

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 01/06/2014
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 2820 BENHAM AVE ELKHART, IN 46517
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W000000	<p>This visit was for an extended annual recertification and state licensure survey (Client Protections and Healthcare Services).</p> <p>Dates of Survey: 12/11, 12/12, 12/18/13 and 1/3, 1/6/14.</p> <p>Facility Number: 000800 Provider Number: 15G280 AIMS Number: 100243460</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/15/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<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.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#3) and 1 additional client (#4), the facility neglected to implement its policy and procedures to prevent neglect of the clients in regards to medications not being administered</p>	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 be reported and consequently investigated within	01/31/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>according to physician orders.</p> <p>Findings include:</p> <p>On 12/11/13 at 1:10 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 12/11/12 to 12/11/13 were reviewed and indicated the following:</p> <p>-A report dated 3/20/13 indicated Client #3 "had been given an evening dose of his Clonazepam (anti-anxiety) 1 mg. He is to get 1 mg at 7 AM and again at 4 PM, but not in the evening." The report indicated the physician was notified.</p> <p>-A report dated 2/21/13 indicated Client #3 "was administered a 1 mg dose of Clonazepam instead of receiving a .5mg dose of Alprazolam (anti-anxiety). The Clonazepam is not a medication which has been prescribed to [Client #3]. It was prescribed to another individual in the house. During the 7:00 AM med pass on 2/21/13, staff noticed that the wrong medication had been administered...". The report indicated Client #3 "did not exhibit any of those side effects."</p> <p>-A report dated 3/29/13 indicated Client #3 "had continued to receive 200 mg of generic Seroquel (anti-psychotic) (daily dose of 50 mg x 4) even though [physician] had decreased this to 150 mg (50 mg x 3 daily)." The report indicated the physician was notified and Client #3 "had not exhibited any distress or issue by continuing at this dosage."</p> <p>-A report dated 4/11/13 indicated Client #3 "had missed his 7 AM dose of Clonazepam .5 mg." The report indicated the physician was notified and Client #3 appeared "unaffected by the missed med."</p>		<p>24 hours of the allegation as stipulated in agency policy. Additionally, investigations must be completed within 5 working days. Per Mosaic policy, all investigations and their subsequent reports must be completed within 5 day. 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. Based on the evidence provided, Mosaic reported each incident, however, failed to identify the chronic medication errors as neglect. Mosaic's safety committee and the investigation coordinator have retrained the agency QIDPs and RNs to better recognize neglect, particularly as it relates to medication administration. Additionally, on February 4, Mosaic retrained all facility staff on Medication Administration. Furthermore, the agency implemented a "buddy check" system to assure medication is passed according physician orders. A "Buddy Check" is a secondary peer review of each medication administration. Finally, the Direct Support</p>				

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	<p>-A report dated 4/24/13 indicated Client #3 "did not receive 2 of 3 Divalproex sod er (Depakote extended release) (anticonvulsant) 500 mg."</p> <p>-A report dated 4/24/13 indicated Client #3's "8 PM 300 mg Seroquel was missed last night." The report indicated Client #3 was monitored and the physician was notified.</p> <p>-A report dated 6/14/13 indicated Client #3 "did not receive his Fosamax 70 mg tablet. This pill is given one time a week at 5:30 AM." The report indicated the physician was notified and instructed staff [Client #3] is to be given this med (medication) on 6/15/13." The report indicated no side effects noted.</p> <p>-A report dated 6/20/13 indicated staff "gave a 5 mg Zyprexa medication to [Client #3] that was not prescribed to him. [Client #3] is supposed to get 50 mg of Seroquel at that time but because of the Zyprexa, the Mosaic RN (Registered Nurse) suggested that the Seroquel be held." The report indicated the physician was notified and did instruct staff to withhold Client #3's dose of Seroquel. The report indicated Client #3 was monitored for lethargy.</p> <p>-A report dated 8/15/13 indicated Client #3 "did not get 2 out of 3 Divalproex 500 mg" on 8/13/13. The report indicated Client #3 "was acting like his normal self."</p> <p>-A report dated 9/3/13 indicated Client #3 "was out of his .5 mg of Clonazepam. Staff 'borrowed' Clonazepam from another client to make sure he received his noon and 8 PM doses. [Client #3] was checked out...and seemed unremarkable."</p> <p>-A report dated 9/4/13 indicated Client #3</p>		<p>Manager, QIDP and facility nurse conduct weekly medication administration observations to assure staff are administering medications according to physician orders. Finally, regarding the issue of tracking trends and medication errors, the system of tracking medication error points was a failure of the Direct Support Manager. The Direct Support Manager was retrained on this policy and received a corrective action for failing to follow the policy. To further reassure this deficiency does not recur, the QIDP will meet with the Direct Support Manager weekly and review staff performance, including medication points given.</p>				

