

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

PRINTED: 01/04/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G227		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2012	
NAME OF PROVIDER OR SUPPLIER  MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 723 CHERRY TREE LN SOUTH BEND, IN 46617			
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 13, 19, 20, 26 and 30, 2012.</p> <p>Facility number: 000751 Provider number: 15G227 AIM number: 100248910</p> <p>Surveyors: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 11, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000					

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed and to ensure clients did not pay for haircuts.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 11/13/12 from 6:15 A.M. until 8:45 A.M.. Upon entering the medication/laundry room of clients #1, #2, #3, #4, #5 and #6's home, the ceiling light fixture was observed to have a missing cover. 1 of 2 living room light fixtures dangled from the ceiling with the wires exposed. The bathroom located in the hallway leading to the clients' bedrooms did not have a toilet paper holder. The toilet paper sat on the back of the toilet. The wall behind the back door had a 3 inch by 3 inch hole.</p> <p>An interview with Residential Instructors (RIs) #1 and #2 was conducted on 11/13/12 at 6:55 A.M. and 7:45 A.M. DSP #2 indicated the light fixture cover</p>	W0104	<p>In regards to evidence cited by the medical surveyor, the the ceiling fixture in the medication/laundry room was repaired and the cover was replaced. Additionally, a toilet paper holder was intalled in the bathroom located in the hallwawy leading to the clients' bedrooms. Each of these repairs was completed on or before 12/14/2012. In order to assure that this deficiency does not recur in this facility, Per Mosaic policy and procedure, quarterly safety inspections are completed for each facility Mosaic operates. As a part of this inspection, Mosaic assures ceiling fixtures and bathrooms are inspected to assure each are properly maintained. As a further means to assure this deficiency does not recur, Mosaic management conducts multiple weekly visits to each facility to assure the site is properly maintained. As a part of this visit, each manager assures lighting fixtures and restrooms arein sufficient condition for client use. In regards to the evidence cited by the medical surveyor regarding reimbursement for client haircuts, clients' #1, #4, #5, and #6 were reimbursed for expenses on or before 12/21/12. In order to assure that</p>	12/14/2012			

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	<p>had been missing for over a year. DSP #1 indicated the living room light fixture needed to be fixed.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/26/12 at 10:30 A.M. The QMRP indicated the mentioned repairs needed to be done.</p> <p>2. A financial record review was conducted on 11/20/12 at 12:15 P.M.. A review of client #1's financial record indicated he paid for a haircut on 4/4/12 in the amount of \$5.00. Further review of the record failed to indicate he had been reimbursed for the expenditure. A review of client #4's financial record indicated he paid for a haircut on 4/18/12 in the amount of \$5.00. Further review of the record failed to indicate he had been reimbursed for the expenditure. A review of client #5's financial record indicated he paid for a haircut on 12/22/11 in the amount of \$15.00. Further review of the record failed to indicate he had been reimbursed for the expenditure. A review of client #6's financial record indicated he paid for a haircut on 4/4/12 in the amount of \$5.00. Further review of the record failed to indicate he had been reimbursed for the expenditure.</p> <p>An interview with Qualified Mental</p>		<p>this deficiency does not recur in this facility, Per Mosaic policy and procedure, quarterly financial audits are conducted to ensure money is properly managed. Specifically, financial records are reviewed to assure peopler supported are reimbursed for haircut expenses in the event they pay for the haircut. As a further means to assure this deficiency does not recur, Mosaic management conducts multiple weekly visits to each facility to assure the site is properly maintained. As a part of this visit, each manager reviews client expenses for the week to assure they are conducted within Mosaic policy.</p>				

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	<p>Retardation Professional (QMRP) was conducted on 11/26/12 at 10:30 A.M.</p> <p>The QMRP indicated the facility is responsible for paying for clients haircuts and further indicated clients should not be paying for haircuts.</p> <p>9-3-1(a)</p>				

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3), to provide assistance to exercise their rights by restricting access to the home's heating/cooling thermostat.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/13/12 from 6:15 A.M. until 8:45 A.M. During the entire observation, the heating/cooling thermostat located in the hallway leading to clients #1, #2 and #3's bedrooms had a clear plastic locked box over the thermostat.</p> <p>An evening observation was conducted at the group home on 11/13/12 from 2:35 P.M. until 5:00 P.M. During the entire observation, the heating/cooling thermostat located in the hallway leading to the clients' bedrooms had a clear plastic locked box over the thermostat.</p> <p>An interview with Residential Instructor</p>	W0125	<p>Mosaic has policies and procedures to be sure to define and describe the rights of persons served. To promote the rights, interests, and well-being of all persons served and to specify how any individual or their guardian may seek enforcement of these rights on behalf of the individual. This policy and procedure explains how all residents are educated on their rights and will describe how every individual served has the right to independent personal decisions and knowledge of available choices. Each client and guardian signs a receipt which documents the annual review of the rights of each person served by Mosaic. Mosaic provides all staff training on the rights of each person served. This training is completed prior to employment as well as presented annually. The staff at this facility were retrained on 12/20/12. In response to the evidence identified by the Medical Surveyor, the lock on the thermostate was removed 12/14/2012. All clients in facility have access to the thermostat.</p>	12/20/2012			

