PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G421	B. WIN			10/19/2012	
NAME OF I	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLITEE	K			DLMSTEAD AVE		
NORMAL	LIFE OF INDIANA	4		EVANSVILLE, IN 47711			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0000							
	This visit was for	or the investigation of	Wo	000			
		or the investigation of	WO	000			
	complaint #IN0	U11/234.					
	Complaint #IN0	00117254: Substantiated,					
	*	e deficiencies related to					
	the allegation(s) are cited at W136, W149, W331 and W460.						
	, W149, W331 ai	N 100.					
	Dates of Survey	r: 10/11, 10/15 and					
	10/19/12	. 10/11, 10/12 and					
	10/15/12						
	Facility Number	r: 000935					
	AIMS Number:						
	Provider Number						
	Trovider realise	. 15 3 121					
	Surveyor:						
	I	edical Surveyor III-Team					
	Leader	edical Salveyor III Team					
	Louder						
	These deficienc	ies also reflect state					
		rdance with 460 IAC 9.					
		completed 10/25/12 by					
		rd, Medical Surveyor III.					
	Ruth Shackello	ia, modicai baiveyoi iii.					

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
		15G421	A. BUII B. WIN			10/19/2012		
			b. Will		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	L.			DLMSTEAD AVE			
NORMAL	LIFE OF INDIANA				VILLE, IN 47711			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0136	The facility must of clients. Therefore that clients have to participate in soci community group Based on interviel of 4 sampled of failed to ensure a of his religious problem. Findings include Confidential interview as attending a 'Confidential interview as not informed different church/Confidential interview A's sister of 10/11/12 at 3:07 ISP (Individual Scient A's sister of A's 5/11/12 ISP a indicate the faciliand/or his guardireligious preferent church/Confidential interview with confidential inte	ial, religious, and activities. ew and record review for lients (A), the facility a client attended a church preference which the approved. Erview M stated client A liblack church." erview M indicated client and the client strending a religious preference. erview M indicated client and not Baptist. It was reviewed on PM. Client A's 5/11/12 Support Plan) indicated was his guardian. Client and/or record did not ity had asked client A ian if the client had a	WO	136	W136: Protection of Clients Rights - IDT with Client A over choice church & attendance with approval from guardian Bill of Rights & Grievance Po with Client A & guardian PC & Staff inserviced on guardian approval, specific to church PC will have biweekly contac with Client A's guardian.	licy	11/16/2012	

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

Event ID: V2X411

Facility ID: 000935

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
ANDILAN	or connection	15G421		LDING		10/19/	
		100121	B. WIN			10/10/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE DLMSTEAD AVE		
NORMAL	LIFE OF INDIANA				VILLE, IN 47711		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION DATE	
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAG	Dia teliate 1 y		DATE
		s his guardian. Client A onger attended church at					
		Client A indicated he					
		American's Baptist					
		st. Client A indicated he					
	_	nding the church and was					
		asked why the client was					
	_	rch anymore, client A					
		ld not attend the church					
		When asked if the client					
		a different church, client					
		cause my parents don't					
		dicated his parents were					
	_ ~	t A indicated he did not					
		church when he lived at					
	home.	ondion whom no nivod di					
	Interview with st	taff#1 on 10/11/12 at					
	7:00 AM indicat	ed client A no longer					
		with the other clients at					
	the group home.	Staff #1 indicated client					
	A's sister did not	want client A to attend a					
	Baptist church.	When asked what					
	religion client A	was, staff #1 stated					
	_	en asked if client A could					
	attend a Catholic	church, staff #1 stated					
		e have not found anyone					
		atholic church. He would					
	have to have stat						
	Interview with a	dministrative staff #1, #2					
	and the Director	of Heath Services on					
	10/15/12 at 9:00	AM, by phone, indicated					
	client A's sister/g	guardian stopped client A					
	•		-				

