STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: October 8, 9, 10, 11, and 15, 2013 Facility number: 000772 Provider number: 15G252 AIM number: 100234940 Surveyor: Tim Shebel, LSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed October 22, 2013 by Dotty Walton, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. Based on record review and interview, the facility failed to assure the Comprehensive Functional Assessment for 1 of 4 sampled clients (client #2) was signed and dated by the person completing the assessment. Findings include: Client #2's record was reviewed on 10/10/13 at 9:23 A.M. A review of client #2's Comprehensive Functional Assessment failed to indicate the assessment was signed and dated by the person completing the assessment. Associate Director #1 was interviewed on 10/10/13 at 10:55 A.M. Associate Director #1 indicated the Qualified Intellectual Disabilities Professional failed to sign and date client #2's Comprehensive Functional Assessment. 9-3-1(a)	W000114	In regards to evidence cited by the medical surveyor, the comprehensive functional assessment was sent to client #2's day program and residential program on 10/16/13 for completion. The completed functional assessment will be completed and reviewed on or before 11/8/13. Findings from the assessment will be presented to the IDT and client #2's Support Plan will be adjusted based on IDT feedback and recommendations. To assure this deficiency does not recur in the facility, Mosaic has Policies and Procedures stating that each client served must have a comprehensive functional assessment. The QIDP for the facility was retrained on this policy on 10/16/13. To further ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple record reviews annually to assure all assessments are completed per policy.	11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement their abuse/neglect policy to thoroughly investigate 7 of 7 reviewed incidents of client to client abuse involving 2 of 4 sampled clients (clients #2 and #3), and 2 additional clients (clients #6 and #7). Findings include: The facility's records were reviewed on 10/8/13 at 1:59 P.M. The following incidents of client to client abuse were reviewed: 1. "Date: 08/22/2013, Narrative: [Client #3] woke up with scratches on his face this morning. Staff noticed it when getting him up for the morning routine. It was obvious by his reaction he (client #3) was frustrated and it was not concise whether it was self inflicted or by a house mate. Upon asking his room mate, (client #2), his room mate admitted to scratching him (client #3) because he (client #3) turned off the light. This is not a new behavior. [Client #2's] behavior plan is tracking physical aggression. [Client #2] is being seen by a psychiatrist in September. PLAN TO RESOLVE: Staff	W000149	In regards to evidence cited by the medical surveyor, per policy and procedure, each incident of suspected client abuse, neglect, mistreatment and exploitation should have been immediately reported and consequently investigated within 24 hours of the allegation as stipulated in agency policy. Additionally, investigations must be completed within 5 working days and in the event additional time is needed, the investigator must complete a summary statement of progress with an anticipated time for completion of the investigation and submitted to the Investigations Coordinator assigned to the matter. To assure this deficiency does not recur, the investigator did conduct a review into the incident, however the progress summary was not completed and submitted to the investigation coordinator. On 10/16/13, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation. Furthermore, Mosaic has policies and procedures that prohibit abuse, neglect, exploitation, or mistreatment of the individuals the agency serves and to inform employees of their responsibilities	11/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notified manager promptly and are going to pay extra close attention to [client #2] when he is in his room with housemate." 2. "Date: 08/12/2013, Narrative: [Client #3] and [client #2] were siting in the living room before leaving for Day Program. [Client #2] suddenly came up to [client #3] and slapped him in his left shoulder area. PLAN TO RESOLVE: [Client #2] was quickly redirected and he calmed down right away. There had been no indication that he was upset. [Client #3] was checked and had no marks or injuries. He (client #3) did not react at all. Staff followed behavior support plans and there were no further altercations the remainder of the shift." 3. "Date: 08/07/2013, Narrative: [Client #2] was in the van and [client #7] was sitting behind him (client #2) sniffing him. [Client #2] said, 'My mother said you cannot sniff me.' and he (client #2) turned around and hit [client #7]. PLAN TO RESOLVE: [Client #2] was quickly re-directed and he calmed down. Staff checked over [client #7] and he had no marks or injuries and stated that he was ok. Staff will ensure that when riding in the same vehicle, the 2 men are not within arms (sic) reach of each other. Staff will continue to follow behavior support plans and work to prevent further altercations."		