

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2015
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00174437.</p> <p>Complaint #IN00174437 Substantiated-Federal/state deficiency related to the allegation was cited at W154.</p> <p>Dates of Survey: 6/30/15 and 7/1, 2, 6/2015.</p> <p>Provider Number: 15G589 Aims Number: 100235510 Facility Number: 001103</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate 2 of 4 incidents reviewed for allegations of (physical aggression) client to client abuse (clients B, C).</p>	W 0154	<p>W154 483.420 (d)(3) STAFF TREATMENT OF CLIENTS As of 7/20/15, all reported incidents involving Alleged Client to Client Abuse/Aggression will receive the same follow up</p>	07/20/2015

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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	<p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 6/30/15 at 2:08p.m.</p> <p>(1) A reportable incident report, dated 3/28/15, indicated client B and client C had a physical altercation. The report indicated client C received a rug burn on his left forearm (with bleeding) and a 3 inch open scratch behind his right ear. The 4/02/15 "Client to Client Physical Aggression Inquiry/Investigation Form" did not contain documentation of the staff involved and staff and client interviews.</p> <p>(2) A reportable incident report dated 4/05/15 indicated client B had "jumped" client C. The report indicated a physical altercation ensued before staff separated the clients. The report indicated client B had redness to his right eye. The facility's 4/09/15 "Client to Client Physical Aggression Inquiry/Investigation Form" did not document which staff were involved and had no staff or client interviews.</p> <p>The facility's "Client to Client Physical Aggression Inquiry/Investigation Form" indicated "Please attach witness statements from all clients present and staff on duty at time of the incident."</p> <p>Professional staff #3 was interviewed on</p>		<p>process as all other agency Inquiry/Investigations. This follow up process will include a thorough review of the incident and any recommendations for additional follow up as needed. This process will ensure that all relevant incidents receive the proper Inquiry/Investigation process and necessary follow up including People Notified of Investigation and Outcome, Recommendations, and or Actions Taken, The Date the Action is Taken By, The Person Responsible, The Date the Action was Completed, and a check that all Follow Up Documents have been received. The Investigation Coordinator will ensure that the inquiry/investigation was thorough and that all appropriate documents and witness interviews are included. The Follow Up Plan Document (See attached) will require the signature and review of the Investigation Coordinator and the Associate or Executive Director. The Inquiry/Investigations of this nature will be filed with all other Inquiries/Investigations.</p>	

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W 0249 Bldg. 00	<p>7/2/15 at 2:04p.m. Staff #3 indicated there were no documented staff/client interviews for the 3/28/15 and 4/05/15 investigations for client to client aggression. Staff #3 indicated the facility should have documented staff and client interviews and documentation to indicate which staff were on duty at the time of the incidents.</p> <p>This federal tag relates to complaint #IN00174437.</p> <p>9-3-2(a)</p> <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 for 2 of 3 sampled clients (B, C), to ensure the clients' identified meal preparation training programs were implemented when opportunities were present.</p> <p>Findings include:</p>	W 0249	<p>W249 483.440 (d)(1) PROGRAM IMPLEMENTATION</p> <p>The Direct Support Manager and all staff that work at this site will be re-trained on Mosaics Individual Service and Supports Policy (See attached) by 8/3/15 to instruct that each person receives individualized services and</p>	08/03/2015			

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	<p>An observation was done on 6/30/15 from 4:48p.m. to 6:42p.m., at the group home. During the observation, facility staff did not encourage clients, who were available to assist (A, B, C, E, F), to participate in all aspects of their meal preparation. During the meal preparation from 5:20p.m to 5:53p.m., staff #4 custodially opened cans of mixed vegetables, poured the vegetables into a bowl and put them into the microwave, drained the noodles and put them into a serving bowl, opened canned peaches and poured them into a serving bowl and put all the serving bowls onto the dining room table. Client F had asked to help with the meal and staff #4 told client F "I got it."</p> <p>Record review for client B was done on 7/2/15 at 12:15p.m. Client B had an individual habilitation plan (IHP) dated 6/1/15. The IHP indicated client B had a training program goal to correctly measure one ingredient in a recipe.</p> <p>Record review for client C was done on 7/2/15 at 11:32a.m. Client C had an IHP dated 12/15/14. The IHP indicated client C had a training program goal to assist with making dinner.</p> <p>Professional staff #2 was interviewed on</p>		<p>supports and to ensure that program implementation as created by the IDT and written in the Individuals Habilitation Plan should occur. This policy instructs from the beginning the nature and necessity of the IDT, the Individual Habilitation Plan, participation in team meetings, service development (assessments, goal development, activity schedules, short term objectives etc.) service monitoring (monthly reviews, service observation reviews, communication etc.) and Active Treatment. All staff that work at this site will be re-trained on the program goals of every individual that lives at this site by 8/3/15. In addition all staff that work at this site will be re-trained on MosaiCs Active Treatment/Active Habilitation training by 8/3/15. The Habilitation Coordinator will conduct a site observation of at least two meals monthly and the Direct Support Manager will conduct a site observation of at least two meals weekly to ensure that program implementation specifically in this area is occurring as written. These site observations will be ongoing for 90 days and will then be reviewed for effectiveness in implementation improvement by the Quality Assurance Coordinator. It will then be determined how frequent the observations should continue, based upon the success of</p>				

