

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G430	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2014
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 475 WOODBINE TERRE HAUTE, IN 47803		
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W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: March 4, 5, 6, 7, 2014</p> <p>Provider Number: 15G430 Aims Number: 100239750 Facility Number: 000944</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/17/14 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident of injury (client #2) of an unknown origin reviewed to ensure all injuries of an unknown origin are thoroughly investigated.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 3/5/14 at 10:45a.m. The incident report review indicated the following: The reportable incident report dated 10/31/13 indicated client #2 had left toe discoloration and was non weight bearing on her left foot. Client #2 would not allow staff to put her shoe and brace on her left foot. The incident report indicated the incident was an injury of unknown origin. There was no documentation of a thorough investigation including client and staff interviews to determine the possible cause of the injury.</p> <p>Professional staff #1 was interviewed on 3/6/14 at 12:02p.m. Staff #1 indicated the above identified incident of injury of an unknown origin had not been thoroughly investigated. Staff #1 indicated they did</p>	W000154	The agency failed to investigate an injury of unknown origin. To ensure this does not recur, the agency has put a place in place to review all injuries on Thursday to ensure that all injuries of unknown origin are reported and investigated. The Thursday meeting will include the House Managers, QIDP and the Associate Director. The agency nurse will be incorporated as needed. All injury reports will also be reviewed on a monthly basis by the House Manager, QIDP and agency nurse during each client's monthly meeting. The IDT will review all injuries on a quarterly basis to establish trends	04/04/2014			

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	not have documented interviews of clients and staff to determine the cause of client #2's 10/31/13 identified injury of unknown origin. 9-3-2(a)						

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#2) to perform reassessment of client #2's needs in regards to the style of drinking cup she needed.</p> <p>Findings include:</p> <p>An observation was done at the facility day program on 3/6/14 at 11:24a.m. At 11:35a.m., client #2 was observed to drink using a straw. Day staff #6 stated client #2 "always" used a straw at the day program.</p> <p>Record review of client #2's 12/18/13 individual habilitation plan (IHP) and dining plan protocols was done on 3/6/14 at 10:32a.m. Client #2's 6/19/13 dining plan protocol indicated client #2 was to use a sippy cup and should never use straws.</p> <p>Professional staff #3 was interviewed on 3/6/14 at 12:02p.m. Staff #3 indicated client #2 had refused to drink from her sippy cups and they have been using</p>	W000210	<p>The agency QIDP failed to revise the client's treatment plan when the specialist recommended that the client use a dysphagia cup with a straw. The client was seen by a specialist who recommended a special dysphagia cup with a straw. System in placeTo ensure recommendations from all disciplines are communicated to the whole team, the agency has implemented an electronic communication system called Scom. This system enables all treatment team members to get information as soon as a client's health needs have changed.In addition to the Scom communication system, the QIDP, nurse, and house manger will review client plans on a monthly basis.The Pharmacy consultant will also review clients' medications on a quarterly basis. This review will include drug interaction and need for medication reduction (among other things).After doing a record review, it appears that that there were other clients affected by this deficient practice. In the future, the agency staff will review client treatment plans on a monthly basis to ensure that the treatment plan reflects what is going on.</p>	04/04/2014			

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	<p>straws. Staff #3 indicated client #2 would drink from the straws. Staff #3 indicated client #2 has continued to receive nectar thickened liquids as was indicated in her plan. Staff #3 indicated the current protocol did indicate no straws. Staff #3 indicated they needed to consult with the speech therapist to see about a reassessment of her drinking cup style.</p> <p>9-3-4(a)</p>						

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W000249	<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 1 of 3 sampled clients (#2) to ensure client #2's identified behavior support plan (BSP) and dining training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 3/6/14 at 11:24a.m. at the facility day program. At 11:28a.m., client #2 was seated at an activity table with staff #5 with her. Client #2 had white gloves on both of her hands. At 11:28a.m., staff #5 indicated client #2 had the gloves on due to her self injurious behavior (SIB). Staff #5 indicated client #2 had put her hand to her mouth earlier and the gloves were then put on her hands. At 11:35a.m., client #2 was observed to drink using a straw. Day staff #6 indicated client #2 always used a straw at the day program.</p> <p>Record review for client #2 was done on</p>	W000249	<p>Day program staff were using behavior management techniques that were not on the BSP (putting gloves on the hands of a client to avoid SIP). Because day program staff were making the client wear gloves, it distorted the number of SIBs recorded. Day Program staff failed to record SIBs because the client was wearing gloves. The agency QIDP failed to review the behavior data (per the BSP) regularly so as to recommend reduction of Behavior medication as per client's BSP. Immediate plan of correction 1. All Day program staff have been trained to follow the behavior support plan (redirection technique) and not the usage of gloves.2. The Day Program Manager will monitor regularly (hourly) her staff to ensure that treatment plans are being followed.3. The QIDP will visit the day program at least once per week to ensure that treatment plans are being followed.4. The agency Associate Director will do unannounced day program visits at least twice per month to monitor treatment plans.</p>	04/04/2014			