as mandatory reporters. Each employee completes training as a part of new staff orientation as well as annual reviews on the agency Abuse, Neglect, Mistreatment and Exploitation Policy and Procedure. Finally, the agency conducts an audit of all investigations semi annually to assure the agency investigation and inquiry policy is sufficiently followed. Addendum In response to the request for additional information, per Mosaic policy, Investigations and their subsequent reports must be completed and submitted to the investigation coordinator within 5 days. Management may request a meeting with the investigation coordinator to discuss progress in an Investigation or a summary of the facts found as they exist at the time.Addendum: Language regarding extension has been removed (11/15/13)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. "Date: 08/02/2013, Narrative: The guys were at the group home preparing to leave for day program. [Client #7] was hitting his own chest as he often does. [Client #2] became agitated and suddenly went over to [client #7] and hit him with an open hand on his (client #7's) left arm shoulder area. PLAN TO RESOLVE: Staff quickly intervened and separated the guys. [Client #2] was given some time to cool off and staff checked to make sure [client #7] was ok. He (client #7) indicated that he was ok and he had no marks, redness or injury. Staff will continue to follow behavior support plans and work to prevent future altercations." 5. "Date: 07/09/2013, Narrative: [Client#7] was sitting in the movie theater watching a movie. While watching the movie, [client #7] was making his normal feet tapping noises and rocking in his seat. [Client #2] started shaking his finger and waving his hand at him [client #7]. He (client #2) did not appear to be angry and staff thought he (client #2) was just joking around. All of a sudden [client #2] got up and came over and hit [client #7] on the back and on the back of the neck. PLAN TO RESOLVE: Staff quickly intervened and redirected [client #2] to come out in the lobby. [Client #2] was given time to cool down. [Client #7]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	communicated that he was ok and had no marks or injuries. Followed up with staff to check in with [client #2] if he is showing similar signs to clarify if he is upset {even if he doesn't appear to be} and to keep a dialogue going to ensure he [client #2] is not getting agitated to the point where he becomes physical." 6. "Date: 06/25/2013, Narrative: [Client #6] and [client #2] had gotten into a verbal confrontation. They were both redirected to different rooms with [client #6] going into the living room. [Client #6] was sitting in the recliner when [client #2] came out of his room and tried kicking [client #6]. He [client #2] then hit [client #6] and was being redirected. However, as [client #6] was moving to a different area, [client #2] ran around staff and hit [client #6] again. While being redirected again, [client#2] went after [client #6] again. Staff did an escort maneuver by placing their arms around [client #2's] waist and turning him away from [client #6]. PLAN TO RESOLVE: [Client #2] was redirected to his room where he took some time to cool off. Staff looked [client #6] over and he had no marks or injuries. The two men were given time apart from each other for the rest of the shift. Staff will continue to follow behavior support plans and do what they can to prevent further			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	altercations." 7. "Date: 05/25/2013, Narrative: [Client #2] was in the parking lot on his way into a movie with his housemates. At this time for no apparent reason he [client #2] got angry with housemate (client #6) and as [client #6] got out of the van [client #2] scratched him. [Client #6] had only a few scratches on his face that were take (sic) of by first aid. Staff separated the two guys and they calmed down. After talking to staff and the two guys this morning [client #2] could not tell me why he was angry and [client #6] was not upset anymore. [Client #6] has no effects from the scratches and is doing fine. PLAN TO RESOLVE: Staff will continue to take the men out in the community but work a little more at reading the signs of agitation in the men. The staff did a good job de-escalating the situation with speed." The aforementioned incidents were further reviewed on 10/10/13 at 9:07 A.M. Further review failed to indicate the incidents of client to client abuse where thoroughly investigated. Associate Director #1 was interviewed on 10/10/13 at 10:55 A.M. Associate Director #1 indicated she had interviews with staff in regard to the seven incidents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of client to client abuse but did not have evidence of a thorough investigation into the seven incidents of client to client abuse. The facility's records were further reviewed on 10/10/13 at 1:48 P.M. Review of the facility's "Abuse, Neglect, Exploitation or Mistreatment Policy and Procedure," dated 1/8/2008, indicated, in part, the following: "Abuse is any real or potential infliction of physical, psychological, or emotional harm, injury, or pains that is the result of non-accidental conduct." And, "The agency will conduct an investigation on all alleged incidents of abuse, neglect, or exploitation that involves an agency employee suspected of being a perpetrator or for client to client allegations in which the perpetrator is served by the agency." 