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	<p>missed his 4 PM Clonazepam (dosage not given) because the group home ran out of the medication. The report indicated the group home called the pharmacy. The report indicated the pharmacy needed a new prescription to fill Client #3's Clonazepam and the medication did not arrive in time to be administered to Client #3.</p> <p>-A report dated 9/26/13 indicated Client #3 "did not receive his Acetaminophen 650 mg and Calcium 600 mg at 8 pm on Sunday 9/22/13." The report indicated staff did not notice "any side effects from missing them."</p> <p>-A report dated 11/8/13 indicated Client #3 had not received his increased dose of Seroquel prescribed for 12 PM. The report indicated Client #3 was prescribed 50 mg of Seroquel for 12 PM and on 10/29/13, Client #3's physician had increased his dosage to 100 mg of Seroquel. The report indicated once Human Rights Committee consent was approved, Client #3 did not receive his increased dosage of Seroquel 11/4, 11/5, 11/6, and 11/7/13.</p> <p>2) On 12/11/13 at 1:10 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 12/11/12 to 12/11/13 were reviewed and indicated the following:</p> <p>-A report dated 9/19/13 indicated "staff was in the process of getting medication to another individual that was sitting next to [Client #4]. While medication was getting ready to be administered, [Client #4] was trying to get the staff persons attention. Staff stopped and talked to [Client #4] about his concerns about going to (outing)." The report indicated "during the brief conversation, staff gave [Client #4] the medication that was meant for the other</p>				

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	<p>individual." The report indicated Client #4 was monitored and experienced drowsiness. A follow up report indicated Client #4 "was given Clonazepam. His side effects included grogginess and sleepiness. He took a monitored nap after day program, but he was up for dinner without any additional issues."</p> <p>The reports indicated staff would receive appropriate training and "med points" for the medication administration errors per the facility policy.</p> <p>During an interview on 12/12/13 at 12:21 PM, the facility nurse indicated the facility has a policy of discipline and retraining staff based on a point system. The nurse indicated staff receive "med points" based on the facility policy which is based on severity of the medication administration error. The facility nurse stated, "Yes, it's terrible we have that many med errors." The facility nurse stated the facility "med point" system helps to identify which staff makes "the most mistakes" but indicated the point system would not indicate if there is a trend of medication errors for certain clients. The facility nurse stated she continues "to emphasize the importance" to staff of passing medications per the physician's orders.</p> <p>During an interview on 12/12/13 at 4:46 PM with the Administrator and the QIDP (Qualified Intellectual Disabilities Professional), the Administrator indicated September 2013 was the staff annual retraining on medication administration. The Administrator indicated the House Manager (HM) was responsible of keeping track of staff "med points" and the QIDP (Qualified Intellectual Disabilities Professional) was responsible for ensuring any retraining was completed. The QIDP indicated</p>						

