is managing negative behaviors appropriately. She can recall the behavior plan as designed and reports following it. Follow up 4-5 weeks. Begin discussion of termination (of visiting therapist) if no new issues arise and she continues with behavior management." The MCR listed a follow up appointment on 1/31/19. - Client A's IDT meeting dated 1/4/19 indicated the reason for the meeting was the thirty day follow up to client A's transition to the new group home. The IDT indicated, "[Client A] walks away instead of having behaviors. She has only had one behavior (since moving into the the new home)... BSPs all remain appropriate." - Client A's BBT dated 1/7/19 at 1:10 PM indicated, "[Client A] is hitting her head off (sic) the wall. She is upset because she wants a baby doll and mom is yelling at her on the phone." Incident Report (IR) dated 1/7/19 at 1:10 PM. The IR elaborated on the BBT for the same time period. The IR indicated, "She (client A) keeps hitting her head off the wall. I asked her three times to stop. Also, I tried to get her to go get her coloring book and color. She yelled and said, 'no.' So I called [Qualified Intellectual Disabilities Professional (QIDP) #2]... was told to follow her behavior plan...". - Client A's BBT dated 1/7/19 at 2:45 PM indicated. "Elopement. Went to end of driveway. I redirected her. Attempting to runaway. Upset because she wants a baby doll and she is not allowed." - Client A's BBT dated 1/8/19 indicated, "Kicking ZRF511 Facility ID: 001022 Page 85 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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03/26/2019

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
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1/10	van seat. Agitatin		1110			DATE
	indicated, "Screar keeps saying she to staff. She broke	dated 1/15/19 at 1:30 PM ning and making gestures. She hates it here and calling names e stuff on the kitchen wall too. bugh the house hitting stuff and o be redirected"				
	indicated, "Taunti	dated 1/15/19 at 4:00 PM ng another housemate whom was already in a bad				
	indicated, "Stealin client) room and n Getting a doll out	dated 1/15/19 at 9:30 PM ng. Going into others (unnamed refusing to return property. of others rooms. (Staff) Tried ction. Didn't work."				
	Upset, stomping,	dated 1/17/19 indicated, "All day. and throwing things, Keeps s. Elopement. Tried to leave the mission."				
	indicated, "[Clien clients. Refused to	dated 1/20/19 at 11:00 AM t A] was cussing at staff and b listen. Smacked [client B]. nt B's) stuff to the ground."				
	indicated, "[Clien	dated 1/20/19 at 2:30 PM t A] threw a fire extinguisher Then threw a snowball at staff."				
	the BBT for the sa indicated, "She (c behaviors She ga throw fire extingu	at 2:00 PM. The IR elaborated on ame time period. The IR lient A) was having bad ot very angry and began to ishers, and one of them nearly n the head We (staff #8 and #7)				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE tried to do a restraint and deescalate the situation, but she (client A) kept wiggling out and was too strong to put in the two person hold. We got several clients in the office because she grabbed a knife after she broke out of the restraint and began to walk towards us. She (client A) pulled every fire alarm and broke the one in the kitchen after [staff #7] and I (staff #8) got the knives locked up.. She then took a fire extinguisher and bashed it against the door of the office and busted a hole in the door. She kept hitting and knocking things over until [Home Manager (HM) #1] got here. She (client A) packed her bags and then soon after left with [QIDP #2]. We (Staff #7 and #8) were told to clean up...". 4. BDDS report dated 1/20/19 outlined the events from the IR dated 1/20/19 at 2:00 PM the BDDS report also indicated, "[Client A] was escorted from the residence for a home visit with her mother." "Plan to Resolve: [Client A] appears to be in good health. All broken items were cleaned and removed from the home ... There are no current health of safety issues in the home... Staff will continue to follow [client A's] BSP. Staff will continue to monitor and report any changes to her health." - Client A's MCR dated 1/31/19 indicated client A had seen [therapist] for a follow up visit. The MCR indicated, "Discussed angry behaviors and reviewed plan for better decisions. [Client A] could recall the plan, four steps, without prompt today and agrees to set the goal of no angry episodes of acting out between now and the next visit in four weeks." The MCR listed the follow up visit as 2/28/19. ZRF511 Event ID: Facility ID: 001022 Page 87 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

PRINTED:

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 5. BDDS report dated 2/4/19 indicated, "(On 2/3/19 at 4:35 PM) [Client A] was upset over not wanting to live in a group home. [Client A] exited the home and began walking to the stop sign at the end of the road. Staff followed and verbally redirected her to return inside the home, but [client A] refused. HM and QIDP notified. [Client A] was taken by a good samaritan driver to a local fire station. Staff arrived and transported home. [Client A] was out line of sight for approximately 45 minutes. Upon returning home, [client A] had continued behaviors. She threw fire extinguishers and knocked pictures off of the wall... [Client A] then called 911. [City] police arrived, spoke with [client A], and left without incident. [Client A] again left the home and walked into the yard after police left. HM followed and was able to verbally redirect to return inside the home. [Client A] was not out of line of sight while in the front yard. [Client A] calmed down and resumed normal activity." "Plan to Resolve: [Client A] appears to be in good health. Staff will continue to follow her BSP. [Client A] does not currently have any alone time allotted in her plan. Staff will continue to monitor and report any changes to her health. IR dated 2/3/19 at 5:30 PM indicated, "[Client B] yelled at [HM #1] when she went outside to talk on the phone. [Client A] told [client B] to shut up and flipped her off. They called each other names and started getting close to one another. [Staff #6] got between them. [Client A] hit [staff #6] then hit [client B] with a closed fist in her right upper arm and also kicked her in her right knee. [HM #1] came back in and calmed them down and [client A] went to her room." - Client A's BBT dated 2/3/19 at 6:15 PM indicated, ZRF511 Facility ID: 001022 Page 88 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE "Kept yelling at peer to shut up. She wants to leave and no one would come get her. She hit the door with her fist crying." IR dated 2/3/19 at 7:30 PM indicated, "[Client A] kept running from door to door to try and leave. She started kicking and elbowing [staff #6]. [Staff #6 and #7] put her in a two man standing restraint for 3 seconds and let her go. [Client B] got in her (client A's) face and tried spitting on her She (client A) tried coming after her (client B) again and was put in another two man standing restraint for 5 seconds. They let her go and (client A) sat outside with manager (HM #1) at 8:30 PM." - Client A's BBT dated 2/3/19 at 8:00 PM indicated, "She (client A) called the cops and they came to the house to talk to her. She threatened peer (unnamed client) and threw a fire extinguisher. She kept pulling the fire alarms. She knocked the bulletin board off the wall in the hallway. She tried running away again, but staff followed her." - Client A's BBT dated 2/4/19 at 7:00 AM indicated, "(Client A) yelled and flipped off [client B]. Tried going after her. Threw remotes, phone, and fire extinguisher ... ". 6. BDDS dated 2/5/19 indicated, (On 2/4/19 at 6:00 PM) Without prior incident, [client A] exhibited targeted behaviors of physical aggression by slapping staff in the face. [Client A] walked through the home knocking over several pieces of furniture and the (stand up) freezer in the home. [Client A] broke a table and threw the top of the table at the staff office door repeatedly. [Client A] then grabbed craft paint and poured paint over the office door, a TV stand, and a laundry basket of clothes. Staff attempted to put [client A] in an agency approved two person standing hold, but

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZRF511 Facility ID: 001022

If continuation sheet

Page 89 of 167

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE were not successful due to level of [client A's] physical aggression. HM and nurse notified. Staff transported to [hospital ER] for evaluation. [Client A] was admitted to [hospital] on 2/4/19 for observation pending transfer to psychiatric hospital. [Client A] was transferred and admitted to Neuropsychiatric hospital of [city] on 2/5/19." "Plan to Resolve: ResCare will remain in contact with Neuropsychiatric hospital of [city] pending discharge. Broken items have been cleaned and removed from the home. Maintenance request submitted for repairs. There are no current health or safety issues in the home." - Client A's Emergency Medicine Physician Progress Note (EMPPN) dated 2/4/19 at 8:02 PM in the hospital ER. The EMPPN indicated the following: "Arrival: 2/4/19 at 7:41 PM." "Arrival mode: Police." "[Client A] presents to the ED (Emergency Department) via [police department] with complaint of homicidal ideation onset prior to arrival. Patient states she doesn't want to be in her group home and want to harm the other clients at the group home and staff. She reports hitting people, throwing paint on the walls, and knocking over the freezer...". - Client A's ED Psychiatric Evaluation (EDPE) dated 2/4/19 at 10:58 PM. The EDPE indicated the following: "Presenting problem: Tonight, patient (client A) became angry, hit her group home staff, threatened to kill staff and other residents... ZRF511 Event ID: Facility ID: 001022 Page 90 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

PRINTED:

03/26/2019

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/	te survey Mpleted 26/2019		
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	home because the said that patient's over the past two order is being obt her safety, and the cooperation with "Social and Famil lived at her curren 30, 2018. Prior to another ResCare ; other group home got into a fight wi jailed for 3 days f currently on prob - Client A's Appli (AED) dated 2/4/ "Applicant (docton named (client A) because patient sl group home. Three damaged a TV. P- "Applicant (docton person named (cli immediately the p judgement is imp - Client A's Neuro Physical (NHHP) following: "Indication for add behavior and phy-	hy History: Patient (client A) has nt group home since November this placement, patient lived in group home since 2016. At the placement, patient (client A) ith another resident and was for that offense. Patient is ation for that assault". ccation for Emergency Detention 19 indicated the following: or in ER) believes that the person above is dangerous to others apped staff members from the two items around home and atient wanting to harm others." or in ER) believes that if the tent A) above is not restrained berson will harm others. patient aired." opsychiatric Hospital History and dated 2/5/19 indicated the mission: Increased aggressive sical and verbal abuses to other ents."						
	"History of presen	nt illness: The patient (client A)						

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508		LDING IG	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/26/2019	
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	<ul> <li>is a [age] year old home Patient had threats to other rest threatened to kill threatsPatient had behaviors, very un</li> <li>Client A's Neuro Evaluation (NHPE following:</li> <li>"Patient (client A) behaviorsWhen because, 'They may any specific reason has a history of ve and destruction of admits to being an She states staff way and she claims she she does not want and she seems orice assaultive ideas to Patient (client A) I danger to others, b aggression She ( control".</li> <li>"Estimated length</li> <li>Client A's Neuro Instructions (NHD The NHDI indicate Psychotic disorder</li> <li>Client A's Individ 1/4/19 indicated the</li> </ul>	female resident of a group d repeatedly made statements of idents and staff whom she Patient denies all these s been experiencing escalating ruly and difficult to redirect". psychiatric Hospital Psychiatric c) dated 2/5/19 indicated the admits to having I ask her why, she said ke me angry,' but could not give ns Patient (client A) clearly rbal and physical aggression property She (client A) gry at staff at the group home. s calling her derogatory names, was being bullied. She says to return to that group home, ented She admits to having wards staff at the group home has been assessed to be a ased on her physical client A) lacks impulse of stay: One to two weeks." psychiatric Hospital Discharge I) dated 2/19/19 at 11:00 AM. ed, "Diagnosis: Impulse control Bipolar".					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

VAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	4475 N	ADDRESS, CITY, STATE, ZIP COD 17TH ST		(X3) DATE SURVEY COMPLETED 02/26/2019	
		E HAUTE, IN 47805			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
<ul> <li>"[Client A] is able to verbalize her needs, wants, and rights. [Client A] needs very little help with her ADLs (Activities of Daily Living) [Client A] is part of the PAIR (Psychiatric Assertive Identification and Referral program) and is on probation for a year due to an incident at her previous home."</li> <li>Client A's Behavior Support Plan (BSP) dated 1/4/19 indicated plans for elopement, inappropriate social behavior, and physical aggression. The BSP did not indicate a BC was consulted regarding the development of client A's BSP.</li> <li>Staff #2 was interviewed on 2/21/19 at 8:55 AM. Staff #2 indicated client A has verbally and physically aggressive behaviors and property destruction. Staff #2 stated, "No other client in the home has behaviors like hers." Staff verbally prompt her to stop, go to her room and calm down. Staff #2 indicated she doesn't believe staff have enough strategies to cope with client A's behaviors. Staff #2 indicated she doesn't believe staff have enough strategies to cope with client A's behaviors. No one is doing anything about it though. We haven't been given anything else to use when she has these huge behaviors."</li> <li>Staff #3 was interviewed on 2/21/19 at 8:17 AM. Staff #3 stated, "The other client a," Staff #3 indicated when client A has a behavior staff</li> </ul>					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE listen to music. Staff #3 stated, "I don't think any of that works though. She keeps having behaviors if she wants to." Staff #3 stated, "I wish we had more strategies to use that worked with her. [HM #1, QIDP #1, and AS #1] haven't given us anything else to try with her that isn't in her BSP." Staff #3 stated, "Whenever [client A] has a behavior and we call a manager, they just tell us to follow her BSP. I think we need more than that." Staff #1 was interviewed on 2/20/19 at 5:16 PM. Staff #1 indicated client A's behaviors are primarily physical. Staff #1 stated, "She is awful. She tore up the house earlier this month. We (staff) try and deal with her behaviors, but it's tough. Sometimes the strategies work, but most of the time they don't." Staff #1 indicated HM #1 has told her to follow client A's BSP and to try and redirect client A. Staff #1 stated, "I just don't think we have enough interventions to try and help her when she has a behavior." HM #1 was interviewed on 2/20/19 at 5:06 PM. HM #1 indicated client A has physical aggression, verbal aggression, and property destruction as identified behaviors. HM #1 stated, "I just don't know if the staff can deal with her. One behavior she (client A) had took three staff members to try and restrain her. We couldn't do it. She's too strong." HM #1 indicated the strategies provided in her BSP are ineffective. HM #1 stated, "The strategies just don't work. She (client A) is impulsive and aggressive. If she wants to have a behavior, we just can't calm her down." HM #1 stated, "I wish I had more to help my staff deal with her (client A). But, nothing's been given to me to share with them to try." HM #1 stated, "[Client A's] therapist created a four step plan to help [client A] cope with behaviors." HM #1 indicated step one: walk away, step two: go to ZRF511 Facility ID: 001022 Page 94 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

PRINTED:

03/26/2019

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019			
	PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805					
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	four: call HM #1. has been trained of it because I attend with her."	AS) #1 was interviewed on						
	2/22/19 at 11:00 a history of verba aggression, and p stated, "Her behaviored by the stated of the stated of the stated of the stated of the state o	AM. AS #1 indicated client A has l aggression, physical roperty destruction. AS #1 viors are a lot more intense than #1 indicated client A's BSP was						
	AS #1 stated, "It's client A had at [p #1 stated she was	DP #2 and revised by QIDP #2. s pretty much the same BSP that rior group home address]." AS unaware of what client A's four who created it. AS #1 stated,						
	assist with having behavior, it shoul staff should be tra "We have been in	erapist made a four step plan to [client A] deescalate during a d be included in her BSP and lined on using it." AS #1 stated, contact with a BC to assist with t A's] BSP. She came here last						
	week and intervie I don't know whe develop a BSP fo don't know why s September 2018 a	wed some of us about [client A]. n she'll meet with [client A] or r her needs." AS #1 stated, "I he wasn't contacted back in as referenced in the BDDS report.						
		he BC) to get involved then."						
	9-3-3(a)							
V 0186	483.430(d)(1-2) DIRECT CARE	STAFF						
Bldg. 00	The facility must staff to manage	provide sufficient direct care and supervise clients in their individual program						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		00	(X3) DATE SURVEY COMPLETED 02/26/2019		
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	<ul> <li>on-duty staff cald 24-hour period for living unit.</li> <li>Based on observati interview for 3 of plus 5 additional of facility failed to en and H had sufficie supervise their neof Findings include:</li> <li>Observations were to 9:14 AM.</li> <li>Upon arrival, cli- Client E stated, "S [client F]. Come of the living room with was the only staff arrival and she was client F with her s A, B, C, and H we stated, "I don't knos supposed to be here</li> <li>At 7:03 AM, cli her hospital bed with laying on her back She did not have a laying in her bowe movement was pro- ankles, and had sp the sheet she was</li> </ul>	e done on 2/22/19 from 7:00 AM ent E answered the front door. Staff is in the bathroom with on in." Clients D, E, and G were in ithout any staff present. Staff #2 working in the home upon is in the bathroom assisting hower. At the same time, clients ere in their bedrooms. Staff #2 bw where [staff #3] is. She was re at 6:00 AM." ent C was awake and laying in rith an air mattress. Client C was t, with a pillow under each hip. In adult brief on. Client C was el movement. The bowel esent from her mid back to her read the width of her body on laying on. The protective pad is saturated, and had soaked	W	0186	The facility will provide sufficient staff to manage and supervise clients in accordant 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 th home. The Area Supervisor and/or Residential Manager is responsible for ensuring that there is sufficient staff in the home always. The Area Supervisor is responsible to review and approve the staffing schedule weekly to ensure that adequate staffs a assigned. The staffing sched has been reviewed for the home and the Area Superviso will monitor that adequate sta are assigned daily. Area Supervisor will train Residential Manager on Job Responsibilities, and ensurin adequate staffing in the home Administrative observations have been implemented in the home daily, seven days a wea and will remain in place until the team determines it is appropriate to decrease the number of observations. This	re e ule or aff 9 e. e	03/28/201	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE - At 7:05 AM, staff #3 arrived for her shift. Staff #3 will ensure all corrections are stated to staff #2, "Sorry I'm late." Staff #3 then implemented per ResCare went to the office to put her personal items away. policy and regulations. Ongoing weekly and monthly - At 7:24 AM, staff #2 and #3 were present in observations and review will client C's room assisting with the cleaning of continue with the QIDP and client C after her bowel movement. At the same Area Supervisor over the time, clients A, B, D, E, F, G, and H were in the location. common areas of the home without staff supervision until 7:39 AM. At 7:39 AM, staff #2 said to staff #3, "She's pretty much done. Are you ok if I leave and go start breakfast?" Staff #2 then left the room. Staff #2 was interviewed on 2/21/19 at 8:55 AM. Staff #2 indicated there was often only one staff member on the night shift. Staff #2 stated, "We need more staff to care for the clients." Staff #2 indicated she's been working her shift by herself the last three nights. Staff #2 stated, "One of our overnights quit. They haven't found coverage for him. It makes it really hard. I've had to do a lot of things not exactly the way I was taught to do them because there isn't a second staff member in the house." Staff #2 indicated she was completing showers by herself in the morning when another staff member was not present. Staff #3 was interviewed on 2/21/19 at 8:17 AM. Staff #3 stated, "We're working short staffed right now. We had one quit that worked overnights." Staff #3 stated, "We should have two staff on overnights. [Staff #2] has been working by herself until I come in at 6:00 AM." Staff #1 was interviewed on 2/20/19 at 5:16 PM. Staff #1 stated, "My shift is staffed sufficiently, but I know other shifts are not. We really need three staff members here when the clients are awake." Staff #1 stated, "With three clients in ZRF511 Event ID: Facility ID: 001022 Page 97 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE wheelchairs, another client on five minute location tracking, and [client C] on timed repositioning it's really difficult to care for the clients appropriately if there isn't enough staff in the home." HM (Home Manager) #1 was interviewed on 2/20/19 at 5:06 PM. HM #1 indicated there are four open positions in the home. HM #1 stated, "We're short on staff. We should have two on overnights, one in the mornings to help, and two or three in the evenings." HM #1 indicated she had not heard staff complain about not having sufficient staff in the home. Staff Schedule (SS) from the home dated Week 1 was reviewed on 2/21/19 at 2:00 PM. SS indicated the following: - On Saturday, one staff (staff #4) worked from 11:00 PM to 8:00 AM. She was the only staff member present in the home caring for clients A, B, C, D, E, F, G, and H during this time frame. - On Sunday, one staff (staff #4) worked from 11:00 PM to 8:00 AM. She was the only staff member present in the home caring for clients A, B, C, D, E, F, G, and H during this time frame. - On Tuesday, one staff (staff #2) worked from 11:30 PM to 6:00 AM. She was the only staff member present in the home caring for clients A, B, C, D, E, F, G, and H during this time frame. - On Wednesday, one staff (staff #2) worked from 11:30 PM to 6:00 AM. She was the only staff member present in the home caring for clients A, B, C, D, E, F, G, and H during this time frame. - On Thursday, one staff (staff #2) worked from 11:30 PM to 6:00 AM. She was the only staff ZRF511

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 001022

If continuation sheet

Page 98 of 167

03/26/2019

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLII		4475	f address, city, state, zip cod N 17TH ST E HAUTE, IN 47805	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION member present in the home caring for clients A,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	PM to 6:00 AM. S present in the hom E, F, G, and H du AS (Area Supervi 2/22/19 at 11:00 A not have enough s D, E, F, G, and H open staffing posi indicated she was voicing concern o stated, "I know we member on night have one. The clie need."	taff (staff #4) worked from 11:00 She was the only staff member he caring for clients A, B, C, D, ring this time frame. sor) #1 was interviewed on AM. AS #1 indicated she does taff to care for clients A, B, C, AS #1 indicated she has four tions at this time. AS #1 unaware of staff in the home ver being short staffed. AS #1 e need more than one staff shift at a time. It's not safe to just ents don't get the care they elates to complaint #IN00286338.			
W 0189 Bldg. 00	initial and contin employee to per effectively, efficie Based on observar interview for 2 of facility failed to e competency in tra Flow Chart (SFC) Five Minute Chec staff completed cl Form (RTF), and	provide each employee with uing training that enables the form his or her duties ently, and competently. tion, record review, and 3 sample clients (A and C), the nsure staff demonstrated cking clients A and C's Sleep , client A's Location Tracking ks (LTFMC), failed to ensure ient C's Reposition Tracking failed to ensure staff in the home rding clients A and C prior to	W 0189	The facility has policies and procedures in place to train employees who work with clients on skills and competencies directed towa clients' health needs and programming objectives. The Area Supervisor will be retrained on ensuring all sta are thoroughly consumer	rds

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE C A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE	
	<ul> <li>Findings include:</li> <li>1. Client A's recording the revional structure</li> <li>Client A's Sleep F</li> <li>2018 indicated the structure</li> <li>"During all sleep visual bed check in the individual is and the individual is awak corresponding box individual is not phospitalization, dracorresponding box 'Hospital' or 'LOA your initials."</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> <li>The SFC dated 1 was completed for frames. The boxes</li> </ul>	d was reviewed on 2/20/19 at ew indicated the following: low Chart (SFC) dated December following: hours, staff will conduct a o less than every two hours. If eeping, place an 'S' in the t, along with your initials. If the e, place an 'A' in the t, along with your initials. If the resent due to leave or aw a line thru (sic) the tes for that date and indicate (Leave of Absence)' along with 2/11/18 did not indicate the SFC the 9:00 PM and 10:00 PM time were blank. 2/12/18 did not indicate the SFC the 9:00 PM and 10:00 PM time were blank. 2/18/18 did not indicate the SFC the 9:00 PM and 10:00 PM time were blank. 2/19/18 did not indicate the SFC the 9:00 PM and 10:00 PM time were blank. 2/19/18 did not indicate the SFC the 9:00 PM and 10:00 PM time were blank.		specific trained to ind health needs, ISP, BS objectives, and HRC Rights Restrictions. All staff will receive competency-based c specific training to in their health needs, HI BSP and objectives. All clients have the p be affected by this de Consumer specific tr reviewing client need a prominent compon agencies all staff mor meetings. The Area Supervisor home observations w ensure staff are imple the plans of clients a client's needs are be Administrative obser have been implement home daily, seven da and will remain in pla the team determines appropriate to decrea number of observation will ensure all correct implemented per Res policy and regulation Ongoing weekly and observations and rev continue with the QIE Area Supervisor over location.	SP, approved onsumer aclude RP, ISP, ootential to eficiency. raining and ds remains ent of the nthly will do veekly to ementing nd the ing met. rvations ted in the ase the ons. This tions are sCare is. monthly View will DP and	DATE	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING		Cor 02/	(X3) DATE SURVEY COMPLETED 02/26/2019	
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	visual bed check r the individual is sl corresponding box individual is awak corresponding box individual is not p hospitalization, dr corresponding box	b hours, staff will conduct a to less than every two hours. If deeping, place an 'S' in the a, along with your initials. If the e, place an 'A' in the a, along with your initials. If the resent due to leave or aw a line thru (sic) the tess for that date and indicate (Leave of Absence)' along with					
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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZID, C		(X3) DATE SURVEY COMPLETED 02/26/2019			
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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

NAME OF PR	F CORRECTION	IDENTIFICATION NUMBER 15G508	A. BUILDI B. WING	ING	00		APLETED	
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	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)	FROFRIATE	DATE	
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		he 9:00 PM and 10:00 PM time						
	frames. The boxes v							
	Area Supervisor (A)	2) #1 was interviewed on						
	· ·	S) #1 was interviewed on						
		A. AS #1 indicated clients A						
		be filled out as indicated. AS						
		is left blank, it is unsure if the						
	-	eted the required bed checks."						
		entire form should be						
		should not be blank areas on						
	the form.							
	2. Observations wer	e done at the home on $2/20/19$						
		35 PM. Staff #1, Staff #5, and						
		(1) #1 were supervising client						
		ation. At 5:16 PM, client A's						
		binder on the shelf in the						
	office.	since on the shell in the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Staff #2 was interviewed on 2/21/19 at 8:55 AM. Staff #2 indicated client A was on five minute location tracking. Staff #2 stated, "I know I'm supposed to fill out a tracking sheet every five minutes. It's really hard to do when we're this busy in the morning." Staff #2 indicated the LTFMC binder was stored in the office so staff could easily locate it. Staff #3 was interviewed on 2/21/19 at 8:17 AM. Staff #3 indicated client A was on five minute location tracking. Staff #3 stated, "I know the binder should be on a staff member at all times. But instead we store it in the office. I don't know why we do that." Staff #1 was interviewed on 2/20/19 at 5:16 PM. Staff #1 indicated client A was on fifteen minute location tracking. Staff #3 stated, "Every fifteen minutes we have to track [client A's] location in the binder." Staff #1 indicated the binder was stored in the office so staff could easily locate it. HM #1 was interviewed on 2/20/19 at 5:06 PM. HM #1 indicated client A was on five minute location tracking. HM #1 stated, "The tracking isn't assigned to any one staff member. They're all responsible for ensuring [client A's] location is known every five minutes." Client A's records were reviewed on 2/20/19 at 1:20 PM. The review indicated the following: - Client A's Human Rights Committee (HRC) approval dated 1/24/19 indicated a restrictive practice related to client A's privacy in regards to five minute location tracking. The HRC indicated the following: "Right to be Modified: Freedom from Privacy. Five ZRF511 Event ID: Facility ID: 001022 Page 105 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING				(X3) DATE SURVEY COMPLETED 02/26/2019	
	NAME OF PROVIDER OR SUPPLIER			4475 N	ADDRESS, CITY, STATE, ZII 17TH ST HAUTE, IN 47805	P COD		
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	minute location tra							
	are to check on ind whereabouts every five minute trackin home." "Reason the Modi safety and welfare	the right will be modified: Staff dividuals (client A's) v five minutes and document on ng forms while at the group fication is Needed: To provide of the individual (client A). istory of elopement."						
	attempted: Individ in the past and all	Measures that have been lual (client A) has had no checks privacy given to her. protes individual (client A) has a ment."						
	right may be resto tracking on individ	be provided in order that the red: Five minute location dual (client A) at all times. This ctive on Individual Support Plan						
	five minute tracking	ed 1/1/19 did not indicate the ng was completed from 10:05 nd 11:05 PM to 11:55 PM. The MC were blank.						
	five minute tracking	ed 1/2/19 did not indicate the ng was completed from 12:00 The boxes on the LTFMC were						
	five minute tracking	ed 1/7/19 did not indicate the ng was completed from 11:20 PM boxes on the LTFMC were						
	- The LTFMC dat	ed 1/8/19 did not indicate the						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	NAME OF PROVIDER OR SUPPLIER		4475 N	ADDRESS, CITY, STATE, ZIP CO I 17TH ST E HAUTE, IN 47805	DD	
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	five minute tracki	ed 1/15/19 did not indicate the ng was completed from 12:00 and 11:05 PM to 11:55 PM. The MC were blank.				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP COD 17TH ST HAUTE, IN 47805		
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	five minute tracki	ted 1/29/19 did not indicate the ng was completed from 9:00 AM boxes on the LTFMC were				