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Event ID: V2X411

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G421		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted '2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Administrative s client's guardian attend a Baptist of staff #1 stated a should have been client entered the Administrative s spoken with client guardian did not client A to attend Administrative s should be allowed his and/or his guardian did not client A to attend Administrative s should be allowed his and/or his guardian did not client A to attend Administrative s should be allowed his and/or his guardian did not client A to attend Administrative s should be allowed his and/or his guardian did not client A to attend Administrative s should be allowed his and/or his guardian attend a Baptist of staff and should have been client entered the Administrative s should be allowed his and/or his guardian attend a should have been client entered the Administrative s spoken with client entered the Administrative s should be allowed his and/or his guardian did not client entered the Administrative s should be allowed his and/or his guardian did not client entered the Administrative s should be allowed his and/or his guardian did not client entered the Administrative s should be allowed his and/or his guardian did not client entered the Administrative s should be allowed his and/or his guardian did not client entered the attendance the atte	taff #1 indicated he had nt A's guardian and the indicate she did not want d a Baptist church. taff #1 indicated client A ed to attend any church of						

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Event ID: V2X411

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0149 483.420(d)(1) STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711 (ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OAPPROVIDER OR SUPPLIER 10/19/2012		
NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0149 483.420(d)(1) STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711 (COMP (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE: OUT OF THE APPROPRIATE DEFICIENCY DATE: OUT OF THE APPROPRIATE DEFICIENCY DATE: OUT OF THE APPROPRIATE DEFICIENCY OUT OF THE AP	10/19/2012	
NORMAL LIFE OF INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0149 483.420(d)(1) 935 E OLMSTEAD AVE EVANSVILLE, IN 47711 (COMP PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DA W0149 483.420(d)(1)		
NORMAL LIFE OF INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0149 483.420(d)(1) EVANSVILLE, IN 47711 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE: The content of the properties of the prope		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W0149 483.420(d)(1)		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0149 483.420(d)(1) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG W0149	(X5)	
W0149 483.420(d)(1)	PLETION	
	ATE	
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	6/2012	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G421		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	indicated "Can with meals" To indicated client A doctor's appoint weight. An attack "Problem List" so "Abnormal weight." Abnormal weight. Assessment (initial client A weighed 5/11/12 assessment (initial client A was 7 per The 5/11/12 assessment (pounds) and 169. The client A was 7 per The 5/11/12 asses "Goal: Stable (pounds) of curre (pounds). (1) Commonitor weights food/beverage chec. (encourage (low) sugar (decreased dietic (nutrition) concernication of the control of t	ht loss 9/24/12" 2 Group Home Nutrition ial assessment) indicated I 176 pounds. The ent indicated client A's weight) was between he assessment indicated bunds above his IBW. Essment indicated weights +/- 5 lbs ent wt (weight): 176# ontinue Regular diet (2) (3) Encourage healthy noices at meals/snacks: 1) low salt, (low) fat, rease) caffeine (4) 3) daily (5) Consult RD ian) (with) nutr.						