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	<p>she was uncertain how errors in medication administration could be potential neglect. The QIDP stated she believed the medication administration errors were average "considering how many medications are passed throughout the year."</p> <p>On 12/11/13 at 3:38 PM, the facility policy of "Medication Administration" dated 5/11/12 indicated "in order to ensure individual safety proper medical treatment, medications will be documented, stored, administered, and destroyed in accordance with applicable regulations." The policy indicated "agency policy and procedure will ensure all aspects of medication administration are monitored and action taken as needed to ensure individual health and safety."</p> <p>On 12/11/13 at 2:00 PM, the facility policy of "Abuse, Neglect, Exploitation, or Mistreatment Policy and Procedure" was reviewed and indicated "neglect is the failure to provide the client with sufficient services, treatment, or supports necessary for well being or the failure to act or intervene in a situation that may result in physical, psychological, or emotional harm." The policy indicated the facility "prohibits abuse, neglect, exploitation, or mistreatment of the individuals the agency serves...".</p> <p>9-3-2(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review, and interview, the facility nursing staff failed to provide care in accordance to client needs for 1 of 3 sampled clients (#2) in regards to failure to develop a wound (pressure ulcer) care plan, failure to monitor the wound, and failure to ensure repositioning was occurring as the physician recommended to promote wound healing and/or prevention of recurring wounds.</p> <p>Findings include:</p> <p>On 12/11/13 between 6:11 AM and 8:23 AM, group home observations were conducted.</p> <p>At 6:46 AM, Client #2 was observed to be assisted with medication administration. Client #2 was observed seated in her wheelchair with her legs together substantially over the seat of her wheelchair as Client #2 was a tall woman with her knees to the right side and her left hip toward the armrest of her wheelchair. At 7:27 AM, Client #2 left for a doctor appointment. During</p>	W000331	<p>In regards to evidence cited by the medical surveyor Mosaic policy and procedure specifies that the health care needs of each individual is to be met. In response to the issue cited by the medical surveyor, on February 4, 2014, all facility staff were trained on this policy, particularly as they relate to client wound care orders. Additionally, on 2/4/2014, all facility staff received training on wound care. Additionally, a Nursing Review showed that the pressure ulcer identified on client #2 has healed. The administration reviewed all wound care plans in each facility and implemented a skin break down checklist and repositioning plan for each person requiring the support to further facilitate proper healing of wounds. 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), the Program Coordinator (QIDP), and agency Registered Nurse. During this visit each assures nursing services are both properly provided and documented in the Health Care Notes. During this</p>	02/04/2014			

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	<p>the observation, Client #2 was not seen out of her wheelchair or repositioned by staff.</p> <p>On 12/11/13 between 11:09 AM and 11:47 AM, day program services were observed. Throughout the observation, Client #2 remained seated in her wheelchair. Client #2 was not observed to be repositioned by staff.</p> <p>On 12/11/13 between 4:30 PM and 6:01 PM, group home observations were conducted. Client #2 was observed only in her wheelchair with her knees leaning toward the right and her left hip toward the left armrest of her wheelchair. Client #2 was not repositioned during the observation.</p> <p>On 12/12/13 at 2:06 PM, record review indicated Client #2's diagnoses included, but were not limited to, severe intellectual disabilities, complete vision loss, constipation, impulse control disorder, and psychotic disorder. Record review indicated Client #2 had a recurrent pressure ulcer in the area of her left hip. Record review indicated the following "Physician Summaries":</p> <p>-2/15/13 summary indicated Client #2 had a 3 cm (centimeters) by 4 cm pressure ulcer on her left hip. The</p>		<p>time, the each reviews the healing progress on any wound sustained.. Any potential concern identified is immediately reported to the facility Administrator.</p>				

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	<p>summary indicated the pressure ulcer was in conjunction with a "metal support of wheelchair." The physician recommended added padding to the chair, a chair adjustment, and to have Client #2 "out of wheelchair as much as possible during day."</p> <p>-2/26/13 summary indicated Client #2 had left hip ulcer "stage 2, chronic." The summary indicated the ulcer "could take several weeks" to see improvement.</p> <p>-3/5/13 wound care clinic summary indicated Client #2's ulcer "healing" and measured "0.8 (centimeters) x (by)1.7 cm x 0.2 cm."</p> <p>-3/19/13 summary indicated Client #2's "wound measures 1.5 x 2.5 x 0.2 cm" and "is bigger this week." The summary indicated "appears to have received too much pressure on her L. (left) hip. Please keep pt. (patient) off her L. (left) hip to keep pressure off as well as watch her position while in her wheelchair so the hip isn't pressing up against the chair arm rest."</p> <p>-3/26/13 summary indicated Client #2's "wound measures 1 x 2.2 x 0.2 cm" and "improved from last week."</p> <p>-4/11/13 summary indicated Client #2's</p>			