03/26/2019 PRINTED: FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE - The LTFMC dated 1/30/19 did not indicate the five minute tracking was completed from 12:00 AM to 8:55 AM, and from 3:35 PM to 11:55 PM. The boxes on the LTFMC were blank. - The LTFMC dated 1/31/19 did not indicate the five minute tracking was completed from 12:00 AM to 8:55 AM, and 11:05 PM to 11:55 PM. The boxes on the LTFMC were blank. - The LTFMC dated 2/1/19 did not indicate the five minute tracking was completed from 12:00 AM to 8:55 AM. The boxes on the LTFMC were blank. - The LTFMC dated 2/2/19 did not indicate the five minute tracking was completed from 9:10 AM to 10:55 AM. The boxes on the LTFMC were blank - The LTFMC dated 2/3/19 did not indicate the five minute tracking was completed from 8:00 PM to 8:40 PM. The boxes on the LTFMC were blank. - The LTFMC dated 2/4/19 did not indicate the five minute tracking was completed from 4:05 AM to 5:55 AM. The boxes on the LTFMC were blank. - The LTFMC dated 2/19/19 did not indicate the five minute tracking was completed from 12:00 AM to 8:55 AM, and 8:50 PM to 11:55 PM. The boxes on the LTFMC were blank. - The LTFMC dated 2/20/19 did not indicate the five minute tracking was completed from 12:00 AM to 6:10 AM, and 11:05 PM to 11:55 PM. The boxes on the LTFMC were blank. AS #1 was interviewed on 2/22/19 at 11:00 AM. AS #1 indicated client A was placed on five ZRF511 Event ID: Facility ID: 001022 Page 109 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE minute location tracking because she is at risk for elopement. AS #1 indicated client A's LTS should be filled out as indicated. AS #1 stated, "If a box is left blank, it is unsure if the staff member completed the required five minute checks." AS #1 indicated the entire form should be completed and there should not be blank areas on the form. AS #1 indicated each line of the form should be filled out as indicated regarding client A's location. 3. Client C's record was reviewed on 2/21/19 at 12:10 PM. The review indicated the following: - Client C's Health Risk Plan (HRP) dated 2/5/19 indicated client C had a risk plan created for Skin Breakdown. The HRP was created by Health Services Manager (HSM). The HRP indicated the following: "Staff will turn [client C] every two hours while in bed to release pressure to the buttocks and hips and while up in her wheelchair she will be repositioned every fifteen minutes." - Client C's Reposition Tracking Form (RTF) dated 2/1/19 did not indicate client C was repositioned from 12:00 AM to 8:00 AM. - Client C's RTF dated 2/3/19 indicated client C was in her wheelchair from 7:00 AM to 3:00 PM when she was placed in her bed on her left side. - Client C's RTF dated 2/5/19 did not indicate client C was repositioned from 6:00 AM to 8:00 AM, and from 4:00 PM to 11:00 PM. - Client C's RTF dated 2/7/19 did not indicate client C was repositioned from 7:00 AM to 1:00 PM. ZRF511 Event ID: Facility ID: 001022 Page 110 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. B	UILDING	DNSTRUCTION 00	CC 02	ATE SURVEY OMPLETED 2 <b>/26/2019</b>
	NAME OF PROVIDER OR SUPPLIER			4475 N	ADDRESS, CITY, STATE, ZIP C 17TH ST E HAUTE, IN 47805	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
		ated 2/8/19 did not indicate itioned from 12:00 AM to 8:00					
	was up in her chai	ated 2/10/19 indicated client C r from 7:00 AM to 1:00 PM when her bed on her right side.					
	client C changed p PM. The documen	ated 2/16/19 did not indicate ositions from 12:00 AM to 11:00 tation for client C's dule for 2/16/19 was blank.					
	client C changed p PM. The documen	ated 2/18/19 did not indicate ositions from 12:00 AM to 11:00 tation for client C's dule for 2/18/19 was blank.					
	client C changed p PM. The documen	ated 2/19/19 did not indicate ositions from 12:00 AM to 11:00 tation for client C's dule for 2/19/19 was blank.					
		ated 2/20/19 did not indicate itioned at 11:00 PM, as					
	client C was repos	ated 2/21/19 did not indicate itioned from 12:00 AM to 7:00 placed in her wheelchair for					
	client C changed p PM. The documen	ated 2/22/19 did not indicate ositions from 12:00 AM to 11:00 tation for client C's dule for 2/22/19 was blank.					
		ewed on 2/22/19 at 11:00 AM.					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM 02/2	te survey Ipleted 26/2019	
	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(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	
	(Licensed Practic	ut in entirety for the [LPN al Nurse) #1], [HM #1], and ctual Disabilities Professional riew."					
	Surveyor Worksh reviewed on 2/21	Community Residential Facility eet (CRFSW) dated 2/20/19 was /19 at 11:00 AM. The CRFSW , #2, #3, #4, #5, #6, and #7 were he home.					
	did not indicate st	d Client Specific Training (CST) taff #5, #6, and #7 had been C prior to providing care in the					
	not indicate staff on client C's care	d Care of Client C Training did #4, #5, and #6 had been trained regarding her medical needs g care in the home.					
	2/22/19 at 11:00 Å be trained on care home. AS #1 stat	(AS) #1 was interviewed on AM. AS #1 indicated staff should e of clients prior to working in the ed, "[HM #1] is responsible for rained prior to working."					
	Surveyor Worksh reviewed on 2/21	Community Residential Facility neet (CRFSW) dated 2/20/19 was /19 at 11:00 AM. The CRFSW , #2, #3, #4, #5, #6, and #7 were he home.					
	did not indicate st	d Client Specific Training (CST) taff #5, #6, and #7 had been A prior to providing care in the					
		iewed on 2/22/19 at 11:00 AM. staff should be trained on care of					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLIE LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP COD N 17TH ST E HAUTE, IN 47805	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
W 0210	"[HM #1] is respo trained prior to wo	rking in the home. AS #1 stated, nsible for ensuring staff is orking." dates to complaint #IN00286338.			
Bldg. 00	INDIVIDUAL PR Within 30 days a interdisciplinary f assessments or to supplement th conducted prior f Based on observat review for 1 of 3 s failed to address c pain assessment. Findings include: Observations were to 9:14 AM. At 7: present in client C cleaning of client 7:34 AM, while st client C, client C s were cleaned. Stat pain, but I really c can call the nurse. take temperatures. we give her medi was unaware if the client C. Staff #2 a pain. Observations were to 5:00 PM. At 3:	fter admission, the team must perform accurate reassessments as needed e preliminary evaluation	W 0210	Health Services Director will train the Facility Nurse on Nursing Assessments, and when to do them. Health Services with train all staff on Pain Assessments, when to do them and when to call the nurse. Health Services Director will audit each clients chart at lea quarterly to ensure ongoing HRP adherence, appropriate completion of Pain Assessments, and Meeting of Clients' Medical Needs. Administrative observations have been implemented in the home daily, seven days a wea 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.	st f e ek s

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Staff #1 adjusted the pillows surrounding client C Ongoing weekly and monthly and tilted her body to the left by adding a pillow observations and review will under her right hip. Client C said, "ow" when she continue with the QIDP and was adjusted from one side to the other. Staff #1 Area Supervisor over the did not assess client C for pain. At 4:30 PM, staff location. #1 and Area Supervisor (AS) #1 transferred client C from her bed to her wheelchair. As client C was lifted and readjusted by staff, client C said, "ow." Staff #1 and AS #1 did not assess client C for pain. Observations were done on 2/26/19 from 7:00 AM to 8:45 AM. At 7:22 AM, client C sat in her wheelchair. AS #1 adjusted client C's position by pulling on the protective pad underneath her. Client C said, "ow" while she was being adjusted. AS #1 did not assess client C for pain. At 8:08 AM, client C sat in her wheelchair. Staff #1 adjusted client C's position by pulling on the protective pad underneath her. Client C said, "ow" while she was being adjusted. Staff #1 did not assess client C for pain. Staff #3 was interviewed on 2/21/19 at 8:17 AM. and on 2/22/19 at 7:40 AM. Staff #3 stated, "I started here in August and [client C] had a bed sore on her back. Now, it's her bottom. I feel bad for her. She shouldn't have to have all these sores." Staff #3 indicated she did not know how to assess client C for pain. Staff #3 stated, "I would think she's in pain with this sore. She says 'ow' when we clean her, but I'm really not sure if she's hurting or if she's trying to get attention." Staff #3 stated, "I know we have a nurse for the home, but I'm really not sure when to call her about [client C] saying 'ow'." Staff #1 was interviewed on 2/21/19 at 5:16 PM, on 2/22/19 at 9:03 AM, and on 2/26/19 at 8:08 AM. Staff #1 stated, "We call the nurse when we need ZRF511 Event ID: Facility ID: 001022 Page 114 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G508 B. WING 02/26/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE her, but that's about it." Staff #1 indicated client C's wound has been present for 16 weeks. Staff #1 stated, "This is the longest we've ever dealt with a bed sore. [Client C's] had a staphylococcus infection (bacterial infection) at the sore. She's also had a yeast infection on the skin surrounding the sore. It's just really bad all around." Staff #1 stated, "I'd be in pain with all that going on. The way she (client C) says 'ow' all the time, I bet she's in pain too." Staff #1 indicated there was not an assessment for client C's pain. Staff #1 stated, "I've never called the nurse about [client C] saying 'ow'. I'm not really sure when I would do that." Client C's record was reviewed on 2/21/19 at 12:10 PM. Client C's record did not include a plan for pain assessment. Licensed Practical Nurse (LPN) #1 was interviewed on 2/22/19 at 11:00 AM. LPN #1 indicated client C does not have a protocol for pain assessment. LPN #1 indicated staff is trained on how to assess client C for pain. LPN #1 indicated she could not provide documentation of staff training for client C's pain assessment. 9-3-4(a) W 0249 483.440(d)(1) **PROGRAM IMPLEMENTATION** Bldg. 00 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, interview, and record The facility has policies and W 0249 03/28/2019 ZRF511 Event ID: Facility ID: 001022 Page 115 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	_	PLETED
		15G508	B. WING		02/2	6/2019
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	COD	
NORMA	L LIFE OF INDIAN	A		I 17TH ST E HAUTE, IN 47805		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOLILD BE	COMPLETION
TAG	<sup>×</sup>	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
		ample clients (A and C), the		procedures in place to	o train	
		plement client A's door alarm		employees who work		
	-	t C's Health Risk Plan (HRP) for		clients on skills and	WICH	
	-	a diagnosed pressure ulcer.		competencies directe	d towards	
	repositioning arter	a diagnosed pressure dieer.		clients' health needs		
	Findings include:			programming objectiv		
	Findings menude.			The Area Supervisor		
	1 Observations we	re conducted on 2/20/19 from				
		M at client A's home. During		retrained on ensuring		
		t A was at home. At 4:20 PM,		are thoroughly consu		
		y door did not have an audible		specific trained to inc		
				health needs, ISP, BS		
	-	the door was opened. At 4:37		objectives, and HRC a	approved	
		tchen door did not have an		Rights Restrictions.		
	audible alarm prese	ent when the door was opened.		All staff will be retrain	hed on the	
		1 / 1 0/21/10 0		implementation and		
		conducted on $2/21/19$ from		monitoring of door al	arms in	
		M at client A's home. During		the home.		
		t A was at home. At 7:24 AM,		All staff will receive		
		y door did not have an audible		competency-based co		
	-	the door was opened. At 7:24		specific training to in		
	,	tchen door did not have an		their health needs, HF	RP, ISP,	
	· ·	ent when the door was opened.		BSP and objectives.		
		e Manager (HM) #1 indicated		All clients have the po		
		arm was not active. HM #1		be affected by this de	-	
		h. HM #1 stated, "I don't know		Consumer specific tra	-	
	-	the alarm) should be." At 8:50		reviewing client need		
		ted the hallway door alarm was		a prominent compone		
		turned the alarm on. HM #1		agencies all staff mor	nthly	
		w why these are off. They		meetings.		
	should be working	all the time."		Administrative observ		
				have been implement		1
		was reviewed on 2/20/19 at 1:20		home daily, seven day	-	
	PM.			and will remain in pla		
				the team determines i		
		r Support Plan (BSP) dated		appropriate to decrea		
		ient A had an identified		number of observatio	ons. This	
	behavior of elopen	nent.		will ensure all correct	tions are	
				implemented per Res		1
	Client A's HRC (H	uman Rights Committee)		policy and regulation	S.	1
	approval dated 1/24	4/19 indicated the following:		Ongoing weekly and		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE ( A. BUILDING B. WING	B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019 P COD	
	PROVIDER OR SUPPLIE		STREET 4475	COD			
NORMA	L LIFE OF INDIAN	A	IERR	E HAUTE, IN 47805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION	SHOULD BE	COMPLETI	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
	"Right to be modif Door Alarms."	fied: Freedom of movement.		observations and re continue with the QI Area Supervisor ove location.	DP and		
	will be restricted t grounds supervise supervised during	right will be modified: [Client A] o areas of the building and d by staff. [Client A] will be all activities in the community. exit doors to elopement					
		odification is needed: To provide for safety, welfare, and health due to lack tills."					
	attempted: Docum	neasures that have been entation indicated the le to provide for his own safety n the community."					
		be provided in order that the red: This area will be an active ISP."					
	2/22/19 at 11:00 A an elopement histo exterior doors wer behavior. AS #1 in	AS) #1 was interviewed on AM. AS #1 indicated client A has ory and the alarms on the e placed due to her identified ndicated alarms should be xterior doors of the home.					
	from 7:15 AM to 9 home, staff #2 and clients. At 7:15 Al her wheelchair at a bottom was flat or client C continued wheelchair at a 90	ere done at the home on 2/21/19 9:28 AM. Upon arrival to the 1#3 were supervising the M, client C was sitting upright in a 90 degree angle. Client C's a the wheelchair. At 7:27 AM, sitting upright in her degree angle. Client C's bottom eelchair. Staff #2 and #3 did not					