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	<p>(RI) #7 was conducted at the group home on 11/13/12 at 4:25 P.M. RI #7 indicated the heating/cooling thermostats were locked at all times.</p> <p>A review of client #1's record was conducted at the facility's administrative office on 11/19/12 at 2:40 P.M. The review failed to indicate the need for the home heating/cooling thermostat to be restricted for client #1.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 11/19/12 at 3:25 P.M. The review failed to indicate the need for the home heating/cooling thermostat to be restricted for client #2.</p> <p>A review of client #3's record was conducted at the facility's administrative office on 11/19/12 at 3:45 P.M. The review failed to indicate the need for the home heating/cooling thermostat to be restricted for client #3.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/26/12 at 10:30 A.M. The QMRP stated, "The thermostat should not be locked that is their home."</p> <p>9-3-2(a)</p>		To further assure this deficiency does not recur, the facility QIDP or home manager conducts multiple visits to the facility to assure the rights of all clients are protected. Specifically, staff assure the facility is free from unnecessary restrictions.				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to implement written objectives during times of opportunity for 3 of 3 sampled clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/13/12 from 6:15 A.M. until 8:45 A.M. During the entire observation period, clients #1 and #3 sat in the dining room. Client #2 walked back and forth from the bedroom hallway to the dining room. Residential Instructors (RI) #1, #2 and #3 would occasionally walk through and visually check on clients #1, #2 and #3 but did not offer meaningful active treatment activities or implement client objectives. Client #1 did not and was not prompted to wear his eyeglasses during the entire observation period.</p> <p>A review of client #1's records was conducted on 11/19/12 at 2:40 P.M. A</p>	W0249	<p>In regards to evidence cited by the medical surveyor, retraining on the specific goals identified in the evidence pertaining active treatment was conducted again on December 20, 2012 for all facility staff. This training was conducted by the facility QIDP. This training session specifically identified the active treatment and support training for each client as identified in their Individual program plan. Specifically, the facility staff was trained on the Individual Program Plan for client #1, #2 and #3. Staff reviewed both the formal in informal objectives in each individual's IPP. Furthermore, staff were retrained on using all formal and informal opportunities in order to implement a continuous active treatment program. To assure this deficiency does not recur in the facility, Mosaic has Policies and Procedures stating that each client served must have an individual program plan. This plan includes needed interventions and services to support achievement of goals and objectives identified in the plan</p>	12/20/2012	

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	<p>review of the client's 6/13/12 Individual Support Plan indicated the following objectives which could have been implemented during the 11/13/12 morning observation period: "Will exercise...will practice reviewing his rights...will complete daily household tasks/chores...Every morning and evening staff will prompt client #1 to wear his eyeglasses...will participate in self medication."</p> <p>A review of client #2's records was conducted on 11/19/12 at 3:25 P.M. A review of the client's 3/26/12 Individual Support Plan indicated the following objectives which could have been implemented during the 11/13/12 morning observation period: "Will complete a chore daily excluding laundry or trash...will learn how to dial on a phone...will practice reviewing his rights, and will use his picture i-pad (computer) daily."</p> <p>A review of client #3's records was conducted on 11/19/12 at 3:45 P.M. A review of the client's 1/25/12 Individual Support Plan indicated the following objectives which could have been implemented during the 11/13/12 morning observation period: "Will learn to communicate his wants and needs...will learn about safety skills...will work on his</p>		through ongoing active To further assure this deficiency does not recur, the facility QIDP or home manager conducts multiple visits to the facility to assure each person living at the facility recieves continuous active treatment. Specifically, that staff implemenet the written program plans.				

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	<p>money goal...will exercise daily...Staff will interact with client #3 every 10-15 minutes as part of his active treatment schedule...Staff will choose a picture from a magazine and ask client #3 to describe it."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 11/26/12 at 10:30 A.M. The QMRP stated client objectives should be implemented "during all times of opportunity." The QMRP further indicated clients #1, #2 and #3 should have been provided with meaningful active treatment activities during the 11/13/12 morning observation period.</p> <p>9-3-4(a)</p>				