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000154	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 7 of 7 reviewed incidents of client to client abuse involving 2 of 4 sampled clients (clients #2 and #3), and 2 additional clients (clients #6 and #7). Findings include: The facility's records were reviewed on 10/8/13 at 1:59 P.M. The following incidents of client to client abuse were reviewed: 1. "Date: 08/22/2013, Narrative: [Client #3] woke up with scratches on his face this morning. Staff noticed it when getting him up for the morning routine. It was obvious by his reaction he (client #3) was frustrated and it was not concise whether it was self inflicted or by a house mate. Upon asking his room mate, (client #2), his room mate admitted to scratching him (client #3) because he (client #3) turned off the light. This is not a new behavior. [Client #2's] behavior plan is tracking physical aggression. [Client #2] is being seen by a psychiatrist in September. PLAN TO RESOLVE: Staff notified manager promptly and are going	W000154	In regards to evidence cited by the medical surveyor, per policy and procedure, each incident of suspected client abuse, neglect, mistreatment and exploitation should have been immediately reported and consequently investigated within 24 hours of the allegation as stipulated in agency policy. Additionally, investigations must be completed within 5 working days and in the event additional time is needed, the investigator must complete a summary statement of progress with an anticipated time for completion of the investigation and submitted to the Investigations Coordinator assigned to the matter. To assure this deficiency does not recur, the investigator did conduct a review into the incident, however the progress summary was not completed and submitted to the investigation coordiantor. On 10/16/13, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation. Furthermore, Mosaic has policies and procedures that prohibit abuse, neglect, exploitation, or mistreatment of the individuals the agency serves and to inform employees of their responsibilities	11/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to pay extra close attention to [client #2] when he is in his room with housemate." 2. "Date: 08/12/2013, Narrative: [Client #3] and [client #2] were siting in the living room before leaving for Day Program. [Client #2] suddenly came up to [client #3] and slapped him in his left shoulder area. PLAN TO RESOLVE: [Client #2] was quickly redirected and he calmed down right away. There had been no indication that he was upset. [Client #3] was checked and had no marks or injuries. He (client #3) did not react at all. Staff followed behavior support plans and there were no further altercations the remainder of the shift." 3. "Date: 08/07/2013, Narrative: [Client #2] was in the van and [client #7] was sitting behind him (client #2) sniffing him. [Client #2] said, 'My mother said you cannot sniff me.' and he (client #2) turned around and hit [client #7]. PLAN TO RESOLVE: [Client #2] was quickly re-directed and he calmed down. Staff checked over [client #7] and he had no marks or injuries and stated that he was ok. Staff will ensure that when riding in the same vehicle, the 2 men are not within arms (sic) reach of each other. Staff will continue to follow behavior support plans and work to prevent further altercations."		as mandatory reporters. Each employee completes training as a part of new staff orientation as well as annual reviews on the agency Abuse, Neglect, Mistreatment and Exploitation Policy and Procedure. Finally, the agency conducts an audit of all investigations semi annually to assure the agency investigation and inquiry policy is sufficiently followed. Addendum In response to the request for additional information, per Mosaic policy, Investigations and their subsequent reports must be completed and submitted to the investigation coordinator within 5 days. Management may request a meeting with the investigation coordinator to discuss progress in an Investigation or a summary of the facts found as exist at the time. Addendum: Language regarding extension has been removed (11/15/13)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. "Date: 08/02/2013, Narrative: The guys were at the group home preparing to leave for day program. [Client #7] was hitting his own chest as he often does. [Client #2] became agitated and suddenly went over to [client #7] and hit him with an open hand on his (client #7's) left arm shoulder area. PLAN TO RESOLVE: Staff quickly intervened and separated the guys. [Client #2] was given some time to cool off and staff checked to make sure [client #7] was ok. He (client #7) indicated that he was ok and he had no marks, redness or injury. Staff will continue to follow behavior support plans and work to prevent future altercations." 