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03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE C. At 9:08 AM, client C was sitting upright in her wheelchair with her hips tilted to the right. Staff #2, #3, and HM #1 did not reposition client C. At 9:23 AM, client C was sitting upright in her wheelchair with her hips tilted to the right. Staff #2, #3, and HM #1 did not reposition client C. Observations were done on 2/22/19 from 7:00 AM to 9:14 AM. At 7:55 AM, staff #3 placed client C into her wheelchair. Client C was now sitting upright in her wheelchair at a 90 degree angle. Client C's bottom was flat on the wheelchair. At 8:10 AM, client C was sitting upright in her wheelchair at a 90 degree angle. Client C's bottom was flat on the wheelchair. Staff #2 and #3 did not reposition client C. At 8:25 AM, client C continued to sit upright in her wheelchair at a 90 degree angle. Client C's bottom was flat on the wheelchair. Staff #2 and #3 did not reposition client C. At 8:31 AM, staff #3 adjusted client C in her wheelchair. Staff #3 pulled on the protective pad under client C in order to shift her hips to the right. At 8:34 AM, staff #3 walked over to client C's wheelchair and sat down next to her at the dining room table. Staff #3 prepared client C's breakfast. Staff #3 did not reposition client C while she was next to her. Staff #3 began assisting client C to eat her breakfast. At 8:46 AM, staff #3 continued assisting client C to eat her breakfast. Staff #3 did not reposition client C. At 8:58 AM, staff #1 arrived to the home for her shift. At 9:01 AM, staff #3 continued assisting client C to eat her breakfast. Staff #1, #2 and #3 did not reposition client C. At 9:14 AM, client C continued to sit tilted to the right in her wheelchair. Staff #1, #2 and #3 did not reposition client C. Staff #3 was interviewed on 2/21/19 at 8:17 AM, and on 2/22/19 at 7:40 AM. Staff #3 indicated ZRF511 Facility ID: 001022 Page 119 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE client C has to change positions frequently. Staff #3 stated, "When [client C] is in bed, she has to change positions every hour. When she's in her wheelchair, she has to shift positions every fifteen minutes." Staff #3 indicated client C is unable to change positions by herself. Staff #3 stated, "[Client C] completely relies upon staff to help her change positions." Staff #3 stated, "I started here in August and [client C] had a bed sore on her back. Now, it's her bottom. I feel bad for her. She shouldn't have to have all these sores." Staff #2 was interviewed on 2/21/19 at 8:55 AM. and on 2/22/19 at 7:48 AM. Staff #2 indicated she had worked at the home for several years. Staff #2 indicated client C has to be repositioned multiple times. Staff #2 stated, "We have to change [client C's] position every 15 minutes when she is in her wheelchair, and every two hours when she is in her bed." Staff #2 indicated client C should only be out of bed for meals. Staff #2 stated, "The wound care center ordered [client C] to be on bed rest. She's not supposed to be out of bed unless she is eating." Staff #1 was interviewed on 2/21/19 at 5:16 PM. and on 2/22/19 at 9:03 AM. Staff #1 indicated she had worked in the home for several years. Staff #1 indicated client C required staff assistance for all position changes. Staff #1 stated, "[Client C] cannot change positions on her own. Staff has to help her. We have to move her every hour when she is in bed, and every fifteen minutes when she's in her wheelchair." Staff #1 indicated client C has been on bed rest since Fall 2018. Staff #1 stated, "It's just really sad. She can't go anywhere because of this bedsore." Client C's record was reviewed on 2/21/19 at 12:10 PM. The review indicated the following: Event ID: ZRF511 Facility ID: 001022 Page 120 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDIN B. WING		COMF 02/26	e survey Pleted 6/2019
	PROVIDER OR SUPPLIE L LIFE OF INDIAN		44	REET ADDRESS, CITY, STATE, ZIP CO 75 N 17TH ST RRE HAUTE, IN 47805	D	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREF TAC	CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE
W 0318 Bldg. 00	<ul> <li>indicated client C Breakdown. The F Services Manager following:</li> <li>"Staff will turn [cl bed to release pres and while up in he repositioned every</li> <li>LPN #1 was interv LPN #1 indicated should be followed client C should be hours, and her pos chair every fifteen trained staff on nu</li> <li>This federal tag re</li> <li>9-3-4(a)</li> <li>483.460</li> <li>HEALTH CARE = The facility must care services reconstructions</li> <li>Based on observat review, the facility Participation: Hea sampled clients (C services failed to conursing assessment</li> </ul>	viewed on 2/22/19 at 11:00 AM. the skin integrity protocol d as written. LPN #1 indicated repositioned in bed every two ition should be changed in her minutes. LPN #1 indicated she rsing related issues for client C. lates to complaint #IN00286338. SERVICES ensure that specific health quirements are met. ion, interview and record y failed to meet the Condition of lth Care Services for 1 of 3 c). The facility health care ensure client C received timely at, intervention, staff training, llowing the identification of the	W 0318	Each home is assigned to oversee the monitori oversight of each indiv medical needs includin documentation of the interventions and prograny injuries or illness. nurse is responsible fo assessing and followin medical issue identified maintaining documenta specific chronic and ac	ng and idual's g ress of Each r g up any d and tion of	03/28/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	COMI	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TEDDE HAUTE IN 47805				
NORMA (X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C The facility health client C received t intervention, staff following the iden	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> care services failed to ensure imely nursing assessment, training, and monitoring tification of the repeated irrence. Please see W331.		E HAUTE, IN 47805 PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) needs on an ongoing until the issue is respon least a weekly visit to to monitor health issue documentation that is maintained in the hom nurse is responsible for completing a monthly note and a quarterly assessment for each assigned. All of the nurses will a re-training on their responsibilities to mo complete documentat specific chronic and a needs on an ongoing until the issue is respon- Health services Direct responsible to insure training is completed	HOULD BE APPROPRIATE basis or olved. sible for at the home ues and s ne. The for y progress individual receive onitor and tion of acute basis or olved. The tor will be that this	(X5) COMPLETIO DATE	
				documented in the entraining file. Client C HRP for skin has been reviewed an place. Client C receives wee treatment and assess provided by Union Ho Wound Care Center a continue until the pre ulcer is cleared. The facility adheres to regulations to provide treatment, assessmen labs as needed to ensic client's optimal health All staff in the home w receive training on Cl	integrity nd is in kly sments ospital nd will ssure o the e medical nts and sure h. will		

	R MEDICARE & MEDIC					MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLI A. BUILDINC B. WING	E CONSTRUCTION B <u>00</u>	СОМ	(X3) DATE SURVEY COMPLETED <b>02/26/2019</b>	
	PROVIDER OR SUPPLIE		4475	ET ADDRESS, CITY, STATE, ZIP C 5 N 17TH ST	COD		
NORMA	L LIFE OF INDIAN	A	TER	RE HAUTE, IN 47805			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	RECTION HOULD BE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	HRP, proper reposition		DATE	
				<ul> <li>when to reposition, w</li> <li>call the nurse, meetin</li> <li>medical needs, and V</li> <li>Order Medical Suppli</li> <li>Health Services Direct</li> <li>train Facility Nurse of</li> <li>Assessments, When</li> <li>Nursing Assessments</li> <li>Understanding of Job</li> <li>Responsibilities, Whe</li> <li>Staff, and Meeting of</li> <li>Medical Needs.</li> <li>Health Service Direct</li> <li>audit each clients cha</li> <li>quarterly to ensure of</li> <li>HRP adherence, appr</li> <li>completion of Nursin</li> </ul>	ng of Vhen to es. ctor will n Nursing to do s, o en to Train Clients' or will art at least ngoing opriate		
V 0331 483.460(c)				Assessments, and Ma Clients' Medical Need Administrative obser- have been implement home daily, seven da and will remain in pla the team determines appropriate to decrea number of observation will ensure all correct implemented per Res policy and regulation Ongoing weekly and observations and rev continue with the QIE Area Supervisor over location.	Is. vations ted in the ys a week ace until it is ase the ons. This tions are cCare s. monthly iew will OP and		
Bldg. 00		ICES provide clients with nursing dance with their needs.					

	T OF HEALTH AND HU R MEDICARE & MEDIC					F	OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COM	PLETED	
		15G508	B. WI	NG		02/2	26/2019	
	PROVIDER OR SUPPLIE	0	-	STREET	ADDRESS, CITY, STATE, ZIP COD			
				-	17TH ST			
NORINA	L LIFE OF INDIANA	4		IERRE	E HAUTE, IN 47805			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		.,	W 0	331	Each home is assigned a		03/28/2019	
		on, interview, and record			to oversee the medical as			
		ample clients (C), the facility			of each person according	to		
	-	iled to ensure client C received			their needs.			
		essment, intervention, staff			Client C HRP for skin inte	grity		
		oring following the			has been reviewed and is	in		
	identification of the	e repeated pressure ulcer			place.			
	occurrence.			Client C receives weekly				
					treatment and assessmen	ts		
	Findings include:	Findings include:			provided by Union Hospit	al		
	U				Wound Care Center and w			
	Observations were	done at the home on $2/20/19$			continue until the pressur			
		35 PM. At 5:29 PM, client C was			ulcer is cleared.	0		
		nt C was non-verbal and			The facility adheres to the			
		tance for all aspects of her			-			
	-	-			regulations to provide me			
	care. Staff #1 removed the adult brief from client C. The brief was resting on client C's hips and				treatment, assessments a	na		
					labs as needed to ensure			
	snugly attached. Staff #1 and Home Manager				client's optimal health.			
	(HM) #1 rolled client C to her right side. Staff #1				All staff in the home will			
		removed the old dressing from client C's left lower			receive training on Client			
	buttocks. The dressing consisted of a non stick				HRP, proper repositioning	Ι,		
	pad 2 inches by 2 i	nches. The non stick pad was			when to reposition, when	to		
	held to the skin by	a 3 inch by 4 inch reinforced			call the nurse, meeting of			
	adhesive bandage.	There was no foam present on			medical needs to include			
	the old dressing. The	he dressing covering client C's			dressing of wounds and			
	left lower buttocks	had a 2 CM (Centimeter) round			appropriate use of medica	d		
		n area did not have drainage.			supplies, and When to Or			
		ng the open area was red for 2			Medical Supplies.			
		the site. Staff #1 did not clean			Health Services Director	vill		
	-	ring the old dressing. Staff #1			train Facility Nurse on Nu			
		ssing by adding a quarter sized			Assessments, When to do	-		
						,		
		ntment (skin protectant) to a			Nursing Assessments,			
	-	f #1 stated, "This non stick pad			Understanding of Job	<b>_</b> .		
		posed to help with healing			Responsibilities, When to			
		e. We used to use Medihoney			Staff, and Meeting of Clier	nts'		
		ounds), but they changed it. We			Medical Needs.			
	don't have that any	more." Staff #1 then put the			Health Service Director w	II		
	prepared collagen	non stick pad with A&D			audit each client chart at	east		
	ointment onto clier	t C's open area. Staff #1 took			quarterly to ensure ongoi	ng		
	1	d adhesive bandage) and	1			-	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **ZRF511** Facility ID: **001022** 

If continuation sheet

Page 124 of 167

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	ì í	ILDING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP 4475 N 17TH ST TERRE HAUTE, IN 47805			DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETIC	
	covered the site. T the new dressing s Observations were from 7:15 AM to 9 home, staff #2 and clients. At 7:15 AM her wheelchair at a bottom was flat on client C continued wheelchair at a 90 was flat on the wh reposition client C continued sitting u degree angle. Clien wheelchair. Staff # client C. At 7:42 A upright in her whe Client C's bottom 9 #2 and #3 did not staff #2 walked ov sat down next to h #2 prepared client assisting client C t not reposition clien sitting upright in h angle. Client C's b wheelchair. Staff # with dining. Staff # 8:07 AM, client C wheelchair at a 90 was flat on the wh assist client C with reposition client C sitting upright in h angle. Client C's b wheelchair at 90 was flat on the wh assist client C with reposition client C sitting upright in h angle. Client C's b wheelchair Staff #	here was no foam present on			completion of Nursing Assessments, Meeting Clients' Medical Needs adherence to Physicia Orders. Administrative observ have been implements home daily, seven day and will remain in place the team determines if appropriate to decreas number of observation will ensure all correcti implemented per Resc policy and regulations Ongoing weekly and n observations and revis continue with the QIDI Area Supervisor over location.	g of s, and in's rations ed in the rs a week ce until t is se the ns. This ions are Care 5. nonthly ew will P and	DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G508 02/26/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE protective pad under client C in order to shift her hips to the left. At 8:33 AM, client C was sitting upright in her wheelchair with her hips slightly tilted to the left. Staff #3 was next to client C. Staff #3 was preparing client C's medications. At 8:38 AM, staff #3 adjusted client C in her wheelchair. Staff #3 pulled on the protective pad under client C in order to shift her hips to the right. At 8:48 AM, HM #1 arrived to assist with morning routine. At 8:53 AM, client C was sitting upright in her wheelchair with her hips tilted to the right. Staff #2, #3, and HM #1 did not reposition client C. At 9:08 AM, client C was sitting upright in her wheelchair with her hips tilted to the right. Staff #2, #3, and HM #1 did not reposition client C. At 9:23 AM, client C was sitting upright in her wheelchair with her hips tilted to the right. Staff #2, #3, and HM #1 did not reposition client C. Observations were done on 2/22/19 from 7:00 AM to 9:14 AM. Upon arrival, staff #2 was the only staff working in the home. Staff #2 was in the bathroom assisting client F with her shower. At 7:03 AM, client C was awake and laying in her hospital bed with an air mattress. Client C was laying on her back, with a pillow under each hip. She did not have an adult brief on. Client C was laying in her bowel movement. The bowel movement was present from her mid back to her ankles, and had spread the width of her body on the sheet she was laying on. The protective pad under client C was saturated, and had soaked through to the sheets underneath. At 7:05 AM, staff #3 arrived for her shift. Staff #3 stated to staff #2, "Sorry I'm late." At 7:08 AM, the cabinet at the end of client C's bed had medical supplies on it. The cabinet had disposable gloves, wipes, Hypafix, A&D ointment, and collagen non stick pads. The cabinet did not have supplies to clean the open area, or any padding to use in dressing ZRF511 Facility ID: 001022 Page 126 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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03/26/2019