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	OF CORRECTION IDENTIFICATION NUMBER: 15G421	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/19/2012			
	PROVIDER OR SUPPLIER LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
	to) difference in scales. Appetite good. Likes most foods. Food requests being honored. Within IBWR (ideal body weight range) (139-169). 0 (zero) dx (diagnosis) (changes) noted, 0 med (changes) noted and 0 new labs noted. Possibly wt. loss d/t (change) in environment, used to live at home before coming to grp (group) home. Continue regular diet, allow 2nds (seconds) as requested. Contact RD if wt. loss trend continues, may need supplements added." The quarterly assessment indicated client A's weight was 161.2 in June 2012, 160 pounds in July 2012 and no weight noted in August 2012. Client A's 10/9/12 quarterly assessment indicated "Signif (significant) wt loss noted: July wt = 160, Sept (September) = 143.2, Oct (October) = 140.8. At lower end of IBW (139-169#). Went to Dr. (doctor) for consult on 9-24-12. Eating normally. Dr. says he can have double portionsClient eating without problems, 0 c/o (complaint of), 0 vomiting, 0 diarrhea and labs taken 10-5-12: were WNL (within normal limits)Recommend adding CIB (Carnation Instant Breakfast) in whole milk at Bkfast (breakfast) and HS (bedtime) d/t 19.2# wt loss x (time) 90 days."						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
11.15 12.11	or conditions	15G421		LDING		10/19/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				DLMSTEAD AVE		
NORMAL	LIFE OF INDIANA			EVANS	VILLE, IN 47711		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ng Monthly Summaries	+	TAG	DELICE TO		DATE
	indicated the following	•					
	marcated the for	iowing.					
	-May 2012 (5/10	0/12) Client A's weight					
	was 176 pounds.	The monthly indicated					
	"Nutritional co	oncerns/changes: no"					
	`	1/12) indicated client A's					
		2 with an IBW of					
139-169. The monthly indicated "Nutritional concerns/changes: none"							
	INUUTUOHAI CC	nicerns/changes. none					
	-August 2012 nurse monthly did not						
	_	t for 8/12. The monthly					
	indicated "Nut	ritional					
	concerns/change	s: no"					
	_	2 monthly indicated client					
	_	43.2. The monthly					
	indicated "Nut						
	concerns/change	S. no					
	 Client A's 7/10/1	2 Nursing Assessment					
		ted client A's wt was					
	· ·	2. The 7/10/12 quarterly					
		not indicate any concerns					
	in regard to clier	nt A's weight loss. The					
	7/10/12 quarterly	y assessment indicated					
	· ·	re plans) current & (and)					
		documentation was					
		assessment in the					
	summary area.						
	Client A's month	nly Nursing Notes from					
	Client A's month	nly Nursing Notes from	\perp				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G421		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED /2012	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	documentation in weight loss and/o the client's weigh	hid not indicate any negard to the client's or concerns in regard to ht. Client A's 9/12 nurse he following (not all					
	physician) [name Labs CBC, CMF (dermatologist) a	appt (appointment) to a forehead, double					
	vomiting, 0 diarr indicate any add	ed client eating 0 c/o, 0 thea." The nurse note did itional information in se assessment of client					
	indicated client A monthly. The 9/ and/or nursing no facility's nurse so regard to how of	2 signed physician orders A was to be weighed 28/12 physician's order otes did not indicate the ought clarification in ten client A's doctor t weighed since the client weight loss.					
	Plan (ISP) and/o client A's IDT (in met, discussed an	2 Individual Support record did not indicate interdisciplinary team) and/or addressed the less from 6/12 to 10/11/12.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G421		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/19/2012	
	PROVIDER OR SUPPLIEI		935 E (ADDRESS, CITY, STATE, ZIP CODE DLMSTEAD AVE SVILLE, IN 47711	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicate the client for the client's w	12 ISP/risk plans did not nt had a risk plan in place reight loss/decreased the client to increase his			
	11:48 AM indic When asked if the double portions stated "Yes." Consider the brought 2 sandwing 10/11/12. Clien eat but 1 sandwing stated "I just downt to lose weighe did not have	elient A on 10/11/12 at ated he had lost weight. The client was bringing to the workshop, client A lient A indicated he wiches in his lunch for the A indicated he did not change for his lunch. Client A not like to eat a lot. If ght." Client A indicated time to eat 2 sandwiches return to work and make			
	manager on 10/1 indicated they w	elient A's workshop case 11/12 at 12:05 PM Yould have to prompt at his lunch as the client			
	and the Director (DOH) on 10/15 phone, indicated the group home indicated client 9/24/12. The Do	administrative staff #1, #2 of Health Services 5/12 at 9:00 AM, by I client A was admitted to on 4/9/12. The DOH A saw his PCP on OH indicated client A was e portions due to weight			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G421		A. BUI	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/19/2012			
	PROVIDER OR SUPPLIER			STREET A	ODDRESS, CITY, STATE, ZIP CODE DLMSTEAD AVE VILLE, IN 47711			
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
		ed what double portions						
	· ·	stated "Doubles of meat						
	_	nd everything they had.						
		owed to have twice the						
		OH indicated the						
	_	hould have notified client the client lost more than						
		month. The DOH						
	•	A's doctor was not						
		DOH indicated the						
	facility's nurse sl	hould have documented						
	client A was losing weight on her							
	monthly summar	ries. The DOH,						
	administrative st	aff #1 and #2 indicated						
	they were not ab	le to locate any						
	information/doc	umentation client A's IDT						
	_	the client's weight loss.						
		ted the facility's nurse						
		ressed/put in place a risk						
	*	nt's weight loss since the						
		e doctor on 9/24/12. The						
		he facility obtained an						
		If from client A's doctor hen asked if the nurse						
		ion on how often client A						
		ed, the DOH indicated						
	_	that in the record. The						
		Facility staff should be						
		nt a double portion of all						
	foods at meals.	r						
	- 1	licy and procedures were						
		11/12 at 1:40 PM. The						
	facility's 3/1/09	policy entitled						

