

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 2820 BENHAM AVE ELKHART, IN 46517		
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 7, 8, 9, and 13, 2012.</p> <p>Facility number: 000800 Provider number: 15G280 AIM number: 100243460</p> <p>Surveyor: Tim Shebel, Medical Surveyor III.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 16, 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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W0130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed to assure privacy for changing an incontinence brief for 1 of 3 additional clients (client #6).</p> <p>Findings include:</p> <p>During the 11/7/12 observation period from 3:04 P.M. until 6:00 P.M., client #6 was observed lying in a hospital bed in the family room of the facility. At 4:40 P.M., direct care staff #1 and #4 changed client #6's incontinence brief in clear view of clients #2, #3 and #4 as they sat in the adjacent open dining area. Direct care staff #1 and #4 did not assure client #6's privacy while changing his incontinence brief.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/8/12 at 11:17 A.M.. QMRP #1 indicated client #6 was in hospice care and spent most of his time in the family room of the facility. QMRP #1 further indicated direct care staff #1 and #4 should have assured client #6 had privacy for incontinence and personal care.</p>	W0130	<p>Mosaic has policies and procedures that define and describe the rights of persons served. These policies explain how the agency promotes the rights, interests, and well-being of all persons served and specifies 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 privacy during treatment and care of personal needs. Each client and guardian signs a receipt which documents the annual review of the rights of each person served by Mosaic. In regards to the evidence provided by the medical surveyor, Mosaic staff assure all hygiene supports provided to people supported, especially the changing of an incontinent brief, are done in a private location. On 11/26/12, a privacy screen was purchased and put in place for use in the event Client #6 required a change of brief while in the family room. Additionally, On 12/12/2012, all facility staff will be retrained on the client bill of rights, specifically the section on the</p>	12/12/2012			

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	9-3-2(a)		right to privacy, and the specific issues regarding Client #6 will be addressed. Finally, to further assure this deficiency does not recur, weekly visits by the facility manager and QMRP are conducted to assure each person living at the facility has their right to privacy. Also, quarterly home visits to the facility by a member of the Human Rights Committee are conducted to assure there are no rights violations occur at the facility.		

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W0149	<p>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 its abuse/neglect policy involving investigations and inquiries to assure the results of all investigations were reported to the administrator within five business days for 1 of 1 reviewed investigation of alleged staff to client abuse for 1 of 3 additional clients (client #4).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 11/7/12 at 1:11 P.M. The review indicated the following allegation of abuse:</p> <p>Name: (Client #4), Date of incident: 4/16/12, Date of knowledge: 4/17/12, Narrative: "Staff reported to the QMRP (Qualified Mental Retardation Professional) that when [direct care staff #10] and two other staff members were assisting [client #4] during a transfer from her wheelchair to the toilet that [direct care staff #10] pushed [client #4's] head back quickly. [Client #4] did not complain of any pain during or since the incident. [Direct care staff #10] was suspended pending the results of the</p>	W0149	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 11/30/2012, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation, specifically as it pertains to incidents where additional time beyond the 5 day completion target is exceeded. Furthermore, Mosaic has policies and procedures that prohibit abuse, neglect, exploitation, or	11/30/2012	