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	<p>"wound measures 0.2 x 0.4 x 0.2 cm." The summary indicated "anticipate full wound closure soon."</p> <p>-4/16/13 summary indicated Client #2's ulcer "improving now 2 x 2 cm." The summary indicated "R. (right) hip prev. (previously) had early pressure ulcer but this is resolved." The summary indicated "changes to wheelchair" made.</p> <p>-4/25/13 summary indicated Client #2's left hip ulcer was "closed." The summary indicated "keep covered to protect area from clothing rubbing on it."</p> <p>-6/18/13 summary indicated "left pressure sore on thigh much improved, cont. (continue) to follow."</p> <p>-9/3/13 summary indicated Client #2 had a "wound on left hip" which measured "3 x 2 cm" and a wound "5 mm (millimeters) x 5 mm x 2" which was "tender to touch." The physician indicated staff should "start rotating b/w (between) back and rt. (right) hip during sleep Q (each) 3-4 hrs. (hours). Return to wound care."</p> <p>-9/17/13 summary indicated Client #2's "left hip skin ulcer is making improvements with cleaning, dressing</p>						

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	<p>changes, and adjustment of pressures."</p> <p>-9/19/13 summary indicated "please (change) dressing if drainage is (greater than) 50% through bandage. Wash (with) soap and water."</p> <p>-9/27/13 summary indicated Client #2's "wound (decreased) in size. Less necrotic tissue present (with) depth exposed at 1.5 cm in depth. Pt. (patient) to keep off of L. (left) area as much as possible. (Change) dressing 2-3x (times) 1 wk (week)."</p> <p>-10/3/13 summary indicated Client #2 wound was "3 x 1 cm with yellow adipose (body fat) tissue." The summary indicated "wound did (decrease) in size since last visit."</p> <p>-10/10/13 summary indicated Client #2's "wound bed (decreased) in size and (increased) in depth" with 2 degrees less "yellow necrotic tissue (dead body tissue)" present.</p> <p>-10/17/13 summary indicated Client #2 had a "possible infection inside" and indicated the wound was 1.5 x 4 cm in size. The summary indicated a 7 day, 3 times daily, antibiotic was prescribed.</p> <p>-10/22/13 summary indicated Client #2's</p>						

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	<p>ulcer had necrotic tissue present and had decreased in size.</p> <p>-10/31/13 summary indicated Client #2's "wound (decreased) in size and no (change) in depth." The summary indicated "yellow necrotic tissue expressed from wound bed. Please gently cleanse area and remove dead tissue. Do not pull on it."</p> <p>-11/6/13 summary indicated Client #2's "wound (had) slight (decrease) in size (with) (increase) in serious drainage. Please add transfer foam to wound to protect healed tissue."</p> <p>-11/21/13 summary indicated Client #2's wound had no change in size.</p> <p>-12/4/13 summary indicated Client #2's wound had a decrease in size but no change in depth. The summary indicated "switched to Iodoform packing. Please pack and cleanse wound daily (underlined)."</p> <p>-12/12/13 summary indicated Client #2's wound was "clean (with) no significant (change) in size."</p> <p>-12/19/13 summary indicated Client #2's wound was "clean and decreasing in size."</p>						

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	<p>Record review indicated Client #2's ISP (Individual Support Plan) dated 11/16/12 included a "Wheel Chair / Wound Care Prevention Plan" dated November 2012 which indicated "[Client #2] is at risk for developing open wounds around her groin area and on other parts of her body including on her bottom. These wounds can be caused by prolonged pressure that does not allow adequate blood flow, chronic swelling, and circulatory problems. This can occur if [Client #2] remains in her chair for excessive amounts of time without opportunity to stretch." The wound prevention plan indicated the following "action steps":</p> <p>- "Staff should encourage [Client #2] to move in her chair to shift her weight every fifteen to twenty minutes.</p> <p>- Upon returning from Day program or an extended trip [Client #2] should be asked to an encouraged to be moved from her chair to a recliner or an exercise mat depending on choice. She should be allowed to remain on the floor for a minimum of one hour or in the recliner with her legs elevated. [Client #2] should complete her PT (physical therapy) exercises daily to promote range of motion.</p>						