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	of correction identification number: 15G421	(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 935 E OLMSTEAD AVE EVANSVILLE, IN 47711					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Procedures: Abuse/Neglect/Exploitation, Death, Incident Reporting & Investigation indicated "Any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated" This federal tag relates to complaint #IN00117254. 9-3-2(a)						

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Event ID: V2X411

Facility ID: 000935

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G421	B. WIN			10/19/	2012
NAME OF T	DROLUDED OF GURNING				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			DLMSTEAD AVE		
	LIFE OF INDIANA		_		VILLE, IN 47711		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W0331	483.460(c)	LOC IDENTIFT ING INFURMATION)	-	IAU	Sa relater j		DATE
VVUJJ I	NURSING SERV	ICES					
		provide clients with nursing					
	services in accord	dance with their needs.					
		ation, interview and	W0	331	W331: Nursing Services		11/16/2012
		r 1 of 4 sampled clients			- Nurse inserviced on P&P related to weight loss or weight gain of		
		s nursing services failed			to weight loss or weight gain of 5lbs requiring doctor notification		
	to meet the nursi	ing need of the client in			per nursing manual.	J. 1	
	regard to the clie	ent's significant weight			- Nurse inserviced on complet	ing	
	loss.				monthly & quarterly reviews.	. 1	
					 Nurse inserviced on re-weight Client A will be weighed wee 		
	Findings include): :			- Client A will be weighed wee - Nurse will visit the site a	ny.	
					minimum of weekly to monitor		
	During the 10/11	1/12 observation period			weights of clients.		
	_	M and 7:25 AM, at the			- Bill of Rights & Grievance Po	-	
		ent A fixed his own			will be completed with Client A his guardian.	4 &	
		t A fixed 2 slices of			- Staff retrained on clients righ	its &	
		jelly and a cup of hot			abuse/neglect/exploitation pol		
		50 AM, staff #1 asked			·		
		d cereal, client A					
		not want any. Staff #1,					
		and/or the facility's					
		present in the home, did					
		nd/or offer client A to eat					
		and/or offer the client a					
	substitute.	and of other the chefit a					
	substitute.						
	Client A's record	l was reviewed on					
		PM. Client A's 9/24/12					
		Report indicated client					
		*					
		f 36 pounds. Eating					
	I	e consult form indicated					
		ordered Fasting blood					
	`	lood count) CMP					
	(Comprehensive	Metabolic Panel and					