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/26/2019		
NAME OF	PROVIDER OR SUPPLIE	ËR	STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST				
NORMA	L LIFE OF INDIAN	A	TERRE	E HAUTE, IN 47805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	changes. At 7:16 A	AM, staff #2 went into client C's					
	room to prepare he	er for the day. Staff #2 stated,					
	"Oh no, she had a	blow out." Staff #2 called to					
	staff #3 and told h	er to bring a bowl of soapy					
	water, a towel, and	d more wipes. At 7:24 AM, staff					
	#2 and #3 were pr	esent in client C's room assisting					
	with the cleaning	of client C after her bowel					
	movement. Staff #	2 stated, "With this wound, we					
	can't put any depen	nds on her." Client C's wound					
	was uncovered. Th	here was not a dressing on the					
	site. Staff #2 state	d, "The wound is supposed to					
	be covered at all ti	mes. I guess the bandage fell					
	off." Staff #2 was	unable to locate the bandage in					
	client C's bed. Stat	ff #2 stated, "It's (the wound)					
	not supposed to ha	we any open air time at all."					
	Staff #2 and #3 co	ntinued to clean client C using					
	wet wipes. At 7:34	AM, while staff #2 and #3					
	continued to clean	client C, client C said, "ow"					
	when her buttocks	were cleaned. Staff #2 stated,					
	"I think she's in pa	in, but I really don't know. She					
	says 'ow' and we c	an call the nurse. The nurse					
	normally just has	us take temperatures. If she has					
	a temperature then	we give her medication." Staff					
	#2 indicated she w	vas unaware if there was a pain					
	assessment for clie	ent C. At 7:36 AM, staff #2 and					
	#3 rolled client C	to her right side again. Staff #2					
	took the same wet	towel she had been using the					
	clean bowel move	ment off of client C and used it					
	to pat over the wo	und. At 7:39 AM, staff #2 said					
	to staff #3, "She's	pretty much done. Are you ok if					
	I leave and go star	t breakfast?" Staff #2 then left					
		remained to provide continued					
	care to client C as	she got ready for the day. Staff					
	#3 prepared to app	bly a new dressing to client C's					
	wound. Staff #3 di	id not clean the site prior to					
	applying a new dr	essing. Staff #3 prepared a new					
		g a quarter sized amount of					
		a non stick pad. Staff #3 then					
		ollagen non stick pad with					
		to client C's open area. Staff #3					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE took Hypafix and covered the site. There was no foam present on the new dressing staff #3 applied. At 7:55 AM, staff #3 placed client C into her wheelchair. Client C was now sitting upright in her wheelchair at a 90 degree angle. Client C's bottom was flat on the wheelchair. At 8:10 AM, client C was sitting upright in her wheelchair at a 90 degree angle. Client C's bottom was flat on the wheelchair. Staff #2 and #3 did not reposition client C. At 8:25 AM, client C continued to sit upright in her wheelchair at a 90 degree angle. Client C's bottom was flat on the wheelchair. Staff #2 and #3 did not reposition client C. At 8:31 AM, staff #3 adjusted client C in her wheelchair. Staff #3 pulled on the protective pad under client C in order to shift her hips to the right. At 8:34 AM, staff #3 walked over to client C's wheelchair and sat down next to her at the dining room table. Staff #3 prepared client C's breakfast. Staff #3 did not reposition client C while she was next to her. Staff #3 began assisting client C to eat her breakfast. At 8:46 AM, staff #3 continued assisting client C to eat her breakfast. Staff #3 did not reposition client C. At 8:58 AM. staff #1 arrived to the home for her shift. At 9:01 AM, staff #3 continued assisting client C to eat her breakfast. Staff #1, #2 and #3 did not reposition client C. At 9:14 AM, client C continued to sit tilted to the right in her wheelchair. Staff #1, #2 and #3 did not reposition client C. Home Manager (HM) #1 was interviewed on 2/20/19 at 5:29 PM. HM #1 stated. "This is the longest we've ever taken anyone to the wound care clinic. I just can't believe it's not healed yet." HM #1 indicated she had re-educated staff about caring for client C. HM #1 stated, "I keep trying to tell staff they need to change her position more, get her out of wet depends, and keep the bandage dry." HM #1 indicated the home only had A&D ZRF511 Facility ID: 001022 Page 128 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ointment at this time for client C's pressure ulcer. HM #1 stated, "We used to have Medihoney ointment. We ran out, and now I think the nurse is trying to get us more. We haven't had it for a long time." HM #1 stated. "I just don't know why the sore is taking so long to heal. I feel like we're doing everything we can for [client C]." Staff #3 was interviewed on 2/21/19 at 8:17 AM, and on 2/22/19 at 7:40 AM. Staff #3 indicated she works day shift, and sometimes will work evenings. Staff #3 stated, "The nurse is here maybe once a week. She comes in to watch staff do medication passes and check on [client C's] catheter." Staff #3 indicated she was unaware of the last time the nurse had visited the home and looked at client C's wound. When asked if the nurse had trained her on the protocol of changing client C's dressing, staff #3 stated, "Have you ever heard of the game telephone? One person tells one person something, then the next person tells the next person something and so on. My training has been like that." Staff #3 indicated staff #1 had trained her in regards to changing client C's dressing on her wound. Staff #3 stated, "We change the dressing in the morning and at night." Staff #3 stated, "I know we're supposed to clean it when we change the dressing. We just don't have any cleaner in the home. We haven't had it for a while." Staff #3 indicated the home has never had a foam to add to the dressing for client C's wound care. Staff #3 indicated client C has to change positions frequently. Staff #3 stated, "When [client C] is in bed, she has to change positions every hour. When she's in her wheelchair, she has to shift positions every fifteen minutes." Staff #3 indicated client C is unable to change positions by herself. Staff #3 stated, "[Client C] completely relies upon staff to help her change positions." Staff #3 stated, "I started here

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZRF511 Facility ID: 001022

If continuation sheet

Page 129 of 167

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE in August and [client C] had a bed sore on her back. Now, it's her bottom. I feel bad for her. She shouldn't have to have all these sores." Staff #2 was interviewed on 2/21/19 at 8:55 AM, and on 2/22/19 at 7:48 AM. Staff #2 indicated she had worked at the home for several years. Staff #2 stated, "Since the new nurse has started, I've only seen her two or three times." Staff #2 indicated she had not been trained by the nurse. Staff #2 stated, "I've been trained by watching other staff, and by reading the risk plan the nurse made for [client C's] skin care." Staff #2 stated, "No one has ever really told me what to do. I just try to do what I think is best." Staff #2 indicated she changes the dressing every two days, or when the dressing is soiled. Staff #2 indicated the home used to have a cleaner to use on client C's wound. Staff #2 stated, "We don't have it anymore. I don't know why." Staff #2 indicated client C has a cream to put on the area. Staff #2 stated, "We have used a few different things. Right now, all we have is A&D ointment." Staff #2 indicated client C has to be repositioned multiple times. Staff #2 stated, "We have to change [client C's] position every 15 minutes when she is in her wheelchair, and every two hours when she is in her bed." Staff #2 indicated client C should only be out of bed for meals. Staff #2 stated, "The wound care center ordered [client C] to be on bed rest. She's not supposed to be out of bed unless she is eating." Staff #1 was interviewed on 2/21/19 at 5:16 PM. and on 2/22/19 at 9:03 AM. Staff #1 indicated she had worked in the home for several years. Staff #1 indicated she works the day shift, and takes client C to many of her wound care center appointments. Staff #1 stated, "I paid attention at the wound care visits and learned how they wanted the dressing changes done. I've tried to teach the other staff ZRF511 Facility ID: 001022 Page 130 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE how to do it. The nurse has never been in to show us how to care for the area. We call the nurse when we need her, but that's about it." Staff #1 indicated the nurse had never attended a wound care center visit. Staff #1 stated, "She's never come during the day and assessed the wound either. I actually don't know if she's ever seen it." Staff #1 indicated the wound should be cleaned each time the dressing is changed. Staff #1 stated, "We used to have squirt bottles with saline in them. We don't have those anymore. I just use a wet wipe now. It's better than nothing." Staff #1 indicated the home had stocked a foam bandage at one time. Staff #1 stated, "We had some, but they're gone. We haven't had them in a while. I know the wound care center told us we could even use a makeup sponge as a foam padding because they were cheaper. We've never had those either." Staff #1 indicated client C's wound has been present for 16 weeks. Staff #1 stated, "This is the longest we've ever dealt with a bed sore. [Client C's] had a staphylococcus infection (bacterial infection) at the sore. She's also had a yeast infection on the skin surrounding the sore. It's just really bad all around." Staff #1 indicated client C required staff assistance for all position changes. Staff #1 stated, "[Client C] cannot change positions on her own. Staff has to help her. We have to move her every hour when she is in bed, and every fifteen minutes when she's in her wheelchair." Staff #1 indicated client C has been on bed rest since Fall 2018. Staff #1 stated, "It's just really sad. She can't go anywhere because of this bedsore." Client C's record was reviewed on 2/21/19 at 12:10 PM. The review indicated the following: - Client C's Individual Support Plan (ISP) dated 3/2/18 indicated client C's diagnoses included, but Event ID: ZRF511 Facility ID: 001022 Page 131 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIR			(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN			4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
	Developmental D (congenital disord (weakness in all f Bowel and Bladde following: "She (client C) is She requires super assistance with ev in the community provide basic heat without continuou staff support". - Client C's Indivi 7/24/18 were writ (LPN) #3. The IN complaints voiced distress noted. [Cl for a rash on her I dermatitis. New o cream) twice daily indicate LPN #3 F assessment on clie INN did not indic trained staff regar - Client C's Media 7/25/18 indicated physician. The rea "Pain on left hip." indicated, "Contac Hydrocortisone. A - Client C's MCR had been seen a p visit was not listed indicated, "Talk to	o, Profound Intellectual and isability, Cerebral Palsy ler of movement), Quadriparesis our limbs), and Incontinent of er. The ISP also indicated the verbal, but on a limited basis. rvision around the clock for eryday life skills and activities and group home unable to th, safety, and nutritional needs is supervision, training, and dual Nursing Notes (INN) dated ten by Licensed Practical Nurse N indicated, "Saw [client C]. No I and no signs or symptoms of ient C] went to convenient care eff hip. Diagnosis was contact rder for hydrocortisone (steroid y until healed." The INN did not had performed a physical ent C's skin integrity issue. The ate LPN #3 had personally ding the care of the site. eal Consult Report (MCR) dated client C had been seen by a ason for the visit was listed as, The physician's notes et dermatitis on left hip. Apply twice daily until healed." dated 7/26/18 indicated client C hysician. The reason for the d. The physician's notes o PCP (Primary Care Physician) left flank. Patient (client C) is					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUII B. WIN	LDING G	NSTRUCTION 00	CO 02	ate survey mpleted /26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN			4475 N	DDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		Р	ID REFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
	Keep in bed, repo	nds. Hold day service for now. osition every two hours. Maybe time for meals and appointments. ent needed."					
	#3. The INN indi home from day pr reposition every t for short time for The INN did not physical assessme issue. The INN di	dated 7/26/18 was written by LPN cated, "No depends. Keep at rogram for now. Keep in bed and wo hours. [Client C] may be up medications and appointment." indicate LPN #3 had performed a ent on client C's skin integrity id not indicate LPN #3 had I staff regarding the care of the					
		nd Care Center Instructions 7/26/18 visit indicated the					
	"Weeks in treatm	ent: 0."					
	"Change dressing excessive drainag and water. Remo- plastic bag and pl wound with Norm clean dressing usi or cotton balls. D force. Pat dry usin cotton balls Ap bed. Foam adhesi	ateal (buttocks) fold." g every day, or as needed for ge Wash your hands with soap ve old dressing, discard into ace into trash. Cleanse the nal Saline prior to applying a ing gauze sponges, not tissues o not scrub or use excessive ng gauze sponges, not tissue or ply Medihoney gel to wound ve with border."					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00		FE SURVEY IPLETED
		15G508	B. WING		02/2	26/2019
	ROVIDER OR SUPPLIEF		4475 N	<sup>°</sup> ADDRESS, CITY, STATE, ZII N 17TH ST	P COD	
NORMAL	LIFE OF INDIANA		TERR	E HAUTE, IN 47805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLETIC
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	)	DATE
	"Turn and repositio	n every two hours (in bed)."				
	"Patient is not to we	ear depends. If able, hold day				
		keep patient in bed. She may				
		for meals and appointments."				
	Client C's INN da	ted 7/31/18 was written by LPN				
		ted, "[Client C] saw wound				
		ent dressing." The INN did not				
		d performed a physical				
		t C's wound. The INN did not				
		d personally trained staff				
	regarding the care of					
	- Client C's INN da	ted 8/1/18 was written by LPN				
	#3. The INN indica	ted, "Wound center called				
	today and wants Va	she (wound cleaner) spray to				
	be put on wound be	fore dressing change. Keflex				
	(antibiotic) was star	ted as a preventative at this				
	time." The INN did	not indicate LPN #3 had				
		al assessment on client C's				
		d not indicate LPN #3 had				
	personally trained s	taff regarding the care of the				
	site.					
	- Client C's INN da	ted 8/7/18 was written by LPN				
	#3. The INN indica	ted, "Also saw wound care				
		rrent treatment." The INN did				
		3 had performed a physical				
		t C's wound. The INN did not				
		d personally trained staff				
	regarding the care of	f the site.				
	- Client C's INN da	ted 8/8/18 was written by LPN				
		ted, "Saw [client C]. No				
		or symptoms of distress				
		The INN did not indicate LPN				
	#3 had performed a	physical assessment on client				
		N did not indicate LPN #3 had				
	personally trained s	taff regarding the care of the		Ĩ		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	A. BUILD B. WING	ING	NSTRUCTION 00	02	DATE SURVEY OMPLETED 2/26/2019
	PROVIDER OR SUPPLII L LIFE OF INDIAN		44	475 N	ddress, city, state, zif 17TH ST HAUTE, IN 47805	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
	site.						
	<ul> <li>#3. The INN indic complaints voiced indicate LPN #3 h assessment on clic indicate LPN #3 h regarding the care</li> <li>Client C's INN d #3. The INN indic wound center. Net</li> <li>Client C's INN d #3. The INN indic complaints or sign noted. Wound loo indicate LPN #3 c assessment and do of her assessment indicate LPN #3 h regarding the care</li> <li>Client C's WCCI Home Manager (H</li> </ul>	lated 8/16/18 was written by LPN cated, "[Client C] seen at the xt appointment 8/23/18." lated 8/17/18 was written by LPN cated, "Saw [client C]. No as or symptoms of distress ks good." The INN did not completed a thorough nursing bocumented a visual description of the wound. The INN did not had personally trained staff					
	"Weeks in treatme						
	"Wound: Left Glu	teal (buttocks) fold. Healed. "					
	"Gel mattress ove	rlay (on bed)."					
	"If patient (client repositioned every	C) is in chair, she needs to be y fifteen minutes."					
	"Turn and repositi	ion every two hours (in bed)."					
	"Patient if wearing	g depends (sic) to make sure it is					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	.DDRESS, CITY, STATE, ZIP CO 17TH ST HAUTE, IN 47805	D		
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
	<ul> <li>#3. The INN india from the wound c activities and turn</li> <li>Client C's INN of #3. The INN india complaints or sign noted at this time</li> <li>Client C's INN of LPN #2. The INN at the house Ha and area on buttoo Instructed [Home clean and dry and much as possible. center on 10/18/1</li> <li>Client C's WCC Staff #1 accompa WCCI indicated t</li> <li>"Weeks in treatm</li> <li>"Wound: Left Ghe "Change dressing excessive drainage</li> </ul>	dated 8/23/18 was written by LPN cated, "[Client C] was discharged are center. She can resume a every two hours." dated 8/29/18 was written by LPN cated, "Saw [client C]. No ns or symptoms of distress ." dated 10/10/18 was written by I indicated, "Saw client (client C) s irritated area below ribcage, cks, where leg and buttocks join. Manager (HM) #1] to keep area to make sure to stay off as Has appointment with wound 8. Will continue to monitor." I from her 10/18/18 visit indicated nied her to the appointment. The he following: ent: 0."					
	wound with Norm clean dressing usi or cotton balls. D force. Pat dry usin cotton balls App bed as directed. C	ace into trash. Cleanse the nal Saline prior to applying a ing gauze sponges, not tissues o not scrub or use excessive ng gauze sponges, not tissue or ply collagen dressing to wound cover wound with foam dressing. May purchase foam makeup					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) I	DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		· · · ·	OMPLETED
		15G508	B. WING	<u></u>		2/26/2019
			OTPT	TT ADDRESS CUTTY CT		
NAME OF P	ROVIDER OR SUPPLIER	2		ET ADDRESS, CITY, ST 5 N 17TH ST	ATE, ZIP COD	
NORMAI	LIFE OF INDIANA			RE HAUTE, IN 47	805	
-	-					
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFEREN	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	COMPLETI
TAG		LSC IDENTIFYING INFORMATION	TAG	DE	EFICIENCY)	DATE
	sponge. Cover with	dry gauze, Hypafix."				
	"Gel mattress overla	ay (on bed)."				
	"If natient (client C	) is in chair, she needs to be				
	repositioned every					
	repositioned every					
	"Turn and repositio	n every two hours (in bed)."				
	"Leave depend off i	if possible. Leave off in bed. If				
	-	please make sure it is loose.				
		go to day service for a few				
		off back, and turned				
	frequently."					
		110/10/10				
		ted 10/19/18 was written by				
		ndicated, "Client (client C) was				
		center on 10/18/18. New he INN did not indicate LPN #2				
		ysical assessment on client C's				
		d not indicate LPN #2 had				
		taff regarding the care of the				
	site.	and regularing the cure of the				
	- Client C's WCCI f	from her 10/25/18 visit indicated				
	Staff #1 accompani	ed her to the appointment. The				
	WCCI indicated ins	structions to care for the				
		tions were the same provided				
		tment for this wound on				
	10/18/18.					
	Client Cla BBL 1	tod 10/26/19				
		ted 10/26/18 was written by ndicated, "Wound center new				
		he INN did not indicate LPN #2				
		ysical assessment on client C's				
		d not indicate LPN #2 had				
		taff regarding the care of the				
	site.					
	- Client C's INN dat	ted 11/1/18 was written by LPN				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CON	ISTRUCTION	(X3) D	ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00		MPLETED
		15G508	B. WIN		<u></u>		2/26/2019
NAME OF	PROVIDER OR SUPPLIEF	3			DDRESS, CITY, STATE	E, ZIP COD	
				4475 N 1		-	
	L LIFE OF INDIANA				HAUTE, IN 47805	)	
(X4) ID		STATEMENT OF DEFICIENCIE	D			N OF CORRECTION ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P.	REFIX TAG	CROSS-REFERENCED T DEFICIE	TO THE APPROPRIATE	COMPLETIC DATE
ind		ted, "Saw client (client C) at the		1110			DATE
		ed. Voices no complaints."					
	-	dicate LPN #2 had performed a					
		t on client C's wound. The					
		e LPN #2 had personally					
		ing the care of the site.					
	- Client C's WCCL	from her 11/1/18 visit indicated					
		ed her to the appointment. The					
		structions to care for the					
		tions were the same provided					
		tment for this wound on					
	10/18/18.						
	- Client C's INN da	ted 11/2/18 was written by LPN					
	#2. The INN indica	ted, "Client (client C) was seen					
	at wound center on	11/1/18. New orders received."					
	The INN did not in	dicate LPN #2 had performed a					
	physical assessmen	t on client C's wound. The					
	INN did not indicat	e LPN #2 had personally					
	trained staff regard	ing the care of the site.					
	- Client C's Nursing	g Quarterly Assessment (NQA)					
		completed by LPN #2. The					
	NQA indicated the						
	"Skin:"						
	"Open areas: No."						
	"4th Quarter Summ	ary: Client has been going to					
	wound center week	ly for area on back and right					
		er has been changed and					
	draining clear yello	w urine. G-Tube site looks					
	normal. No signs of	r symptoms of infection."					
	- Client C's INN da	ted 11/8/18 was written by LPN					
	#2. The INN indica	ted, "Saw client at ResCare Day					
		or good. Respirations easy.					
		nts." The INN did not indicate					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/	te survey Mpleted 26/2019
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	LPN #2 had perfo client C's wound.	rmed a physical assessment on The INN did not indicate LPN #2 ined staff regarding the care of				
	HM #1 accompan WCCI indicated it wound. The instru at the initial appoi 10/18/18. The WC had been cultured	from her 11/8/18 visit indicated ied her to the appointment. The instructions to care for the ictions were the same provided intment for this wound on CCI indicated client C's wound for bacteria. The culture ind was positive for a acteria infection).				
	#2. The INN indic at wound care cen received." The IN performed a physi wound. The INN	ated 11/9/18 was written by LPN eated, "Client (client C) was seen ter on 11/8/18. New orders N did not indicate LPN #2 had cal assessment on client C's did not indicate LPN #2 had staff regarding the care of the				
	staff #1 accompar WCCI indicated in wound. The instru	I from her 11/15/18 visit indicated nied her to the appointment. The instructions to care for the actions were the same provided ntment for this wound on				
	staff #1 accompar WCCI indicated i wound. The basic provided at the in on 10/18/18. The	from her 11/21/18 visit indicated tied her to the appointment. The instructions to care for the instructions were the same tial appointment for this wound instructions included, "Need to ders on the wound."				
	- Client C's INN d	ated 11/21/18 was written by				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE LPN #2. The INN indicated, "Client (client C) was seen at wound care center on 11/15/18. No new orders...". The INN did not indicate LPN #2 had performed a physical assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site. - Client C's INN dated 11/26/18 was written by LPN #2. The INN indicated, "Saw client at the resting in bed (sic)... Color good. Respirations easy and non-labored ... Denies any complaints." The INN did not indicate LPN #2 had performed a physical assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site. - Client C's INN dated 11/28/18 was written by LPN #2. The INN indicated, "Client (client C) was seen at wound care center on 11/21/18. Orders received." The INN did not indicate LPN #2 had performed a physical assessment on client C's wound. The INN did not indicate LPN #2 had personally trained staff regarding the care of the site - Client C's WCCI from her 11/29/18 visit indicated staff #1 accompanied her to the appointment. The WCCI indicated instructions to care for the wound. The instructions were the same provided at the initial appointment for this wound on 10/18/18. The assessment of the wound by the wound care center nurse indicated. "Tenderness on palpation. Stage 3 pressure ulcer. Measurements: 1.4 CM (Centimeters) by 1.4 CM by 0.3 CM." - Client C's INN dated 11/30/18 was written by LPN #2. The INN indicated, "Client (client C) was seen at wound care center on 11/29/18. New ZRF511