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W 0260 Bldg. 00	<p>7/2/15 at 11:38a.m. Staff #2 indicated clients B and C had cooking goals to assist with meal preparation. Staff #2 indicated these training programs should have been implemented at all opportunities</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview, the facility failed for 1 of 3 sampled clients (A) to at least annually review and revise client A's individual habilitation plan (IHP). Findings include: Record review for client A was done on 7/2/15 at 1:06p.m. Client A's training program review indicated client A's current documented annual IHP was over a year old and was dated 6/26/14.</p>	W 0260	<p>implementation.</p> <p>W260 483.440 (f)(2) PROGRAM MONITORING & CHANGE This expired annual review was due to an oversight as a result of employee turnover in the habilitative coordinator position. This annual review and IDT meeting was completed on 7/7/15 for this specific individual and the updated IHP is in process. Mosaic had previously scheduled an audit for all SGL IHP dates to occur on 7/22/15. Mosaic will ensure that this audit is conducted and that all of the</p>	07/22/2015

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W 0488 Bldg. 00	<p>Interview of staff #1 (qualified intellectual disability professional, QIDP) on 7/2/15 at 1:40p.m., indicated client A's current IHP was past due. Staff #1 indicated the annual IHP had not been completed annually (within 365 days).</p> <p>9-3-4(a)</p> <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. Based on observation and interview for 3 of 3 sampled clients (A, B, C,) and 2 additional clients (E, F), the facility failed to encourage the clients to participate in meal preparation to the extent they were capable.</p> <p>Findings include:</p> <p>An observation was done on 6/30/15 from 4:48p.m. to 6:42p.m., at the group home. During the observation, facility staff did not encourage clients, who were available to assist (A, B, C, E, F), to participate in all aspects of their meal preparation. During the meal preparation from 5:20p.m to 5:53p.m., staff #4 custodially opened cans of mixed</p>			W 0488	<p>findings will be reviewed by the Quality Assurance Coordinator on that date to ensure that there have been no other annual plans that have expired. Mosaic will in the future conduct this audit within the week of a vacancy created in the habilitative coordinator position to ensure that we have accurate dates to rely on for meeting planning and timely updates.</p> <p>W488 483.440 (d)(4) DINING AREAS AND SERVICESAll staff that work with individuals at this site will be re-trained on Mosaics policy and procedure for Dietary and Nutritional Counseling Services with additional emphasis on the Food Preparation and Service Section. This training will be completed by 8/3/15. The Habilitation Coordinator will conduct a site observation of at least two meals weekly and the Direct Support Manager will conduct a site observation of at least one meal daily to ensure that dietary/habilitation supervision specifically is occurring during mealtimes. These site observations will be ongoing for 45 days and will then be reviewed for effectiveness in</p>		08/03/2015

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	<p>vegetables, poured the vegetables into a bowl and put them into the microwave, drained the noodles and put them into a serving bowl, opened canned peaches and poured them into a serving bowl and put all serving bowls onto the dining room table. Client F had asked to help with the meal and staff #4 told client F "I got it."</p> <p>Interview of professional staff #2 on 7/2/15 at 11:35a.m. indicated all the clients were capable of assisting with the meal preparation with some staff assistance. Staff #2 indicated the clients should have been more involved with the family style meal.</p> <p>9-3-8(a)</p>		<p>implementation improvement by the Quality Assurance Coordinator. It will then be determined how frequent the observations should continue, based upon the success of implementation.</p>				