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				(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G421	B. WIN	G		10/19/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					DLMSTEAD AVE		
NORMAL	LIFE OF INDIANA			EVANS	VILLE, IN 47711		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	l ` • ′	bs. The 9/24/12 consult					
		have double portions					
		The consult form also					
		A was to set up a return					
		ment due to the client's					
	_	ched paper which had a					
	"Problem List" s						
	"Abnormal weig	ht loss 9/24/12"					
		2 Group Home Nutrition					
	,	ial assessment) indicated					
		d 176 pounds. The					
		ent indicated client A's					
		weight) was between					
		ne assessment indicated					
	_	ounds above his IBW.					
		essment indicated					
		weights +/- 5 lbs					
		ent wt (weight): 176#					
		ontinue Regular diet (2)					
	_	(3) Encourage healthy					
	food/beverage cl	noices at meals/snacks:					
	, , ,) low salt, (low) fat,					
	` / • `	rease) caffeine (4)					
	_	s daily (5) Consult RD					
	(registered dietic						
	(nutrition) conce	erns."					
	Client A's 8/21/1	2 quarterly review note					
		A's weight at doctor's					
	office 3 months	ago was 176 pounds. The					
	quarterly assessr	ment indicated "Wt. at					
	, ·	July + 160# (decrease					
	16#). Large wt.	difference maybe d/t (due					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G421	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/19/	ETED
	PROVIDER OR SUPPLIER		935 E O	ODDRESS, CITY, STATE, ZIP CODE DLMSTEAD AVE VILLE, IN 47711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Likes most foods honored. Within weight range) (1 (diagnosis) (char (changes) noted Possibly wt. loss environment, use coming to grp (gregular diet, allor requested. Contacontinues, may rathe quarterly ass A's weight was 1 pounds in July 2 in August 2012. Client A's 10/9/1 indicated "Significated "Significated" July wt = 143.2, Oct (Octoend of IBW (139) (doctor) for consinormally. Dr. saportionsClient 0 c/o (complaint diarrhea and labs WNL (within no limits)Recomm (Carnation Instanmilk at Bkfast (b	ed to live at home before roup) home. Continue w 2nds (seconds) as act RD if wt. loss trend leed supplements added." sessment indicated client 61.2 in June 2012, 160 012 and no weight noted 2 quarterly assessment (significant) wt loss (significant) wt loss (significant) wt loss (significant) wt loss (significant). Went to Dr. (ult on 9-24-12. Eating lys he can have double eating without problems, of), 0 vomiting, 0 (staken 10-5-12: were rmal)				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G421	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 10/19/	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE DLMSTEAD AVE VILLE, IN 47711	!	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	Client A's Nursii indicated the following	ng Monthly Summaries owing:					
	was 176 pounds.	7/12) Client A's weight The monthly indicated ncerns/changes: no"					
	weight was 161.2 139-169. The m	/12) indicated client A's 2 with an IBW of onthly indicated ncerns/changes: none"					
	_						
	_						
	Quarterly indicated 160.0 on 7/10/12 assessment did not in regard to client 7/10/12 quarterly "HCP (health carvalid." No other indicated on the summary area.	2 Nursing Assessment ted client A's wt was 2. The 7/10/12 quarterly of indicate any concerns at A's weight loss. The rassessment indicated are plans) current & (and) documentation was assessment in the					
	Client A's month	ly Nursing Notes from					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G421	B. WIN	G		10/19/	2012
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					DLMSTEAD AVE		
NORMAI	LIFE OF INDIANA	A.		EVANS	VILLE, IN 47711		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		did not indicate any					
		n regard to the client's					
	_	or concerns in regard to					
	the client's weig	ht. Client A's 9/12 nurse					
	notes indicated t	the following (not all					
	inclusive):						
	-9/24/12 "Seen b	by PCP (primary care					
	physician) [nam	e of doctor]. New orders.					
	Labs CBC, CMI	P, TSH. Derm					
	(dermatologist) appt (appointment) to						
	remove lesion on forehead, double portions at meals"						
	•						
	-9/22/12 "Assess	sed client eating 0 c/o, 0					
		rhea." The nurse note did					
	· ·	itional information in					
	1	rse assessment of client					
	A's eating.	assessment of enem					
	l'15 Guille.						
	 Client A's 9/28/1	12 signed physician orders					
		A was to be weighed					
		/28/12 physician's order					
	1	otes did not indicate the					
	_						
		ought clarification in					
	_	ften client A's doctor					
		t weighed since the client					
	had a significant	t weight loss.					
	O1: 1 A 1 5/11 / 1	10.1.11.1.0					
		12 Individual Support					
	` ′	or record did not indicate					
	1	sing services addressed					
	_	t loss. Client A's 5/11/12					
	ISP/risk plans di	d not indicate the client					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G421			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/19/2012
	PROVIDER OR SUPPLIEI L LIFE OF INDIANA		935 E 0	ADDRESS, CITY, STATE, ZIP CODE DLMSTEAD AVE SVILLE, IN 47711	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	_	n place for the client's reased weight to assist the e his weight.			
	11:48 AM indic. When asked if the double portions stated "Yes." Compute 2 sandwing 10/11/12. Client eat but 1 sandwing stated "I just dowant to lose weighe did not have	elient A on 10/11/12 at lated he had lost weight. The client was bringing to the workshop, client A lient A indicated he wiches in his lunch for the A indicated he did not like to eat a lot. I ght." Client A indicated time to eat 2 sandwiches return to work and make			
	manager on 10/1 indicated they we client A to go ear wanted to work. Interview with a and the Director	dministrative staff #1, #2 of Health Services			
	phone, indicated the group home indicated client 9/24/12. The Doplaced on double loss. When asked	i/12 at 9:00 AM, by I client A was admitted to on 4/9/12. The DOH A saw his PCP on OH indicated client A was e portions due to weight ed what double portions I stated "Doubles of meat			