5. "Date: 07/09/2013, Narrative: [Client#7] was sitting in the movie theater watching a movie. While watching the movie, [client #7] was making his normal feet tapping noises and rocking in his seat. [Client #2] started shaking his finger and waving his hand at him [client #7]. He (client #2) did not appear to be angry and staff thought he (client #2) was just joking around. All of a sudden [client #2] got up and came over and hit [client #7] on the back and on the back of the neck. PLAN TO RESOLVE: Staff quickly intervened and redirected [client #2] to come out in the lobby. [Client #2] was given time to cool down. [Client #7] communicated that he was ok and had no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	marks or injuries. Followed up with staff to check in with [client #2] if he is showing similar signs to clarify if he is upset {even if he doesn't appear to be} and to keep a dialogue going to ensure he [client #2] is not getting agitated to the point where he becomes physical." 6. "Date: 06/25/2013, Narrative: [Client #6] and [client #2] had gotten into a verbal confrontation. They were both redirected to different rooms with [client #6] going into the living room. [Client #6] was sitting in the recliner when [client #2] came out of his room and tried kicking [client #6]. He [client #2] then hit [client #6] and was being redirected. However, as [client #6] was moving to a different area, [client #2] ran around staff and hit [client #6] again. While being redirected again, [client#2] went after [client #6] again. Staff did an escort maneuver by placing their arms around [client #2's] waist and turning him away from [client #6]. PLAN TO RESOLVE: [Client #2] was redirected to his room where he took some time to cool off. Staff looked [client #6] over and he had no marks or injuries. The two men were given time apart from each other for the rest of the shift. Staff will continue to follow behavior support plans and do what they can to prevent further altercations."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7. "Date: 05/25/2013, Narrative: [Client #2] was in the parking lot on his way into a movie with his housemates. At this time for no apparent reason he [client #2] got angry with housemate (client #6) and as [client #6] got out of the van [client #2] scratched him. [Client #6] had only a few scratches on his face that were take (sic) of by first aid. Staff separated the two guys and they calmed down. After talking to staff and the two guys this morning [client #2] could not tell me why he was angry and [client #6] was not upset anymore. [Client #6] has no effects from the scratches and is doing fine. PLAN TO RESOLVE: Staff will continue to take the men out in the community but work a little more at reading the signs of agitation in the men. The staff did a good job de-escalating the situation with speed." The aforementioned incidents were further reviewed on 10/10/13 at 9:07 A.M. Further review failed to indicate the incidents of client to client abuse where thoroughly investigated. Associate Director #1 was interviewed on 10/10/13 at 10:55 A.M. Associate Director #1 indicated she had interviews with staff in regard to the seven incidents of client to client abuse but did not have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evidence of a thorough investigation into the seven incidents of client to client abuse. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed to implement effective corrective action in regard to 7 of 7 reviewed incidents of client to client abuse involving 2 of 4 sampled clients (client #2 and #3), and 2 additional clients (clients #6 and #7). Findings include: The facility's records were reviewed on 10/8/13 at 1:59 P.M. The following incidents of client to client abuse were reviewed: 1. "Date: 08/22/2013, Narrative: [Client #3] woke up with scratches on his face this morning. Staff noticed it when getting him up for the morning routine. It was obvious by his reaction he (client #3) was frustrated and it was not concise whether it was self inflicted or by a house mate. Upon asking his room mate, (client #2), his room mate admitted to scratching him (client #3) because he (client #3) turned off the light. This is not a new behavior. [Client #2's] behavior plan is tracking physical aggression. [Client #2] is being seen by a psychiatrist in September. PLAN TO RESOLVE: Staff notified manager promptly and are going	W000157	In regards to evidence cited by the medical surveyor, per policy and procedure, each incident of suspected client abuse, neglect, mistreatment and exploitation should