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	<p>-Staff should encourage [Client #2] to never sit in her chair for more than six hours at a time."</p> <p>Record review indicated the facility RN wrote a daily log entry dated 8/27/13 which indicated she had visited Client #2. The nurses note indicated "wound is approximately the size of a quarter located on lateral upper thigh, actually where the old hip incision is. The is a semi hard area under the wound which does not appear as blood or infection when palpated. The actual open area is not deep but rather superficial." No other nurses notes were available for review.</p> <p>On 12/12/13 at 3:29 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated she believed Client #2 had "hit her hip on a safety bar" during a transfer and "it was just a red mark." The QIDP indicated she was uncertain if the area was caused by pressure. The QIDP stated "no skin check sheet" was used to monitor Client #2's wound. The QIDP stated the facility used a electronic communication system and the nurse had communicated wound care instructions through their electronic message system but did not "per say"</p>						

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	<p>provide wound care training or develop a wound care plan. The QIDP indicated she believed the nurse's electronic instructions were adequate to address the needs of Client #2.</p> <p>On 12/12/13 at 4:56 PM during another interview, the QIDP stated the facility did not use a "skin breakdown" monitoring sheet for Client #2 because her last pressure wound healed "so quickly." The QIDP stated the skin breakdown monitoring forms are only used when "additional monitoring is needed, above and beyond the normal." The QIDP stated the form wasn't needed because she was "fine." The QIDP indicated staff reported when they had cleaned Client #2's wound by writing an electronic shift log. The QIDP stated they have been able to tell whether staff were properly treating the wound area by reading "the wound care doctor notes" and by whether "product supplies are diminishing." The QIDP stated the nurse "periodically" checked on the wound herself and put it in an electronic log.</p> <p>On 12/18/13 at 9:52 AM, the QIDP stated "the second sore is not in the same place as her first one. It is lower and more towards the top of her thigh than the first one and does not hit anywhere</p>						

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	<p>on her chair. So, it's not a recurrence, although it is on the same leg."</p> <p>On 1/3/14 at 1:34 PM during an interview, the House Manager (HM) stated the facility does use a wound "monitoring sheet if needed, but no, there was not an every day monitoring sheet because she (Client #2) went weekly to wound care." The HM stated Client #2 was supposed to be repositioned to help heal and prevent pressure wounds but there was "no monitoring of repositioning."</p> <p>9-3-6(a)</p>			

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 6 of 7 clients who received medications (clients #1, #2, #3, #4, #6, and #7), to administer medications per physician's orders.</p> <p>Findings include:</p> <p>On 12/11/13 at 1:10 PM, the facility BDDS (Bureau of Development Disabilities Services) reports from 12/11/12 to 12/11/13 were reviewed and indicated the following:</p> <p>-A report dated 1/9/13 indicated Client #4 "is to receive (1) 500 mg (milligrams) pill and (1) 250 mg pill of Divalproex SOD ER (extended release, anticonvulsant) at 8:00 PM to equal 750 mg. On 1/8/13, he received only his 500 mg pill. His 250 mg pill of Divalproex was not passed." The report indicated Client #4 had "no seizure activity, side effects or abnormal behavior."</p> <p>-A report dated 3/20/13 indicated Client #3 "had been given an evening dose of his Clonazepam (anti-anxiety) 1 mg. He is to get 1 mg at 7 AM and again at 4 PM, but not in the evening." The report indicated the physician was notified.</p> <p>-A report dated 2/21/13 indicated Client #3 "was administered a 1 mg dose of Clonazepam instead of receiving a .5mg dose of Alprazolam (anti-anxiety). The Clonazepam is not a medication which has been prescribed to [Client #3]. It was prescribed to another individual in the house. During the 7:00 AM med pass on 2/21/13, staff noticed that the wrong medication</p>	W000368	In regards to evidence cited by the medical surveyor, Mosaic policy and procedure specifies all medication administered is to be administered without error. All Mosaic Staff are trained on this policy in conjunction with Core A and Core B medication administration training at new staff orientation as well as an annual retraining. Additionally, on February 4, Mosaic retrained all facility staff on Medication Administration. Furthermore, the agency implemented a "buddy check" system to assure medication is passed according physician orders. A "Buddy Check" is a secondary peer review of each medication administration. Finally, the Direct Support Manager, QIDP and facility nurse conduct weekly medication administration observations to assure staff are administering medications according to physician orders. Finally, regarding the issue of tracking trends and medication errors, the system of tracking medication error points was a failure of the Direct Support Manager. The Direct Support Manager was retrained on this policy and received a corrective action for failing to follow the policy. To further reassure this	02/04/2014			