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER: 15G421	A. BUILDING	00	10/19/2012
	130421	B. WING		10/13/2012
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
NODMAI	LIFE OF INDIANA		DLMSTEAD AVE VILLE, IN 47711	
			VILLE, IIN 411 I I	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	· · · · · · · · · · · · · · · · · · ·	IAG		DATE
	and vegetables and everything they had.			
	He should be allowed to have twice the			
	amount." The DOH indicated the			
	facility's nurse should have notified client			
	A's doctor when the client lost more than			
	5 pounds in one month. The DOH			
	indicated client A's doctor was not			
	contacted. The DOH indicated the			
	facility's nurse should have documented			
	client A was losing weight on her			
	monthly summaries. The DOH indicated			
	the facility's nurse should have			
	addressed/put in place a risk plan for the			
	client's weight loss since the client went			
	to the doctor on 9/24/12. The DOH			
	indicated the facility obtained an order for			
	the CIB from client A's doctor on			
	10/11/12. When asked if the nurse sought			
	clarification on how often client A should			
	be weighed, the DOH indicated she did			
	not find that in the record. The DOH			
	indicated facility staff should be offering			
	the client a double portion of all foods at			
	meals.			
	This federal tag relates to complaint			
	#IN00117254.			
	9-3-6(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G421	B. WING		10/19/2012
NAME OF A	OD OLUBER OR GURRI IEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEI	R	935 E (OLMSTEAD AVE	
	L LIFE OF INDIANA		<u>_</u> L	SVILLE, IN 47711	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0460	Each client must well-balanced die specially-prescrib Based on observed record review for (A), the facility	receive a nourishing, et including modified and ped diets. vation, interview and or 1 of 4 sampled clients failed to ensure the staff ent's prescribed diet for	W0460	W460: Food & Nutrition Service - IDT & update to BSP to addrest Client A's non-compliance related to diet Staff trained on updated BSF	ess ated
	double portions. Findings include	e:	- Staff retrained on appropriate substitutions for diet of Client A Staff retrained on Client A's diet/menu/plans PC will be in the home a		e A.
	between 5:00 Al group home, client wheat toast with chocolate. At 5 client A if he had indicated he did staff #2, staff #3 nurse, who was not encourage at	1/12 observation period M and 7:25 AM, at the ent A fixed his own at A fixed 2 slices of a jelly and a cup of hot :50 AM, staff #1 asked d cereal, client A not want any. Staff #1, a and/or the facility's present in the home, did and/or offer client A to eat and/or offer the client a		minimum of weekly to ensure staff are appropriately followin Client A's diet/menu/plans.	
	10/11/12 at 3:07 Medical Consul A had a "Loss o normally" The client A's doctor work of CBC (b	d was reviewed on PM. Client A's 9/24/12 t Report indicated client f 36 pounds. Eating the consult form indicated to ordered Fasting blood clood count) CMP to Metabolic Panel and			