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	<p>investigation. Plan to Resolve: An investigation is in progress to determine if the incident occurred. Staff suspended pending the results of an investigation."</p> <p>A review on 11/7/12 at 2:10 P.M. of the facility's "[Group home] inquiry (investigation)" of the 4/16/12 alleged abuse incident indicated the QMRP submitted the findings to the administrator on 4/26/12.</p> <p>The facility's "Investigations and Inquiries" policy, dated 10/1/09, was reviewed on 11/7/12 at 2:11 P.M.. The policy indicated, in part, the following: "Investigations must be completed within 5 working days. However, if additional time is needed, the investigator must complete a summary statement of progress with an anticipated time for completion of the investigation and (sic) submitted to the Investigations Coordinator assigned to the matter."</p> <p>Associate Director #1 was interviewed on 11/7/12 at 2:19 P.M.. Associate Director #1 stated, "I'm sure he (administrator) was verbally notified of the results (investigation results within five days of the incident) but we have no written proof of that."</p> <p>9-3-2(a)</p>		<p>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 assure the agency investigation and inquiry policy is sufficiently followed.</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to implement its abuse/neglect policy involving investigations and inquiries to assure the results of all investigations were reported to the administrator within five business days for 1 of 1 reviewed investigation of alleged staff to client abuse for 1 of 3 additional clients (client #4).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 11/7/12 at 1:11 P.M. The review indicated the following allegation of abuse:</p> <p>Name: (Client #4), Date of incident: 4/16/12, Date of knowledge: 4/17/12, Narrative: "Staff reported to the QMRP (Qualified Mental Retardation Professional) that when [direct care staff #10] and two other staff members were assisting [client #4] during a transfer from her wheelchair to the toilet that [direct care staff #10] pushed [client #4's] head back quickly. [Client #4] did not complain of any pain during or since the</p>	W0156	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 11/30/2012, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation, specifically as it pertains to incidents where additional time beyond the 5 day completion target is exceeded. Furthermore, Mosaic has policies	11/30/2012			

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	<p>incident. [Direct care staff #10] was suspended pending the results of the investigation. Plan to Resolve: An investigation is in progress to determine if the incident occurred. Staff suspended pending the results of an investigation."</p> <p>A review on 11/7/12 at 2:10 P.M. of the facility's "[Group home] inquiry (investigation)" of the 4/16/12 alleged abuse incident indicated the QMRP submitted the findings to the administrator on 4/26/12.</p> <p>Associate Director #1 was interviewed on 11/7/12 at 2:19 P.M.. Associate Director #1 stated, "I'm sure he (administrator) was verbally notified of the results (investigation results within five days of the incident) but we have no written proof of that."</p> <p>9-3-2(a)</p>		<p>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 assure the agency investigation and inquiry policy is sufficiently followed.</p>		

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility's QMRP (Qualified Mental Retardation Professional) failed to revise objectives when no progress was achieved for three consecutive months for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 11/8/12 at 9:36 A.M.. Review of the client's 3/28/12 IPP (Individual Program Plan) indicated the client had an objective to "use I-pad (computer) to discuss mood, wants, and/or needs." Review of the QMRP monthly reviews and data collected for the implementation of the objective indicated the following: September, 2012 - 8 of 8 trials attempted indicated "No I-pad." August, 2012 - no data available. July, 2012 - 11 of 11 trials attempted indicated "No I-pad." Further review indicated the client had an objective to "use communication book." Review of QMRP monthly reviews and data collected for the implementation of the objective indicated the following: September, 2012 - 8 of 8 trials attempted indicated the client "refused." August,</p>	W0159	<p>It is Mosaic Policy and Procedure that each client served has an individual program plan. This plan includes needed interventions and services to support achievement of goals and objectives identified in the plan through programming. Each staff receives training on this plan annually and as changes and updates to the plan are made. The training includes strategies that will enable the clients to achieve each goal and objective and revisions as they are accomplished or static. Due to the evidence provided by the medical surveyor, Client #2's communication goal was reviewed and changed. The new communication goal (as approved by the IDT) will begin December 1. Retraining on the updates/revision of goals identified in the evidence pertaining to client #2's communication goal will be retrained on 12/12/2012. This training session will specifically identify the standard for goal revision and monitoring for Client #2's progress on his communication goal. To further assure this deficiency does not recur, weekly visits by the facility manager and QMRP are</p>	12/12/2012			

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	<p>2012 - 17 of 17 trials attempted indicated the client "refused." July, 2012 - 10 of 10 trials attempted indicated the client "refused."</p> <p>QMRP #1 was interviewed on 11/8/12 at 11:17 A.M.. The QMRP indicated the facility was "in the process" of getting an I-pad for client #2's use. QMRP #1 further indicated she had not modified or changed the aforementioned objectives in regard to client #2's three month lack of progression.</p> <p>9-3-3(a)</p>		<p>conducted to assure each client's individual program plan is properly implemented. Finally, the agency conducts an audit which entails a review of monthly reports assuring progress on Individual Program Plans is properly documented. This audit is conducted semi annually.</p>		