have been immediately reported and consequently investigated within 24 hours of the allegation as stipulated in agency policy. Additionally, investigations must be completed within 5 working days. To assure this deficiency does not recur, the investigator did conduct a review into the incident, however the progress summary was not completed and submitted to the investigation coordinator. On 10/16/13, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation. Furthermore, Mosaic has policies and procedures that prohibit abuse, neglect, exploitation, or mistreatment of the individuals the agency serves and to inform employees of their responsibilities as mandatory reporters. Each employee completes training as a part of new staff orientation as well as annual reviews on the agency Abuse, Neglect, Mistreatment and Exploitation Policy and Procedure. Finally, the agency conducts an audit of all investigations semi annually to	11/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to pay extra close attention to [client #2] when he is in his room with housemate." 2. "Date: 08/12/2013, Narrative: [Client #3] and [client #2] were siting in the living room before leaving for Day Program. [Client #2] suddenly came up to [client #3] and slapped him in his left shoulder area. PLAN TO RESOLVE: [Client #2] was quickly redirected and he calmed down right away. There had been no indication that he was upset. [Client #3] was checked and had no marks or injuries. He (client #3) did not react at all. Staff followed behavior support plans and there were no further altercations the remainder of the shift." 3. "Date: 08/07/2013, Narrative: [Client #2] was in the van and [client #7] was sitting behind him (client #2) sniffing him. [Client #2] said, 'My mother said you cannot sniff me.' and he (client #2) turned around and hit [client #7]. PLAN TO RESOLVE: [Client #2] was quickly re-directed and he calmed down. Staff checked over [client #7] and he had no marks or injuries and stated that he was ok. Staff will ensure that when riding in the same vehicle, the 2 men are not within arms (sic) reach of each other. Staff will continue to follow behavior support plans and work to prevent further altercations."		assure the agency investigation and inquiry policy is sufficiently followed. Addendum In response to the request for additional infomration, per Mosaic policy, completed investigations will be reviewed by the Investigations Coordinator utilizing the Investigation Checklist to ensure that the process was thorough and complete before it goes to Management to review and determine what action should be taken. The Investigation Checklist will be placed with the completed Investigation Report in a locked confidential file. Additionally, the Agency, with support from the Organizational Excellence Director reviews each Investigation Report for which they are responsible for both quality assurance using the Investigation Checklist as well as assuring any and all recommendations are implemented.Addendum: Language regarding extension has been removed (11/15/13)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. "Date: 08/02/2013, Narrative: The guys were at the group home preparing to leave for day program. [Client #7] was hitting his own chest as he often does. [Client #2] became agitated and suddenly went over to [client #7] and hit him with an open hand on his (client #7's) left arm shoulder area. PLAN TO RESOLVE: Staff quickly intervened and separated the guys. [Client #2] was given some time to cool off and staff checked to make sure [client #7] was ok. He (client #7) indicated that he was ok and he had no marks, redness or injury. Staff will continue to follow behavior support plans and work to prevent future altercations." 5. "Date: 07/09/2013, Narrative: [Client#7] was sitting in the movie theater watching a movie. While watching the movie, [client #7] was making his normal feet tapping noises and rocking in his seat. [Client #2] started shaking his finger and waving his hand at him [client #7]. He (client #2) did not appear to be angry and staff thought he (client #2) was just joking around. All of a sudden [client #2] got up and came over and hit [client #7] on the back and on the back of the neck. PLAN TO RESOLVE: Staff quickly intervened and redirected [client #2] to come out in the lobby. [Client #2] was given time to cool down. [Client #7] communicated that he was ok and had no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	marks or injuries. Followed up with staff to check in with [client #2] if he is showing similar signs to clarify if he is upset {even if he doesn't appear to be} and to keep a dialogue going to ensure he [client #2] is not getting agitated to the point where he becomes physical." 