STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G373	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	8556 S US HWY 41 TERRE HAUTE, IN 47802

(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 recertification and state licensure survey. Dates of Survey: February 19, 20, 21 and 24, 2014. Provider Number: 15G373 Aims Number: 100249240 Facility Number: 000887 Surveyor: Mark Ficklin, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed February 28, 2014 by Dotty Walton, QIDP.	W000000		
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 1 of 4 incidents reviewed for allegations of (physical aggression) client to client abuse (clients #1, #2). Findings include: The facility's reportable incidents were reviewed on 2/19/14 at 2:54p.m. A reportable incident report, dated 1/7/14,	W000154	Mosaic has a policy that all client to client incidents should be investigated. This case was just an oversight. To ensure that we will not miss any investigation on client to client incidents, House Managers, Program Coordinators, and the Associate Director will review all client to client incident reports on a weekly basis during their Thursday meeting. If there are any client to client incidents that have not been investigated, an	03/21/2014

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.

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	indicated: client #1 threw client #2 to the floor after a staff had given client #1 a verbal prompt to get his things for a shower. Client #2 landed on his right side and hit his head on the floor. Client #2 received a scratch on his forehead and a nose bleed. There was no documented investigation completed. Professional staff #1 was interviewed on 2/24/14 at 3:04p.m. Staff #1 indicated there was no documented investigation for client to client aggression which occurred on 1/7/14. Staff #1 indicated the facility should have completed a "Client to Client Investigation" form that was to be used for client to client aggression. 9-3-2(a)		investigation will be started right away. In addition to reviewing them weekly, this information will also be reviewed monthly by the leadership team during the TEAMS meeting to note for trends.	
W000210	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. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#1) to perform reassessment of client #1's needs with independently eating from a regular style	W000210	The agency's interdisciplinary team failed to reassess a client's needs, resulting in the client experiencing some challenges with scooping food during dinner..To solve the immediate	03/21/2014

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	plate. Findings include: An observation was done on 2/20/14 from 4:29p.m. to 5:54p.m. At 5:02p.m., client #1 was eating peas and carrots on a regular style plate. Client #1's plate was moving around on the table as he attempted to scoop up the peas and carrots. Client #1 held his plate up at an angle, put his mouth on his plate and scooped the vegetables into his mouth. Staff #4, who was at the dining table with client #1, stated client #1 "sometimes had issues with his plate moving." Record review for client #1 was done on 2/24/14 at 12:41p.m. Client #1's 11/11/13 individual support plan (ISP) indicated client #1 was to use a regular style plate. Interview on 2/24/14 at 3:04p.m. of professional staff #1 indicated they were not aware client #1 had issues with using a regular style plate. Staff #1 indicated client #1 needed re-evaluation to assess his assistance/needs with scooping his food. 9-3-4(a)		challenge, the client was assessed and now uses a weighted plate. To ensure that this deficiency does not recur, the House Manager will do monthly visits during different shifts to observe individuals in service. The Program Coordinator will also visit quarterly to ensure client needs are met. Any observed needs will be discussed during clients' monthly and quarterly meetings and addressed appropriately.	

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W000257	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 failed for 1 of 4 sampled clients (#1), to ensure client #1's training program in which client #1 was failing to progress (money training), was reviewed and revised as necessary by the facility's qualified intellectual disabilities professional (QIDP). Findings include: Record review for client #1 was done on 2/24/14 at 12:41p.m. Client #1's 11/11/13 individual support plan (ISP) indicated client #1 had a money training program to swipe his debit card at the point of sale once per week. The QIDP monthly data reviews for 6/13 through 12/13 were reviewed on 2/24/14 at 12:41p.m. The QIDP monthly program reviews indicated client #1 had achieved 0% for every month from 6/13 through 12/13, except for 25% in 8/13. There was no documentation the QIDP had	W000257	The agency QIDP failed to revise the client's training program when client was failing to progress on his money training goal.The agency has a policy that clients' training programs should be reviewed quarterly and revised as needed. The agency House Manager will review client goals on a weekly basis to ensure that the goal is being run and data is being collected. Any gaps in data collection or lack of progress will be reported to the agency QIDP. The agency QIDP will review and revise clients' training programs on a monthly basis. The QIDP will meet with each client's IDT on a quarterly basis to review progress on training goals and make changes as needed. The agency will sample clients programs every six months to ensure training programs are being reviewed and revised as needed.	03/21/2014

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	revised the money program from 6/13 through 2/14. Professional staff #1 was interviewed on 2/24/14 at 3:04p.m. Staff #1 indicated client #1's money training program data, from 6/13 through 12/13, indicated client #1 had achieved 0% for every month except 8/13. Staff #1 indicated there was no documentation the QIDP had addressed and revised client #1's money training program. Staff #1 indicated client #1 was in need of a program revision for his money training. 9-3-4(a)			