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 001022

If continuation sheet

Page 140 of 167

03/26/2019

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	.ddress, city, state, zip cod 17TH ST HAUTE, IN 47805	
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETIO
	had performed a p wound. The INN	The INN did not indicate LPN #2 physical assessment on client C's did not indicate LPN #2 had I staff regarding the care of the			
	dated 12/4/18 ind (RDS): Only cam restWants to ge only to be in her of shower, and for o	lisciplinary Team (IDT) meeting icated, "ResCare Day Service e six days last quarter due to bed t out of bed. Has restrictions chair to eat, receive medications, ne hour after she eats then to lay octors orders from the wound			
	HM #1 accompar WCCI indicated i wound. The instru	I from her 12/6/18 visit indicated nied her to the appointment. The nstructions to care for the actions were the same provided intment for this wound on			
	#2. The INN india at wound care cer The INN did not physical assessme INN did not indic	dated 12/7/18 was written by LPN cated, "Client (client C) was seen nter on 12/6/18. No new orders." indicate LPN #2 had performed a ent on client C's wound. The rate LPN #2 had personally rding the care of the site.			
	LPN #2. The INN at the Christmas p distress." The INN performed a phys wound. The INN	dated 12/12/18 was written by I indicated, "Saw client (client C) party. Appears to be in no N did not indicate LPN #2 had ical assessment on client C's did not indicate LPN #2 had I staff regarding the care of the			
	- Client C's WCC	I from her 12/13/18 visit indicated			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	te survey 1pleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP I 17TH ST E HAUTE, IN 47805	° COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
	staff #1 accompar WCCI indicated i wound. The instru	nied her to the appointment. The nstructions to care for the actions were the same provided intment for this wound on				
	HM #1 accompan WCCI indicated i wound. The instru	I from her 12/27/18 visit indicated ied her to the appointment. The instructions to care for the actions were the same provided intment for this wound on				
	LPN #2. The INN seen at wound can did not indicate L assessment on clie	lated 12/27/18 was written by indicated, "Client (client C) was e center on 12/13/18." The INN PN #2 had performed a physical ent C's wound. The INN did not had personally trained staff e of the site.				
	LPN #2. The INN Color good. Resp Lungs clear, abdo quadrants. G-Tub tube) site clean dr symptoms of infe- draining clear, yel indicate LPN #2 H assessment on clia	lated 12/28/18 was written by findicated, "Saw client (client C). irations easy and non-labored. men soft, bowel sounds in four e (nutritional stomach feeding y and intact, No signs or ction. Foley catheter patent and llow urine." The INN did not had performed a physical ent C's wound. The INN did not had personally trained staff e of the site.				
	#2. The INN indic at wound care cer did not indicate L assessment on clio	lated 1/3/19 was written by LPN cated, "Client (client C) was seen ater. No new orders." The INN PN #2 had performed a physical ent C's wound. The INN did not nad personally trained staff				

	T OF HEALTH AND HU R MEDICARE & MEDIO						ORM APPROVI MB NO. 0938-03
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	r í	JILDING	DNSTRUCTION 00	(X3) DATI COMF	E SURVEY PLETED 5/2019
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					17TH ST		
NORMA	L LIFE OF INDIAN	4		TERRE	HAUTE, IN 47805		-
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETI
TAG	regarding the care	R LSC IDENTIFYING INFORMATION		TAG			DATE
	legarding the care	of the site.					
	- Client C's INN d	ated 1/4/19 at 10:45 AM was					
		. The INN indicated, "Saw client					
		p in wheelchair. Color good.					
		and non-labored. Lung fields ft and non-tender. Bowel					
		drants. Foley catheter patent					
	-	yellow urine. Denies any					
	~	omfort." The INN did not					
		ad performed a physical					
		nt C's wound. The INN did not					
	regarding the care	ad personally trained staff					
		of the site.					
	- Client C's WCCI	from her 1/10/19 visit did not					
		ho accompanied her to the					
		WCCI indicated instru					
		r the wound. The					
		e the same provided at the					
	initial appointm	ent for this wound on					
	10/18/18. The a	ssessment of the wound by					
	the wound care	center nurse indicated,					
	"Tenderness on	palpation. Stage 3 pressure					
	ulcer. Measurer	nents: 2 CM by 1.9 CM by					
	0.2 CM."- Clier	t C's INN dated 1/11/19 at					
	10:00 AM was	written by LPN #2. The					
		"Client (client C) was seen at					
		ter on $1/10/19$ . New orders					
		NN did not indicate LPN					
		ed a physical assessment on					
	-	d. The INN did not indicate					
	-	sonally trained staff					
		tre of the site Client C's					
		/19 at 7:30 PM was written					
	by LPN #2. The	INN indicated, "Saw client					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZRF511 Facility ID: 001022

If continuation sheet Page 143 of 167

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC
TAG	(client C). Color and non-labored abdomen soft ar sounds in four q patent and drain Denies any com INN did not ind performed a phy C's wound. The #2 had personal care of the site. 1/18/19 visit ind her to the appoint indicated instruct The instructions the initial appoint 10/18/18 Clien was written by I "Wound care ce in orders. To ret The INN did no performed a phy C's wound. The #1 had personal care of the site. 1/24/19 visit ind her to the appoint indicated instruct The instructions the initial propertion the site.	R LSC IDENTIFYING INFORMATION good. Respirations easy Lung fields clear, ad non-tender. Bowel uadrants. Foley catheter ing clear, yellow urine. plaints of discomfort." The icate LPN #2 had vsical assessment on client INN did not indicate LPN by trained staff regarding the - Client C's WCCI from her licated staff #1 accompanied atment. The WCCI extions to care for the wound. were the same provided at atment for this wound on at C's INN dated 1/18/19 LPN #1. The INN indicated, inter visit today. No changes urn 1/24/19 at 11:00 AM." t indicate LPN #1 had vsical assessment on client INN did not indicate LPN by trained staff regarding the - Client C's WCCI from her licated HM #1 accompanied atment. The WCCI extions to care for the wound. were the same provided at atment for this would on at C's WCCI from her licated HM #1 accompanied atment. The WCCI extions to care for the wound. were the same provided at atment for this wound on at C's Reposition Tracking ed 2/1/19 did not indicate	TAG			DATE

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>
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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	Cor 02/	te survey Mpleted <b>26/2019</b>
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP C 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	8:00 AM Cli indicated client 7:00 AM to 3:0 in her bed on h dated 2/5/19 di repositioned fr and from 4:00 C's Health Risk indicated client Skin Breakdow Health Service indicated the for Breakdown.""T Redness, irritat from open area at the base of th G-Tube site.""O instructs staff t give [client C] scheduled as w a shower, incon catheter is out. irritation or ope change, turn, o record and repo any abnormal for C] every two h pressure to the up in her whee every fifteen m	positioned from 12:00 AM to ent C's RTF dated 2/3/19 C was in her wheelchair from 00 PM when she was placed er left side Client C's RTF d not indicate client C was om 6:00 AM to 8:00 AM, PM to 11:00 PM Client c Plan (HRP) dated 2/5/19 C had a risk plan created for m. The HRP was created by s Manager (HSM). The HRP ollowing:"Risk for Skin Triggers to notify the nurse: ion, open areas, bleeding s on buttocks, coccyx (bone he spine), hips, or around Call 911 if [client C's] nurse o do so.""Actions:""Staff will a shower or bath as ash and dry thoroughly after ntinence of feces, or urine if "Staff will assess for redness, en areas with each depends r G-Tube feeding.""Staff will ort to the nurse immediately indings.""Staff will turn [client ours while in bed to release buttocks and hips and while chair she will be repositioned inutes.""The doctor will be ructed by the nurse after				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	A. BUILDING B. WING	construction <u>00</u>	CO	ate survey Mpleted /26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475	T ADDRESS, CITY, STATE, ZII N 17TH ST RE HAUTE, IN 47805	? COD	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
	assessment by	the Home Manager to make				
	an appointmen	t with the wound clinic ASAP				
	(As Soon As P	ossible) to have treatment				
	start (sic) on th	e area if breakdown				
	occurs.""Staff	will transport to the wound				
		nents as schedule and inform				
	the nurse of fin	dings via consult form.""Staff				
	-	rect support professionals				
		nanager, Area Supervisor				
		e."- Client C's RTF dated				
		indicate client C was				
	_	om 7:00 AM to 1:00 PM				
		CI from her 2/7/19 visit				
		#1 accompanied her to the				
		The WCCI indicated				
		care for the wound. The basic				
		ere the same provided at the				
		nent for this wound on				
		instructions included, "Apply				
	•	am to peri-wound skin." The				
		he wound by the wound care				
		dicated, "Tenderness on				
		e 3 pressure ulcer.				
		2 CM by 1.6 CM by 0.2 's INN dated 2/7/19 was				
		1 #1. The INN indicated,				
	-	om wound clinic to apply				
		am, collagen to wound bed,				
	-	ssing". The INN did not				
		1 had performed a physical				
		client C's wound. The INN				
		e LPN #1 had personally				
		· · · · · · · · · · · · · · · · · ·				

OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	ENTIFICATION NUMBER A. BUILDING 5G508 B. WING		<u></u>		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIE L LIFE OF INDIAN		4	4475 N <sup>-</sup>	DDRESS, CITY, STATE, ZIP CO 17TH ST HAUTE, IN 47805	D		
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		EFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE PROPRIATE	COMPLETIC DATE	
IAU		garding the care of the site		IAG			DATE	
	-	dated 2/8/19 did not indicate						
		positioned from 12:00 AM to						
	-	nt C's RTF dated 2/10/19						
		C was up in her chair from						
		0 PM when she was placed						
		er right side Client C's						
		arge Instructions dated						
	-	ed the following:"Admission:						
		harge: 2/16/19."Diagnosis:						
		Tract Infection). Stage 3						
	· · ·	left buttocks, present upon						
		lient C's RTF dated 2/16/19						
		client C changed positions						
		I to 11:00 PM. The						
		for client C's repositioning						
		16/19 was blank Client C's						
		8/19 did not indicate client C						
	changed position	ons from 12:00 AM to 11:00						
	• •	nentation for client C's						
	repositioning so	chedule for 2/18/19 was						
		C's INN dated 2/18/19 was						
	written by LPN	#1. The INN indicated,						
	"Visited with [o	client C] this morning. Sitting						
	in lazy boy cha	ir. Foley catheter in place						
	draining clear y	vellow urine. G-Tube in place						
	with split dress	ing. Clean, dry, and intact".						
	-	ot indicate LPN #1 had						
	performed a ph	ysical assessment on client						
	C's wound. The	INN did not indicate LPN						
	#1 had personal	lly trained staff regarding the						
	-	- Client C's RTF dated						
	I		 ZRF511		D: 001022 If contin		age 147 of 10	

OMB NO. 0938-039

(X3) DATE SURVEY COMPLETED 02/26/2019

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

NAME OF PROVIDER OR SUPPLIER

NORMAL LIFE OF INDIANA

CENTERS FOR MEDICARE & MEDIC	AID SERVICES			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CON	ISTRUCTION
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00
	15G508	B. WI	NG	
			OTDEET AL	NDRESS CITY STATE 710

#### STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805

#### TERRE HAUTE, IN 47805

(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) COMPLETIO DATE
	2/19/19 did not indicate client C changed			
	positions from 12:00 AM to 11:00 PM. The			
	documentation for client C's repositioning			
	schedule for 2/19/19 was blank Client C's			
	RTF dated 2/20/19 did not indicate client C			
	was repositioned at 11:00 PM, as			
	scheduled Client C's RTF dated 2/21/19			
	did not indicate client C was repositioned			
	from 12:00 AM to 7:00 Am when she was			
	placed in her wheelchair for breakfast			
	Client C's RTF dated 2/22/19 did not			
	indicate client C changed positions from			
	12:00 AM to 11:00 PM. The documentation			
	for client C's repositioning schedule for			
	2/22/19 was blank Bureau of			
	Developmental Disabilities Services (BDDS)			
	reports, Incident Reports (IRs), and			
	Investigations were reviewed on 2/20/19 at			
	2:30 PM. The review did not indicate a			
	BDDS report, IR, or investigation for the			
	pressure ulcer client C was treated for at the			
	wound care center in July 2018 and August			
	2018. The review did not indicate a BDDS			
	report, IR, or investigation for the pressure			
	ulcer client C was currently being treated for			
	at the wound care center since October			
	2018 The facility's Community Residential			
	Facility Surveyor Worksheet (CRFSW)			
	dated 2/20/19 was reviewed on 2/21/19 at			
	11:00 AM. The CRFSW indicated staff #1,			
	#2, #3, #4, #5, #6, and #7 were staff			
	working in the home. Client C's undated			

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICE</b>	S
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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	te survey Mpleted 26/2019
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST HAUTE, IN 47805	DD	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
	indicate staff # trained on clien the home. Clien C Training did #6 had been tra regarding her r providing care (AS) #1 was in 11:00 AM. AS trained on care the home. AS # responsible for to working." A responsible for staff on client's positioning cha in entirety for t [Qualified Inte Professional (C #1 was intervie AM. LPN #1 in nurse for client just started at F But, I've been in since January." the home week LPN #1 stated, look at [client of Foley catheter at the staff shift	Training (CST) did not 5, #6, and #7 had been at C prior to providing care in at C's undated Care of Client not indicate staff #4, #5, and ained on client C's care medical needs prior to in the home. Area Supervisor terviewed on 2/22/19 at #1 indicated staff should be of clients prior to working in #1 stated, "[HM #1] is ensuring staff is trained prior S #1 indicated the nurse was providing medical training to needs. AS #1 stated, "The ange forms should be filled out the [LPN #1], [HM #1], and llectual Disabilities DIDP) #1] to review." LPN wed on 2/22/19 at 11:00 ndicated she is the primary C's home. LPN #1 stated, "I desCare a few months ago. n charge of [client C's] home LPN #1 indicated she was in ly providing care for client C. "When I go into the home, I C's] wound. I also check her and her G-Tube site. I look at notes and review the MARs dministration Record). I ask				

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		A. BUILDING B. WING	00	02/2	te survey 1pleted 26/2019	
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP COD 17TH ST HAUTE, IN 47805		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
	remind them to she did not rev regarding client when she was indicated client ulcer. LPN #1 pressure ulcer deal of intervent indicated client the past. LPN # one (a pressure She just can't s That's why she LPN #1 indicat should be folloo indicated client bed every two should be chant minutes. LPN # out of bed unlet medications. S #1 indicated st dressing daily, LPN #1 stated, it with normal foam Band-Aid think they have haven't been th #1 indicated client	v [client C] is doing and o turn her." LPN #1 indicated iew any documentation t C's repositioning schedule visiting the home. LPN #1 t C has a stage 3 pressure stated, "Yes, a stage 3 is serious. It requires a great ntion to heal it." LPN #1 t C has had a pressure ulcer in #1 stated, "I know she's had e ulcer) on and off for years. eem to keep her skin intact. has a skin integrity protocol." ted the skin integrity protocol wed as written. LPN #1 t C should be repositioned in hours, and her position ged in her chair every fifteen #1 stated, "She shouldn't be ess she's eating or getting he's on strict bed rest." LPN aff should be changing the and as needed if it is soiled. "They're supposed to clean saline, then put collagen and a d on it." LPN #1 stated, "I e the supplies they need. I ere in a while to check." LPN ient C went to the wound ekly for treatment. LPN #1 r she's missed one				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP COD 17TH ST HAUTE, IN 47805	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0407 Bldg. 00	but I think that' stated, "I've new center visit witt could go." LPN the wound care LPN #1 stated, verify the order them." LPN #1 wound care cer #1 indicated sh related issues for never trained st dressing chang already know w the staff change stated, "That's fi the wound. That LPN #1 stated, documentation wound. I have to of the site."9-3- 483.470(a)(1) CLIENT LIVING The facility must different ages, d social needs in op proximity unless promote the grow those housed to Based on record r sampled clients (A	ENVIRONMENT in not house clients of grossly evelopmental levels, and close physical or social the housing is planned to with and development of all gether. eview and interview for 1 of 3 A), the facility housed client A in emates that were of significantly	W 0407	The facility strives for client inclusion and success in all placement decisions. The facility follows all processes and requirements of client	03/28/201

	R MEDICARE & MEDI			CONSTRUCTION		1B NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLIE		4475	T ADDRESS, CITY, STATE, ZIP COD N 17TH ST RE HAUTE, IN 47805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETIC
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	UPRIATE	DATE
	Findings include:			admissions and transitio	ns	
				established by BDDS. Th		
		was reviewed on 2/20/19 at 1:20		and BDDS met on the tra		
	PM.			of client A to this facility		
	Client A's Order	of No Contact and No Trespass		visits and approvals wer		
		ed 9/12/18 from [school		obtained prior to admiss The facility will monitor a		
	. ,	ONCNT indicated, "On at least		evaluate client A's place		
		ient A] has tried to enroll her		to determine if it remains		
	toy doll in school	at [elementary school]. [Client		appropriate. Client A's se	upports	
		o enter the school through door		will be reviewed and		
		er the family daycare program.		evaluated to determine if		
	-	18, (client A) entered the school		necessary supports are		
		up to a student, grabbed her by		to ensure the best possil		
		ot let go. The student was able e ONCNT indicated client A was		outcomes for all individu supported in the facility.	ais	
		cess to all [school corporation]		supported in the facility.		
	property.					
		ior Baseline Tracking (BBT)				
	chairs, cussing, th	ated, "Not listening, throwing reatening".				
	- Client A's BBT d	lated 9/6/18 indicated, "Not				
		o run away. Crying. Yelling.				
	Hitting staff. She restraint by staff).	was put in a hold (physical '				
	- Client A's BBT o	lated 9/7/18 indicated, "[Client				
		med client) came in the building				
	fighting. [Client A] open hand slapped peer. Had to be put in hold."					
	- Client A's BBT d	lated 9/14/18 indicated, "started				
	crying because of Screaming '[Exple	her dolls. Flipping everyone off. tive] ResCare'."				
		OS (Bureau of Developmental				
	Disabilities Services) reports and investigations were reviewed on 2/20/19 at 2:30 PM. The review					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/	te survey Mpleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	DDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	indicated the follo	owing:				
	<ul> <li>behavior, [client <i>A</i> extinguisher at [C] she walked throug and redirected [cl extinguisher from Staff observed a t on her (CFH's) rig Nurse notified."</li> <li>2. BDDS report d A] displayed targ Aggression). [Cli [CFH] was outsid home. [Client A] attempted to throw preventing contact arrived and separatinformed the poli charges. The polit transported [client was arrested for F and kicking the w notified. On 9/18/</li> </ul>	ated 9/17/18 indicated, "During a A] through (sic) a fire Client at Former Home (CFH)] as gh the kitchen. Staff intervened ient A]. Staff removed the fire a the area and put it in the office wo inch black and blue bruise ght side (on her upper thigh). ated 9/18/18 indicated, "[Client eted behaviors of PA (Physical ent A and CFH] were arguing, le yelling to [client A] inside the grabbed the fire extinguisher and w it at [CFH]. Staff intervened tt. 911 was contacted. The police ated [client A and CFH]. [CFH] ce that she wanted to press ce handcuffed, arrested, and tt A] to [county jail]. [Client A] Battery resulting in bodily injury rindows in the police car. Nurse (18 at 8:30 AM, [client A] had held until her next court date on				
	health. No appare	[CFH] appears to be in good int injuries were observed on . ResCare will remain in				
	communication w updates are (sic) o medications to the there. Behavior m contracted to assi (Behavior Suppor	ith [county jail] and provide obtained. Staff provided her e jail to provide during her time nanagement services have been st with [client A's] BSP t Plan) and targeted behaviors.				
		ng with BDDS to find a potential ent for [client A]."				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	<b>A</b> . 1	BUILDING WING	DNSTRUCTION 00	COI	ate survey Mpleted 26/2019
	PROVIDER OR SUPPLIE			4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	Client A's record r Behavior Consulta 9/18/18 incident to A's BSP or provide developing staff in targeted behavior r 3. BDDS report da A] was released fr recognizance and y psychiatric evaluar Staff transported h evaluation. He the (Emergency Room referral to an inpat and per the evaluar requirements to be scheduled appoint increase Abilify (a (Milligrams) to 15 (seizures) from 50 with [psychiatrist] "Plan to Resolve: [ health and no appa ResCare will rema A's] mother while working with BDI home. Staff will co her health." - Client A's Interdid dated 12/3/18 indii the transition from group home]. The	eview did not indicate a ant (BC) was contacted after the provide assistance with client e consultation regarding atterventions for client A's needs. atted 9/21/18 indicated, "[Client om [county jail] on her own was instructed to have a tion or medication adjustment. ter to [psychiatrist] for n referred her to [hospital ER n)] for evaluation and possible ient unit. Labs were performed tion, [client A] did not meet the admitted. Orders: Maintain ment with [psychiatrist], intipsychotic) from 10 MG MG daily, increase Zonegran MG to twice daily and follow up					
	physical aggressio steps with [client A	n Reviewed all escalating A] if she gets upset [Client A] nembers) about having baby					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	te survey 1pleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
ING	dolls and team ren	ninded her that her dolls are at . She (client A) is determined to				DATE
	A] threw glass at Smashed items. P herself. Threw a f away. Flipped off	dated 12/10/18 indicated, "[Client staff along with other things. ulled fire alarm. Tried hurting ruit cup at [client C]. Tried to run staff. Called staff, 'ugly ple times. Marked on walls."				
	12/13/18 indicate for a follow up vi	cal Consult Report (MCR) dated d client A had seen [psychiatrist] sit. The MCR indicated, "Patient occasional behavioral				
	had seen [therapis MCR indicated, " group home. She appropriately. She designed and repo weeks. Begin disc visiting therapist) continues with be	dated 1/3/19 indicated client A t] for a follow up visit. The [Client A] is now settled into a is managing negative behaviors e can recall the behavior plan as rts following it. Follow up 4-5 sussion of termination (of if no new issues arise and she havior management." The MCR appointment on 1/31/19.				
	reason for the me up to client A's tra The IDT indicated of having behavior	heeting dated 1/4/19 indicated the eting was the thirty day follow unsition to the new group home. I, "[Client A] walks away instead rs. She has only had one oving into the the new home) ppropriate."				
	"[Client A] is hitt She is upset becau	dated 1/7/19 at 1:10 PM indicated, ing her head off (sic) the wall. use she wants a baby doll and her on the phone."				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	A. E	UILDING	DNSTRUCTION 00	CO	ate survey Mpleted 1 <b>26/2019</b>
	PROVIDER OR SUPPLE			4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	IR elaborated on the The IR indicated, head off the wall. Also, I tried to get and color. She yell [Qualified Intellect (QIDP) #2] was plan". - Client A's BBT was plan". - Client A's BBT was plan". - Client A's BBT was a baby doll - Client A's BBT was a baby doll was a baby doll - Client A's BBT was a baby doll	dated 1/15/19 at 1:30 PM ning and making gestures. She nates it here and calling names e stuff on the kitchen wall too. ough the house hitting stuff and					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	JILDING	NSTRUCTION 00		3) DATE S COMPLE 02/26/2	TED
	PROVIDER OR SUPPLIE		4475 N	ADDRESS, CITY, STATE, 17TH ST HAUTE, IN 47805	ZIP COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE D THE APPROPRIATE		(X5) COMPLETIO DATE
	house without per						
	indicated, "[Client clients. Refused to Knocked her (clien - Client A's BBT of indicated, "[Client across the house. T IR dated 1/20/19 at the BBT for the sa indicated, "She (cl behaviors She go throw fire extingu hit me (staff #8) in tried to do a restra but she (client A) strong to put in the several clients in t knife after she bro began to walk tow every fire alarm an after [staff #7] and locked up She the bashed it against the busted a hole in th knocking things of #1] got here. She (client A)	dated 1/20/19 at 11:00 AM (A) was cussing at staff and (b) listen. Smacked [client B]. Int B's) stuff to the ground." dated 1/20/19 at 2:30 PM (A) threw a fire extinguisher Then threw a snowball at staff." (A) threw a fire extinguisher Then threw a snowball at staff." (A) the IR elaborated on ume time period. The IR lient A) was having bad (t very angry and began to ishers, and one of them nearly (the head We (staff #8 and #7)) int and deescalate the situation, kept wiggling out and was too (e) two person hold. We got the office because she grabbed a ke out of the restraint and (ards us. She (client A) pulled and broke the one in the kitchen (I) (staff #8) got the knives (e) nook a fire extinguisher and the door of the office and (e) door. She kept hitting and ver until [Home Manager (HM)) (client A) packed her bags and t with [QIDP #2]. We (Staff #7 to clean up".					
	from the IR dated report also indicate	ated 1/20/19 outlined the events 1/20/19 at 2:00 PM the BDDS ed, "[Client A] was escorted e for a home visit with her					
	"Plan to Resolve:	[Client A] appears to be in good					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CC A. BUILDING B. WING	00	CON 02/2	te survey Mpleted 26/2019
	PROVIDER OR SUPPLIE L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP C 17TH ST HAUTE, IN 47805	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY ( health. All broken	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION I items were cleaned and I home There are no current	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
	health of safety is continue to follow	sues in the home Staff will / [client A's] BSP. Staff will or and report any changes to her				
	had seen [therapis MCR indicated, " reviewed plan for could recall the pl today and agrees t episodes of acting	dated 1/31/19 indicated client A st] for a follow up visit. The Discussed angry behaviors and better decisions. [Client A] an, four steps, without prompt to set the goal of no angry g out between now and the next s." The MCR listed the follow up				
	at 4:35 PM) [Client to live in a group and began walking the road. Staff fol her to return insid refused. HM and taken by a good sa	ated 2/4/19 indicated, "(On 2/3/19 nt A] was upset over not wanting home. [Client A] exited the home g to the stop sign at the end of lowed and verbally redirected e the home, but [client A] QIDP notified. [Client A] was amaritan driver to a local fire				
	[Client A] was ou 45 minutes. Upon continued behavio and knocked pictu then called 911. [0 [client A], and lef again left the hom police left. HM for redirect to return in not out of line of s	red and transported home. t line of sight for approximately returning home, [client A] had ors. She threw fire extinguishers ares off of the wall [Client A] City] police arrived, spoke with t without incident. [Client A] are and walked into the yard after ollowed and was able to verbally inside the home. [Client A] was sight while in the front yard.				
	activity."	down and resumed normal [Client A] appears to be in good				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE health. Staff will continue to follow her BSP. [Client A] does not currently have any alone time allotted in her plan. Staff will continue to monitor and report any changes to her health. IR dated 2/3/19 at 5:30 PM indicated, "[Client B] yelled at [HM #1] when she went outside to talk on the phone. [Client A] told [client B] to shut up and flipped her off. They called each other names and started getting close to one another. [Staff #6] got between them. [Client A] hit [staff #6] then hit [client B] with a closed fist in her right upper arm and also kicked her in her right knee. [HM #1] came back in and calmed them down and [client A] went to her room." - Client A's BBT dated 2/3/19 at 6:15 PM indicated, "Kept yelling at peer to shut up. She wants to leave and no one would come get her. She hit the door with her fist crying." IR dated 2/3/19 at 7:30 PM indicated, "[Client A] kept running from door to door to try and leave. She started kicking and elbowing [staff #6]. [Staff #6 and #7] put her in a two man standing restraint for 3 seconds and let her go. [Client B] got in her (client A's) face and tried spitting on her She (client A) tried coming after her (client B) again and was put in another two man standing restraint for 5 seconds. They let her go and (client A) sat outside with manager (HM #1) at 8:30 PM." - Client A's BBT dated 2/3/19 at 8:00 PM indicated. "She (client A) called the cops and they came to the house to talk to her. She threatened peer (unnamed client) and threw a fire extinguisher. She kept pulling the fire alarms. She knocked the bulletin board off the wall in the hallway. She tried running away again, but staff followed her."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZRF511 Facility ID: 001022