6. "Date: 06/25/2013, Narrative: [Client #6] and [client #2] had gotten into a verbal confrontation. They were both redirected to different rooms with [client #6] going into the living room. [Client #6] was sitting in the recliner when [client #2] came out of his room and tried kicking [client #6]. He [client #2] then hit [client #6] and was being redirected. However, as [client #6] was moving to a different area, [client #2] ran around staff and hit [client #6] again. While being redirected again, [client#2] went after [client #6] again. Staff did an escort maneuver by placing their arms around [client #2's] waist and turning him away from [client #6]. PLAN TO RESOLVE: [Client #2] was redirected to his room where he took some time to cool off. Staff looked [client #6] over and he had no marks or injuries. The two men were given time apart from each other for the rest of the shift. Staff will continue to follow behavior support plans and do what they can to prevent further altercations."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7. "Date: 05/25/2013, Narrative: [Client #2] was in the parking lot on his way into a movie with his housemates. At this time for no apparent reason he [client #2] got angry with housemate (client #6) and as [client #6] got out of the van [client #2] scratched him. [Client #6] had only a few scratches on his face that were take (sic) of by first aid. Staff separated the two guys and they calmed down. After talking to staff and the two guys this morning [client #2] could not tell me why he was angry and [client #6] was not upset anymore. [Client #6] has no effects from the scratches and is doing fine. PLAN TO RESOLVE: Staff will continue to take the men out in the community but work a little more at reading the signs of agitation in the men. The staff did a good job de-escalating the situation with speed." Client #2's record was reviewed on 10/10/13 at 9:23 A.M. The review indicated client #2's last behavior assessment was dated 4/2012. Client #2's Behavior Support Plan was last updated on 4/25/13. Further review of client #2's record indicated the client was seen for an intake assessment for psychiatric services on 9/23/13 and had an appointment to be seen by a psychiatrist on 11/4/13.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Associate Director #1 was interviewed on 10/10/13 at 10:55 A.M. Associate Director #1 indicated assessment of client #2's behavior and corrective actions should have been taken sooner to assist in effectively managing client #2's physical aggression. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessment for 1 of 4 clients (client #1) was reviewed at least annually. Findings include: Client #1's record was reviewed on 10/10/13 at 8:55 A.M. The review indicated the client's most current Comprehensive Functional Assessment was dated 7/12. Associate Director #1 was interviewed on 10/10/13 at 10:55 A.M. Associate Director #1 stated the Qualified Intellectual Disabilities Professional "must have overlooked reviewing [client #1's] assessment (Comprehensive Functional Assessment)." 9-3-4(a)	W000259	In regards to evidence cited by the medical surveyor, the comprehensive functional assessment was sent to client #2's day program and residential program on 10/16/13 for completion. The completed functional assessment will be completed and reviewed on or before 11/8/13. Findings from the assessment will be presented to the IDT and client #2's Support Plan will be adjusted based on IDT feedback and recommendations.To assure this deficiency does not recur in the facility, Mosaic has Policies and Procedures stating that each client served must have a comprehensive functional assessment. The QIDP for the facility was retrained on this policy on 10/16/13. To further ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple record reviews annually to assure all assessments are completed per policy. Addendum In response to the request for additional information, upon hire and as needed, Mosaic trains each QIDP on completing not only the required assessment, but additional assessments as well. After review of this QIDP's	11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN 46514	

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			caseload, this missing functional assessment was an isolated incident. Each of the other 7 residents had current functional assessments completed. Mosaic utilizes multiple data sources to develop an ISP. The following assessments are completed: Personal Outcomes Interview, Safety Assessment, Natural Supports Assessment, Self Assessment, Nursing Assessment, Rights Assessment, Informed Consent Assessment, Dietary Assessment, and the Functional Assessment. Data collected is reviewed in a pre-planning meeting prior to the ISP meeting. In this case, the dated functional assessment was overlooked.Monitoring is conducted through multiple record reviews completed through the year (as stated above). A full and comprehensive record review is completed annually for all people in the facility. Additional full reviews are conducted any time the agency experiences turnover with a QIDP or House Manager. Additionally, the agency conducts a sample review with an outside source 3-4 times a year to assure records are in compliance. This particular assessment fell between the last assessment and the next one scheduled for late October.