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed to ensure 3 of 3 sampled clients (clients #1, #2 and #3), had follow-up examinations as recommended by the physician.</p> <p>Findings include:</p> <p>A review of client #1's medical record was conducted on 11/19/12 at 2:40 P.M. Client #1's record indicated a most current vision evaluation/assessment dated 9/2/11 which indicated: "Return in 1 year for complete evaluation." Review of client #1's record failed to indicate he had a follow up completed. No further documentation was available for review to indicate client #1 had a follow-up visit as recommended.</p> <p>A review of client #2's medical record was conducted on 11/19/12 at 3:25 P.M.. Client #2's record indicated a most current vision evaluation/assessment dated 4/3/10 which indicated a recommendation by the optometrist to return in 1 year. Review of client #2's record failed to indicate he had a follow up completed. No further documentation was available for review to indicate client #2 had a follow-up visit as recommended.</p>	W0322	<p>In regards to evidence cited by the medical surveyor in part 1, the vision screening was completed on 12/6/12 for client #1. Findings and recommendations have been incorporated into Client #1's IPP. A summary will be maintained in the client's master file after the assessment has been completed. Additionally, the vision screening was completed on 12/6/12 for client #2. Findings and recommendations have been incorporated into Client #2's IPP. A summary will be maintained in the client's master file after the assessment has been completed. the vision screening has been scheduled for completion on 12/6/12 for client #3. Findings and recommendations will be incorporated into Client #3's IPP immediately after the assessment. A summary will be maintained in the client's master file after the assessment has been completed. To assure this deficiency does not recur, the agency RN completes the annual health summary for each person served in the facility. The RN tracks the completion of each required screening. The RN communicates to the facility manager when an annual screening or assessment is due. This is completed on agency nursing notes. The manager</p>	12/20/2012			

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	<p>A review of client #3's medical record was conducted on 11/19/12 at 3:45 P.M. Client #3's record indicated a most current vision evaluation/assessment dated 1/31/11 which indicated a recommendation by the optometrist to return in 1 year. Review of client #3's record failed to indicate he had a follow-up completed. No further documentation was available for review to indicate client #3 had a follow up visit as recommended.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted 11/26/12 at 10:30 A.M. The QMRP indicated there was no documentation in the clients' records to show the follow-up visits occurred as recommended by the optometrist.</p> <p>9-3-6(a)</p>		<p>schedules and assures each screening or assessment is completed and reports back to the facility RN via facility nursing notes. To assure this deficiency does not recur, Mosaic policy and procedure requires an annual physical be completed prior to admission, updated annually or as the individual's doctor recommends. To further assure this deficiency does not recur, Mosaic has a records review committee conducts a quarterly audit reviewing a 10% sample of client records to assure the file is up to date and accurate. This audit assures that all medical evaluations are current and the IPP reflects the findings of the those evaluations.</p>		

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W0323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #2), to provide an annual physical.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 11/19/12 at 3:25 P.M. Client #2's record indicated a most current annual physical dated 8/30/11. Client #2's record did not contain evidence he had a more current annual physical.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 11/26/12 at 10:30 A.M. The QMRP indicated the group home manager failed to assure client #2 went for an annual physical. The QMRP further indicated client #2 did not have an annual physical since the 8/30/11 physical.</p> <p>9-3-6(a)</p>	W0323	<p>In regards to evidence cited by the medical surveyor, the annual physical has been scheduled for completion on 1/6/13 for client #2. Findings and recommendations have been incorporated into Client #2's IPP. A summary will be maintained in the client's master file after the assessment has been completed. To assure this deficiency does not recur, the agency RN completes the annual health summary for each person served in the facility. The RN tracks the completion of each required screening. The RN communicates to the facility manager when an annual screening or assessment is due. This is completed on agency nursing notes. The manager schedules and assures each screening or assessment is completed and reports back to the facility RN via facility nursing notes. To assure this deficiency does not recur, Mosaic policy and procedure requires an annual physical be completed prior to admission, updated annually or as the individual's doctor recommends. To further assure this deficiency does not recur, Mosaic has a records review committee conducts a quarterly audit reviewing a 10% sample of</p>	12/21/2012			

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			client records to assure the file is up to date and accurate. This audit assures that all medical evaluations are current and the IPP reflects the findings of the those evaluations.		