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	<p>had been administered...". The report indicated Client #3 "did not exhibit any of those side effects."</p> <p>-A report dated 3/29/13 indicated Client #3 "had continued to receive 200 mg of generic Seroquel (antipsychotic) (daily dose of 50 mg x 4) even though [physician] had decreased this to 150 mg (50 mg x 3 daily)." The report indicated the physician was notified and Client #3 "had not exhibited any distress or issue by continuing at this dosage."</p> <p>-A report dated 4/11/13 indicated Client #2 had "missed her 8 PM dose of Famotidine (stomach ulcers) 20 mg." The report indicated Client #2 had "no remarkable issues related to the missed med."</p> <p>-A report dated 4/11/13 indicated Client #3 "had missed his 7 AM dose of Clonazepam .5 mg." The report indicated the physician was notified and Client #3 appeared "unaffected by the missed med."</p> <p>-A report dated 4/24/13 indicated Client #1 "only received 1 of 3 Divalproex." The report did not indicated dosage of each tablet.</p> <p>-A report dated 4/24/13 indicated Client #3 "did not receive 2 of 3 Divalproex sod er (Depakote extended release) 500 mg."</p> <p>-A report dated 4/24/13 indicated Client #3's "8 PM 300 mg Seroquel was missed last night." The report indicated Client #3 was monitored and the physician was notified.</p> <p>-A report dated 5/14/13 indicated Client #4 "had not received his dose of Invega ER (extended release) (antipsychotic) 3 mg tablet at the HS</p>		<p>deficiency does not recur, the QIDP will meet with the Direct Support Manager weekly and review staff performance, including medication points given.</p>				

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	<p>(evening) med pass on 5/12/13."</p> <p>-A report dated 5/21/13 indicated on 5/19/13 at the 8 PM med pass, Client #2 "was given her 8 AM Furosemide (diuretic) 20 mg instead of receiving her Famotidine 20 mg." The report indicated the physician was notified and instructed staff to continue to give medications as prescribed. The report indicated Client #2 "was acting normal."</p> <p>-A report dated 5/29/13 indicated Client #4 "did not receive his noon Olanzapine (antipsychotic) 5 mg tablet on Sunday 5/26/13. Staff did not pack the med (medication) and give to his mother whom was taking him for a visit." The report indicated "no side effects" were noted.</p> <p>-A report dated 6/10/13 indicated Client #2 "did not receive her Furosemide (diuretic) 20 mg on 6/9/13. Staff did not report to any one (sic) that she took her last one on 6/8 2013." The report indicated the physician was notified and instructed to continue to give medications as ordered.</p> <p>-A report dated 6/14/13 indicated Client #3 "did not receive his Fosamax (thinning of bones) 70 mg tablet. This pill is given one time a week at 5:30 AM." The report indicated the physician was notified and instructed staff [Client #3] is to be given this med (medication) on 6/15/13." The report indicated no side effects noted.</p> <p>-A report dated 6/15/13 indicated Client #4 "did not receive his noon dose of 5 mg (milligrams) Olanzapine." The report indicated the pharmacy did not send the medication due to waiting for "prior authorization." The report indicated the pharmacy sent an emergency supply to the home but the nurse instructed staff it was too late to</p>						