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	<p>3/6/14 at 10:32a.m. Client #2's current BSP (12/18/12) indicated client #2's BSP addressed her SIB. The plan indicated staff were to redirect her hand from her mouth and redirect her to an activity. The BSP did not include the use of gloves as an SIB intervention. Client #2's 12/18/13 individual habilitation plan (IHP) and dining plan protocols were reviewed on 3/6/14 at 10:32a.m. Client #2's 6/19/13 dining plan protocol indicated client #2 was to use a sippy cup and should never use straws.</p> <p>Professional staff #2 was interviewed on 3/6/14 at 12:02p.m., Staff #2 indicated client #2 had the identified behavior of SIB included in her BSP. Staff #2 indicated the use of gloves as a behavior intervention for SIB was not included in client #2's BSP. Staff #2 indicated the facility day program should not have used gloves on client #2. Staff #2 indicated client #2 had refused to drink from her sippy cups and they have been using straws. Staff #2 indicated client #2 would drink from the straws. Staff #2 indicated the current dining protocol did indicate no straws.</p> <p>9-3-4(a)</p>		<p>5. House Manager will review behavior data sheets weekly to ensure staff are doing data entry and also connect with the Day program manager to ensure treatment plans are being followed. Long term plan of correction 1. Agency QIDP will collect and review data on a monthly basis during clients' monthly meeting. This meeting will be attended by the House Manager, Day program Manager, QIDP, and agency nurse. 3. IDT will also review client data on a quarterly basis to ensure treatment plans are revised as needed. 4. The agency quality review team will also review client information every six months to ensure that there is follow through with this plan.</p>				

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W000316	<p>483.450(e)(4)(ii) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (#2) who received behavior control medications, to ensure client #2 received an annual medication reduction.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 3/6/14 at 10:32a.m. Client #2's 12/18/13 individual habilitation plan (IHP) indicated client #2 received the behavior medications Revia, Zyprexa and Prozac for obsessive compulsive disorder. Client #2's behavior data indicated client #2 had (2) documented self injurious behaviors (SIB) from 8/13 through 1/14. Client #2's medication reduction plan indicated a medication reduction would be considered if client #2 had 10 or less SIBs over a 3 month period. The plan indicated if the criteria was met a request would be made to the psychiatrist to reduce medications as appropriate. There was no documentation the interdisciplinary team (IDT) had addressed a possible behavior medication reduction. There was no documentation by the psychiatrist regarding a contraindication to a medication</p>	W000316	<p>The agency QIDP failed to review BSP data and recommend behavior medication reduction as per the BSP. In addition, there was no SIB data because staff were using gloves to prevent SIB. This is not on the client's BSP and staff have been re-trained to use redirection as per plan. To avoid this deficiency from recurring, the following measures have been put in place;</p> <ol style="list-style-type: none"> 1. The Pharmacy Consultant will review all behavior control medication on a quarterly basis based on the BSP guidelines. If there is need to reduce some behavior control medication, the Pharmacy Consultant will make recommendations and share them with the agency nurse, QIDP and the Psychiatrist. 2. The agency IDT will meet regularly on a quarterly basis to coordinate, monitor, and review all client treatment plans. To ensure these meetings are taking place, the Associate Director will get a calendar on when these meetings are taking place and randomly attend some of them. 3. The IDT will review data for clients on behavior control medication on a quarterly basis to ensure that the treatment plans are being followed. If there are no behaviors, the IDT will make 	04/04/2014
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	<p>reduction. There was no documentation client #2's medication had been reduced during the past year.</p> <p>Interview of staff #1 on 3/6/14 at 12:02p.m. indicated the facility's IDT had not met and discussed a possible annual reduction for client #2. Staff #1 indicated client #2 had met the criteria for a behavior medication reduction.</p> <p>9-3-5(a)</p>		<p>recommendations to the Psychiatrist to reduce the medication. 4. The agency Quality Review Committee will also review records of clients on Behavior control medication. The Quality Committee will make recommendations to the Pharmacy consultant and the psychiatrist.</p>	