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NAME OF PROVIDER OR SUPPLIER  MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 723 CHERRY TREE LN SOUTH BEND, IN 46617			
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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 2 clients observed during the morning medication administration (clients #1 and #4) to ensure staff administered 5 of 11 of the clients' medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/13/12 from 6:15 A.M. until 8:45 A.M. At 7:25 A.M., Residential Instructor (RI) #2 was observed administering client #1's prescribed medications, "Aspirin 325 mg (milligram) (arthritis) tablet...Potassium CLER (chloride extended release) tablet (supplement)...Spironolactone 25 mg tablet (fluid retention from congestive heart failure)...Carvedilol 6.25 mg tablet (congestive heart failure) with a 1 ounce Dixie cup of water. At 6:30 A.M., a review of the client's 11/12 MAR/Medication Administration Record and of the medication punch cards dated 11/12 indicated: "Aspirin 325 mg (milligram) (arthritis) tablet...take with food/meal...Potassium CLER (chloride</p>	W0369	<p>In regards to evidence cited by the medical surveyor, Mosaic policy and procedure specifies all medication administered, are administered without error. All Mosaic Staff are trained on this policy in conjunction with Core A and Core B medication administration at new staff orientation and updated annually or as needed. To assure this deficiency does not recur, Mosaic retrained all facility staff were retrained on the agency medication administration policy and procedure on December 20, 2012. To further ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple visits each week to every facility by the house manager (Direct Support Manager) and the Program Coordinator (QIDP). During this visit, the manager assures medications are administered in accordance with Mosaic policy and procedure. Furthermore, the agency Registered Nurse conducts monthly reviews. During this time, the RN reviews the facility's medication administration records to assure medications are administered in accordance with Mosaic Policy. Any potential concern identified is</p>	12/20/2012			

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	<p>extended release) tablet (supplement)...take with food/meal...Spironolactone 25 mg tablet (fluid retention from congestive heart failure)...take with food/meal...Carvedilol 6.25 mg tablet (congestive heart failure)...take with food/meal. Client #1 did not eat any food during the morning observation.</p> <p>At 7:40 A.M., client #4 was observed receiving his prescribed medications. Client #4 received his Calcium 600 mg with Vitamin D (osteoporosis) with a 1 ounce Dixie cup of water. At 7:43 A.M., a review of client #4's 11/12 MAR and of the medication punch cards dated 11/12 indicated: "Calcium 600 mg plus Vitamin D tablet...1 tablet two times a day...Take with food/meal." Client #4 was observed to eat breakfast at 8:35 A.M.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 11/26/12 at 10:30 A.M.. The QMRP indicated the clients should have been given their medications with at least 8 ounces of water and with food. The QMRP further indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p>		immediately reported to the facility QMRP.				

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (client #3), the facility failed to assure the staff provided food in accordance with client's diet order.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/13/12 from 6:15 A.M. until 8:45 A.M. At 8:25 A.M., Residential Instructor/RI #3 served oatmeal into a bowl, placed eggs on a plate and poured coffee into a cup. RI #3 asked client #3 if he wanted sugar in his coffee and handed him the white sugar bowl. Client #3 put 3 tablespoons of sugar in his coffee cup and drank the entire cup of coffee. Client #3 was not offered sugar substitute or redirected.</p> <p>A review of client #3's record was conducted on 11/19/12 at 3:45 P.M. Review of client #3's most current Nutritional Assessment dated 9/7/12 indicated: "1200 ADA diet (American Diabetic Association)...weight 200 pounds...weight range: 106 pounds plus or minus 10 pounds."</p>	W0460	<p>In regards to evidence cited by the medical surveyor, Mosaic's Dietary Policy and Procedure states that each client must receive a balanced diet including modified and specially prescribed diets as prescribed by the agency Registered Dietician. On 12/20/2012, Mosaic staff received retraining on client #3's 1200 ADA diet as specified in the IPP and the Annual Nutritional Assessment. The staff were also retrained on each client's dietary plan to assure all residents in the facility receive nourishing, well balanced meals. To ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple visits each week to every facility by the house manager (Direct Support Manager) and the Program Coordinator (QIDP). During this visit, each assures that direct care staff provides nourishing, well balanced meals in accordance with each individual's dietary plan.</p>	12/20/2012			

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/26/12 at 10:30 A.M. The QMRP indicated staff should have followed client #3's prescribed diet and should have redirected him from having regular sugar due to him being a diabetic.  9-3-8(a)						

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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed to ensure 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), were involved in meal preparation during breakfast.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/13/12 from 6:15 A.M. until 8:45 A.M. Beginning at 7:50 A.M., RI/Residential Instructor #3 put bread into the toaster, prepared a pot of oatmeal and scrambled eggs, while clients #1, #2, #3, #4, #5 and #6 sat nearby with no activity. At 8:05 A.M., RI #3 put the prepared meal on the dining table where the clients sat. Clients #2, #3, #4, #5 and #6 ate independently. Clients #1, #2, #3, #4, #5 and #6 did not assist in meal preparation.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 11/26/12 at 10:30 A.M.. The QMRP indicated the clients were capable of assisting in meal preparation and further indicated they should be assisting</p>	W0488	Mosaic's Dietary Policy and Procedure states that each individual served should participate in the preparation and service during all meals. On December 20, 2012, All facility staff received training on conducting meal time goals and objectives in accordance with each individual's Individual Program Plan. To ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple visits each week to every facility by the house manager (Direct Support Manager) and the Program Coordinator (QMRP). During this visit, each assures the facility encourages and teaches each client meal preparation tasks.	12/20/2012			

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	in meal preparation at meal times.  9-3-8(a)			