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure a medication was locked except when it was being prepared for administration for 1 of 4 sampled clients (client #3). Findings include: Direct care staff #3 was observed passing medications to client #3 during the 10/8/13 observation period from 3:07 P.M. until 5:30 P.M. At 3:20 P.M., direct care staff #3 called client #3 to the medication room and then prepared the client's medications for administration. Direct care staff #3 left the medication room for 22 seconds to wash her hands. During this time, the client's medications were openly accessible to client #3 who was waiting to take his medications. Associate Director #1 was interviewed on 10/10/13 at 10:55 A.M. Associate Director #1 indicated direct care staff should have had all medications locked when staff were not in the medication room. 9-3-6(a)	W000382	In regards to evidence cited by the medical surveyor Mosaic policy and procedure specifies all medication must be kept in a secured location. All Mosaic Staff are trained on this policy at new staff orientation and updated annually or as needed. Additionally, Direct Support Staff were trained on the importance of not leaving medications unlocked when the need to step away from the room arises. To assure this deficiency does not recur, Mosaic trained all facility staff including the facility QIDP were retrained on the agency medication administration policy and procedure on or before 11/8/13.Training was focused on storage and assuring medications are properly secured at all times. 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 ProgramCoordinator (QIDP). During this visit, the manager assures medications are secured.Furthermore, the agency Registered Nurse conducts monthly reviews. During this time, the RN reviews the facility's storage practices. Any potential	11/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			concern identified is immediately reported to the facility QIDP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000488	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, record review, and interview, the facility failed to assure 4 of 4 sampled clients (clients #1, #2, #3, and #4), participated in family style dining to the full extent of their assessed capabilities. Findings include: Clients #1, #2, #3, and #4 were observed at the group home during the 10/9/13 observation period from 7:07 A.M. until 8:33 A.M. During the observation, direct care staff #6 prepared individual servings of oatmeal and toasted English muffins and poured orange juice and milk and placed these items for each individual client as clients #1, #2, #3, and #4 sat at the table. Clients #1, #2, #3, and #4 were not prompted or assisted by direct care staff #6 in preparing the oatmeal or English muffins or in pouring their own juice and milk. Client #1's records were reviewed on 10/10/13 at 8:55 A.M. A review of the client's 7/12 Comprehensive Functional Assessment indicated client #1 was developmentally capable, with staff assistance, of assisting with meal	W000488	Mosaic's Dietary Policy and Procedure states that each individual served should participate in the preparation and service during all meals. On or before November 8, 2013, All facility staff received training on conducting meal time goals and objectives in accordance with each individual's Individual Program Plan. Additionally, the previous Direct Support Manager responsible for assuring family style dining doesn't hold that position. 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 the facility encourages and teaches each client meal preparation tasks. The Direct Support Manager and QIDP collectively observe 10-12 meals a week at varying times to assure family style dining is implemented.	11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preparations and participating in family style dining. Client #2's records were reviewed on 10/10/13 at 9:23 A.M. A review of the client's undated Comprehensive Functional Assessment indicated client #2 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in family style dining. Client #3's records were reviewed on 10/10/13 at 9:50 A.M. A review of the client's 4/13/13 Comprehensive Functional Assessment indicated client #3 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in family style dining. Client #4's records were reviewed on 10/10/13 at 10:27 A.M. A review of the client's 9/25/13 Comprehensive Functional Assessment indicated client #4 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in family style dining. Associate Director #1 was interviewed on 8/22/13 at 11:07 A.M. Associate Director #1 indicated clients #1, #2, #3 and #4 were developmentally capable of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	1319 LAWN AVE ELKHART, IN 46514

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	participating in the preparation of their own meals with verbal prompts or hand over hand assistance from direct care staff. 9-3-8(a)			