001022

If continuation sheet Pac

Page 159 of 167

03/26/2019

PRINTED:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	COMI	e survey pleted 6/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	DDRESS, CITY, STATE, ZIP COD 17TH ST HAUTE, IN 47805		
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY of - Client A's BBT indicated, "(Clien B]. Tried going a: and fire extinguis 6. BDDS dated 2/ PM) Without prior targeted behavior slapping staff in t through the home furniture and the [Client A] broke a table at the staff of then grabbed craft the office door, a	5/19 indicated, (On 2/4/19 at 6:00 r incident, [client A] exhibited s of physical aggression by he face. [Client A] walked knocking over several pieces of (stand up) freezer in the home. a table and threw the top of the ffice door repeatedly. [Client A] t paint and poured paint over TV stand, and a laundry basket	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	agency approved were not successf physical aggressic transported to [ho A] was admitted to observation pendi- hospital. [Client A to Neuropsychiat	ttempted to put [client A] in an two person standing hold, but ul due to level of [client A's] on. HM and nurse notified. Staff spital ER] for evaluation. [Client o [hospital] on 2/4/19 for ng transfer to psychiatric A] was transferred and admitted tic hospital of [city] on 2/5/19." ResCare will remain in contact				
	discharge. Broken removed from the	atric hospital of [city] pending i items have been cleaned and home. Maintenance request airs. There are no current health the home."				
	Progress Note (El	gency Medicine Physician MPPN) dated 2/4/19 at 8:02 PM . The EMPPN indicated the				
	"Arrival: 2/4/19 a	t 7:41 PM."				
"Arrival mode: Police."						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	te survey Mpleted 26/2019
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	Department) via [ complaint of hom arrival. Patient sta group home and w the group home and people, throwing over the freezer - Client A's ED Ps dated 2/4/19 at 10 following: "Presenting probl- became angry, hit threatened to kill Patient states that home because the said that patient's over the past two order is being obt her safety, and tha cooperation with "Social and Famil lived at her currer 30, 2018. Prior to another ResCare g other group home got into a fight wi jailed for 3 days f currently on proba - Client A's Appli (AED) dated 2/4/ "Applicant (docto named (client A).	sychiatric Evaluation (EDPE) :58 PM. The EDPE indicated the em: Tonight, patient (client A) her group home staff, staff and other residents she wants to leave the group re are too many people. [HM #1] behavior has been escalating daysAn emergency detention ained for this patient to ensure tt of others and to ensure				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	te survey ipleted 26/2019
	PROVIDER OR SUPPLI		4475 N	ADDRESS, CITY, STATE, ZIP ( 17TH ST HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	group home. Thre	w items around home and atient wanting to harm others."				
	person named (cli	r in ER) believes that if the ent A) above is not restrained person will harm others. patient aired."				
		ppsychiatric Hospital History and dated 2/5/19 indicated the				
		mission: Increased aggressive sical and verbal abuses to other ents."				
	is a [age] year old home Patient ha threats to other re threatened to kill. threatsPatient ha	nt illness: The patient (client A) female resident of a group d repeatedly made statements of sidents and staff whom she Patient denies all these as been experiencing escalating nruly and difficult to redirect".				
		ppsychiatric Hospital Psychiatric E) dated 2/5/19 indicated the				
	behaviorsWhen because, 'They ma any specific reaso has a history of ve and destruction of admits to being ar She states staff wa and she claims sh she does not want and she seems ori	admits to having I ask her why, she said ake me angry,' but could not give ns Patient (client A) clearly erbal and physical aggression f property She (client A) ngry at staff at the group home. as calling her derogatory names, e was being bullied. She says to return to that group home, ented She admits to having owards staff at the group home				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	provider or suppli L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP CO 17TH ST E HAUTE, IN 47805	D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	Patient (client A) danger to others, aggression She control".	has been assessed to be a based on her physical (client A) lacks impulse of stay: One to two weeks."				
	Instructions (NHI	opsychiatric Hospital Discharge DI) dated 2/19/19 at 11:00 AM. ted, "Diagnosis: Impulse control r Bipolar".				
	- Client A's Indivi 1/4/19 indicated t	dual Support Plan (ISP) dated he following:				
	"Is the individual adult? Yes."	(client A) and emancipated				
	and rights. [Clien: her ADLs (Activi is part of the PAII Identification and	e to verbalize her needs, wants, A] needs very little help with ties of Daily Living) [Client A] R (Psychiatric Assertive Referral program) and is on ar due to an incident at her				
	1/4/19 indicated p inappropriate soci aggression. The E	vior Support Plan (BSP) dated lans for elopement, al behavior, and physical SP did not indicate a BC was ng the development of client A's				
	Client E indicated home. Client E sta sets off the fire al cover my ears. It's staff will help clie	viewed on 2/20/19 at 4:25 PM. client A had behaviors in the ated, "She throws things and arms. I don't like that. I have to s too loud." Client E indicated ent A with her behaviors by r mother. Client E stated, "She'll				

AND PLAN OF CORRECTION ID		x1) provider/supplier/clia identification number 15G508	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLI L LIFE OF INDIAN		4475 N	ADDRESS, CITY, STATE, ZIP I 17TH ST E HAUTE, IN 47805	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	(client A) will go keeps doing these	after anyone in her way. She things. She calls me foul she's going to hit me with				
	Client G indicated living room. Client the TV she (client alarms in the hous all. She does it all and go to my room	rviewed on 2/20/19 at 4:30 PM. d client A broke the TV in the nt G stated, "They haven't fixed t A) broke yet. She makes the se go off too. I don't like that at the time. I have to cover my ears m." Client G indicated staff tells her room when she's having				
	Client B stated, "I asked why she did	rviewed on 2/20/19 at 4:48 PM. I don't like her (client A)." When dn't like client A, client B stated, ist don't like all the stuff she				
	Client H stated, " She has them all t go to my room a l me when she's thu house." Client H i client A during he	rviewed on 2/20/19 at 4:55 PM. [Client A] has bad behaviors. he time. I don't like it at all, so I iot. I'm scared she's going to hit rowing things around the indicated staff attempt to restrain er behaviors. Client H stated, rks. Most of the time, it seems to oset."				
	Client A indicated home #1] to [curr had a behavior wi stated, "[CFH] go Now I'm on proba either because sho this home a lot be	rviewed on 2/20/19 at 5:00 PM. d she had moved from [group ent group home] because she th another client. Client A t upset and pressed charges. ation. I can't go to day service e's there." Client A stated, "I like tter than my last one anyway. I e lower functioning clients.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE When asked why she liked being with the lower functioning clients better, client A stated, "I don't know. I guess I like being more independent than them." Client A stated, "I have friends here at the house. [Client B] and I really get along." Staff #2 was interviewed on 2/21/19 at 8:55 AM. Staff #2 stated, "[Clients A and B] don't get a long very well at all. They fight all the time. I think they both aggravate each other and escalate each others behaviors." Staff #2 indicated client A has verbally and physically aggressive behaviors and property destruction. Staff #2 stated, "No other client in the home has behaviors like hers." Staff #2 indicated when client A has a behavior staff verbally prompt her to stop, go to her room and calm down. Staff #2 stated, "I think [client A] likes living here with lower functioning clients because it gives her power over them. She feels more in control." Staff #2 stated, "I don't think [client A] fits into this home. The other ladies who live here just aren't like her." Staff #3 was interviewed on 2/21/19 at 8:17 AM. Staff #3 stated, "The other clients in the home don't have behaviors like hers (client A)." Staff #3 indicated when client A has a behavior staff verbally prompt her to stop, count to ten, and listen to music. Staff #3 stated, "I don't think any of that works though. She keeps having behaviors if she wants to." Staff #3 stated, "Many of the other clients are elderly, in wheelchairs, and need more assistance than her. I don't think [client A] is a good fit for this home." Staff #1 was interviewed on 2/20/19 at 5:16 PM. Staff #1 indicated client A's behaviors are primarily physical. Staff #1 stated, "She is awful. She tore up the house earlier this month. We (staff) try and deal with her behaviors, but it's ZRF511 Facility ID: 001022 Page 165 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

03/26/2019

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/26/2019 15G508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4475 N 17TH ST NORMAL LIFE OF INDIANA TERRE HAUTE, IN 47805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE tough. Sometimes the strategies work, but most of the time they don't." Staff #1 indicated she had been scared of client A. Staff #1 stated, "I was left here with her (client A) and a couple other clients. I was scared she's come after me or one of the other ladies." Staff #1 stated, "She's (client A) is too much for the other clients. No one else has behaviors like hers." Staff #1 stated, "[Client A] says, 'This ain't the place for me' all the time. I agree with her. I don't think she fits into this house at all." HM #1 was interviewed on 2/20/19 at 5:06 PM. HM #1 indicated client A has physical aggression, verbal aggression, and property destruction as identified behaviors. HM #1 stated, "I just don't know if the staff can deal with her. One behavior she (client A) had took three staff members to try and restrain her. WE wouldn't do it. She's too strong." HM #1 indicated the strategies provided in her BSP are ineffective. HM #1 stated, "The strategies just don't work. She (client A) is impulsive and aggressive. If she wants to have a behavior, we just can't calm her down." HM #1 indicated the other clients in the home do not like when client A has behaviors. HM #1 stated, "[Client G] used to watch TV with her (client A). But she doesn't want to anymore. She tells [client A] that she makes her (client G's) ears hurt when she sets off the fire alarms." HM #1 stated, "There are multiple clients in the home who can't defend themselves if she (client A) were to go after them during a behavior." Area Supervisor (AS) #1 was interviewed on 2/22/19 at 11:00 AM. AS #1 indicated client A has a history of verbal aggression, physical aggression, and property destruction. AS #1 stated, "Her behaviors are a lot more intense than other clients." AS #1 stated, "Clients normally jet Event ID: ZRF511 Facility ID: 001022 Page 166 of 167 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2019

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CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G508		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4475 N 17TH ST TERRE HAUTE, IN 47805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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	
	behavior. They don' #1 stated, "Clients i themselves when [c Clients have to depa AS #1 stated, "I dor for the home. I think would agree."	r when she's having a t want to be around her." AS n the home can not defend lient A] has a behavior. end on staff to protect them. of think [client A] is a good fit c the other ladies (clients) tes to complaint #IN00286338.						

ZRF511 Facility ID: 001022