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G421	B. WIN	G		10/19/2	012
NAME OF E	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER				LMSTEAD AVE		
NORMAL	LIFE OF INDIANA			EVANS	VILLE, IN 47711		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	l ` • ′	bs. The 9/24/12 consult					
		have double portions					
		The consult form also					
		A was to set up a return					
		ment due to the client's					
	~	ched paper which had a					
	"Problem List" s	ection indicated					
	"Abnormal weig	ht loss 9/24/12"					
	Client A's 5/11/1	2 Group Home Nutrition					
		ial assessment) indicated					
	` `	d 176 pounds. The					
		ent indicated client A's					
		weight) was between					
		ne assessment indicated					
	_	ounds above his IBW.					
		essment indicated					
		weights +/- 5 lbs					
		ent wt (weight): 176#					
		ontinue Regular diet (2)					
	_	(3) Encourage healthy					
	food/beverage cl	noices at meals/snacks:					
	` ` `) low salt, (low) fat,					
	(low) sugar (dec	rease) caffeine (4)					
	Encourage fluids	s daily (5) Consult RD					
	(registered dietic	cian) (with) nutr.					
	(nutrition) conce	erns."					
	Client A's 8/21/1	2 quarterly review note					
		A's weight at doctor's					
		ago was 176 pounds. The					
		nent indicated "Wt. at					
	1 2	July + 160# (decrease					
	1 - 1	•					
	10#). Large wt.	difference maybe d/t (due					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
ANDILAN	OI CORRECTION	15G421		LDING	00	10/19/	
		100721	B. WIN			10/19/	20 12
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NORMAL	LIFE OF INDIANA				DLMSTEAD AVE VILLE, IN 47711		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		scales. Appetite good.					
		s. Food requests being					
		IBWR (ideal body					
	• • • • • • • • • • • • • • • • • • • •	39-169). 0 (zero) dx					
		nges) noted, 0 med					
	`	and 0 new labs noted.					
	Possibly wt. loss	` • /					
	*	ed to live at home before					
	0 01 0	roup) home. Continue					
	_	w 2nds (seconds) as					
	•	act RD if wt. loss trend					
		need supplements added."					
		sessment indicated client					
	_	61.2 in June 2012, 160					
	pounds in July 2	012 and no weight noted					
	in August 2012.						
		2 quarterly assessment					
	•	(significant) wt loss					
	_	= 160, Sept (September) =					
	, ,	ber) = 140.8. At lower					
	,	9-169#). Went to Dr.					
	(doctor) for cons	ult on 9-24-12. Eating					
	normally. Dr. sa	ys he can have double					
	•	eating without problems,					
	0 c/o (complaint	of), 0 vomiting, 0					
	diarrhea and labs	s taken 10-5-12: were					
	WNL (within no	rmal					
	limits)Recomn	nend adding CIB					
	(Carnation Instar	nt Breakfast) in whole					
	milk at Bkfast (b	reakfast) and HS					
	(bedtime) d/t 19.	2# wt loss x (time) 90					
	days."	• •					
	j						

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G421	B. WIN			10/19/	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
NORMAI	LIFE OF INDIANA				VLMSTEAD AVE VILLE, IN 47711		
				<u> </u>	VILLE, IIV 7 77 11		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
		2 monthly Nursing				Į	
		by PCP (primary care					
		e of doctor]. New orders.					
	Labs CBC, CMF	-					
		appt (appointment) to					
	l ' - '	n forehead, double					
	portions at meals	*					
	Portions at moun	·····					
	Interview with c	lient A on 10/11/12 at					
		ated he had lost weight.					
		ne client was bringing					
		to the workshop, client A					
		ient A indicated he					
		riches in his lunch for					
	~	t A indicated he did not					
		ch for his lunch. Client A					
		not like to eat a lot. I					
		ght." Client A indicated					
		time to eat 2 sandwiches					
		return to work and make					
	money.						
	3 -						
	Interview with c	lient A's workshop case					
		1/12 at 12:05 PM					
	_	ould have to prompt					
	1	t his lunch as the client					
	wanted to work.						
	Interview with a	dministrative staff #1, #2					
	and the Director	of Health Services					
	(DOH) on 10/15	/12 at 9:00 AM, by					
	` ′	client A was admitted to					
		on 4/9/12. The DOH					
		A saw his PCP on					

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Facility ID: 000935

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
	15G421	A. BUILDING B. WING		10/19/2012
			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		DLMSTEAD AVE	
NORMAL	LIFE OF INDIANA	EVANS	VILLE, IN 47711	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1110	9/24/12. The DOH indicated client A was	1110		3.112
	placed on double portions due to weight			
	loss. When asked what double portions			
	meant, the DOH stated "Doubles of meat			
	and vegetables and everything they had.			
	He should be allowed to have twice the			
	amount." The DOH indicated facility			
	staff should be offering the client a double			
	portion of all foods at meals.			
	This Calculates related to 1.14			
	This federal tag relates to complaint			
	#IN00117254.			
	9-3-8(a)			
) 5 G(a)			

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