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W0257	<p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on record review and interview, the facility's QMRP (Qualified Mental Retardation Professional) failed to revise objectives when no progress was achieved for three consecutive months for 1 of 3 sampled clients (client #2) .</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 11/8/12 at 9:36 A.M.. Review of the client's 3/28/12 IPP (Individual Program Plan) indicated the client had an objective to "use I-pad (computer) to discuss mood, wants, and/or needs." Review of QMRP monthly reviews and data collected for the implementation of the objective indicated the following: September, 2012 - 8 of 8 trials attempted indicated "No I-pad." August, 2012 - no data available. July, 2012 - 11 of 11 trials attempted indicated "No I-pad." Further review indicated the client had an objective to "use communication book." Review of QMRP monthly reviews and data collected for the implementation of the objective indicated the following:</p>	W0257	<p>It is Mosaic Policy and Procedure that each client served has an individual program plan. This plan includes needed interventions and services to support achievement of goals and objectives identified in the plan through programming. Each staff receives training on this plan annually and as changes and updates to the plan are made. The training includes strategies that will enable the clients to achieve each goal and objective and revisions as they are accomplished or static. Due to the evidence provided by the medical surveyor, Client #2's communication goal was reviewed and changed. The new communication goal (as approved by the IDT) will begin December 1. Retraining on the updates/revision of goals identified in the evidence pertaining to client #2's communication goal will be retrained on 12/12/2012. This training session will specifically identify the standard for goal revision and monitoring for Client #2's progress on his communication goal. To further</p>	12/12/2012			

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	<p>September, 2012 - 8 of 8 trials attempted indicated the client "refused." August, 2012 - 17 of 17 trials attempted indicated the client "refused." July, 2012 - 10 of 10 trials attempted indicated the client "refused."</p> <p>QMRP #1 was interviewed on 11/8/12 at 11:17 A.M.. The QMRP indicated the facility was "in the process" of getting an I-pad for client #2's use. QMRP #1 further indicated the aforementioned objectives had not been modified or changed in regard to client #2's three month lack of progression.</p> <p>9-3-4(a)</p>		<p>assure this deficiency does not recur, weekly visits by the facility manager and QMRP are conducted to assure each client's individual program plan is properly implemented. Finally, the agency conducts an audit which entails a review of monthly reports assuring progress on Individual Program Plans is properly documented. This audit is conducted semi annually.</p>		

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W0312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the individual program plan of 1 of 2 sampled clients, who used behavior controlling drugs, (client #3).</p> <p>Findings include:</p> <p>Client #3's medical records were reviewed on 11/8/12 at 7:22 A.M.. A review of the client's 11/12 Medication Administration Record indicated client #3 was receiving Xanax 0.5 milligrams three times a day (anti-anxiety medication).</p> <p>Client #3's records were further reviewed on 11/13/12 at 12:20 P.M.. A review of the client's 4/10/12 Individual Program Plan and his 3/5/12 Behavior Management Program failed to indicate client #3's use of Xanax was addressed.</p> <p>Associate Director #1 was interviewed on 11/13/12 at 12:34 P.M.. Associate Director #1 indicated client #3's use of Xanax had not been incorporated into his</p>	W0312	In regards to evidence cited by the medical surveyor, the psychotropic drug usage was addressed in the individual program plan of client #3, who used behavior controlling drugs. The plan has been approved by the IDT. The plan has been submitted for HRC approval. In order to assure this deficiency does not recur in this facility, Mosaic's Behavior support Policy and Procedure identifies when medications may be used to control inappropriate behavior. All medications used to manage maladaptive behavior are to initially be reviewed and approved by the client's IDT and the agency Human rights committee thereafter. All programs must contain a desensitization program or medication reduction plan to work toward the reduction and eventual elimination of restrictive measures. On 11/26/2012, Program Coordinators received retraining on this policy and procedure as to better identify other plans that this practice may affect. Finally, the agency conducts an audit which entails a review of monthly reports assuring progress on Individual	12/03/2012			

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	Behavior Management Plan. 9-3-5(a)		Program Plans is properly documented. This audit is conducted semi annually.		