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	<p>take the medication. The report indicated the doctor was notified and instructed staff to give as directed the next day.</p> <p>-A report dated 6/16/13 indicated Client #4 "did not receive his noon dose of 5 mg Olanzapine due to [Pharmacy] did not send it due to waiting on prior authorization."</p> <p>-A report dated 6/20/13 indicated staff "gave a 5 mg Zyprexa (anti-anxiety) medication to [Client #3] that was not prescribed to him. [Client #3] is supposed to get 50 mg of Seroquel at that time but because of the Zyprexa, the Mosaic RN (Registered Nurse) suggested that the Seroquel be held." The report indicated the physician was notified and did instruct staff to withhold Client #3's dose of Seroquel. The report indicated Client #3 was monitored for lethargy.</p> <p>-A report dated 8/15/13 indicated Client #3 "did not get 2 out of 3 Divalproex 500 mg" on 8/13/13. The report indicated Client #3 "was acting like his normal self."</p> <p>-A report dated 8/19/13 indicated Client #4 "was given 10 mg of Olanzapine instead of 5 mg the previous day at noon." The report indicated "staff reported no issues throughout weekend."</p> <p>-A report dated 8/19/13 indicated Client #6 "had missed her 8 PM Keflex (antibiotic) medication the night before."</p> <p>-A report dated 9/3/13 indicated Client #3 "was out of his .5 mg of Clonazepam. Staff 'borrowed' Clonazepam from another client to make sure he received his noon and 8 PM doses. [Client #3] was checked out...and seemed unremarkable."</p>				

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	<p>-A report dated 9/4/13 indicated Client #3 missed his 4 PM Clonazepam (dosage not given) because the group home ran out of the medication. The report indicated the group home called the pharmacy. The report indicated the pharmacy needed a new prescription to fill Client #3's Clonazepam and the medication did not arrive in time to be administered to Client #3.</p> <p>-A report dated 9/19/13 indicated "staff was in the process of getting medication to another individual that was sitting next to [Client #4]. While medication was getting ready to be administered, [Client #4] was trying to get the staff persons attention. Staff stopped and talked to [Client #4] about his concerns about going to (outing)." The report indicated "during the brief conversation, staff gave [Client #4] the medication that was meant for the other individual." The report indicated Client #4 was monitored and experienced drowsiness. A follow up report indicated Client #4 "was given Clonazepam. His side effects included grogginess and sleepiness. He took a monitored nap after day program, but he was up for dinner without any additional issues."</p> <p>-A report dated 9/26/13 indicated Client #3 "did not receive his Acetaminophen 650 mg and Calcium 600 mg at 8 pm on Sunday 9/22/13." The report indicated staff did not notice "any side effects from missing them."</p> <p>-A report dated 11/8/13 indicated Client #3 had not received his increased dose of Seroquel prescribed for 12 PM. The report indicated Client #3 was prescribed 50 mg of Seroquel for 12 PM and on 10/29/13, Client #3's physician had increased his dosage to 100 mg of Seroquel. The report indicated the Human Rights</p>						

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	<p>Committee approved the increase, Client #3 did not receive the increased dosage on 11/4, 11/5, 11/6, and 11/7/13.</p> <p>-A report dated 11/13/13 indicated Client #1 "had received a dose of her Aldrenoate sodium (thinning of bones) on Sat (Saturday) 11-9 (2013) instead of getting her Zantac." The report indicated the nurse was waiting "to get further instructions from PCP (Primary Care Physician) as she only gets the Sodium once a week." The report indicated no side effects noted at that time.</p> <p>-A report dated 11/20/13 indicated Client #7 received Keppra (anticonvulsant) 750 mg at 1 PM on 11/18/13 in error. Client #7 was only prescribed Depakote 125 mg daily at 1 PM. The report indicated Client #7 also did not received her 4 PM and 8 PM doses of Levetiracetam (anticonvulsant) 750 mg on 11/15, 11/16, 11/17, 11/18, and 11/19/13. The report indicated Client #7 was an emergency placement and the facility transcribed her physician orders incorrectly on the MAR (Medication Administration Records) which caused the medication administration errors.</p> <p>-A report dated 11/24/13 indicated Client #7 was given (2) 200 mg tabs of Topiramate (anticonvulsant) at bedtime instead of just (1) 200 mg tab of Topiramate. The report indicated the nurse "was notified and was instructed to not give her, her AM dose as it would over medicate her."</p> <p>-A report dated 12/7/13 indicated Client #7 did not receive her 8 PM dose of Topiramate 200 mg on 12/7/13. The report indicated Client #7 had "no apparent side effects."</p>				

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W000460	<p>The reports indicated staff would receive appropriate training and "med points" for the medication administration errors per the facility policy.</p> <p>During an interview on 12/12/13 at 12:21 PM, the facility nurse indicated the facility has a policy of discipline and retraining staff based on a point system. The nurse indicated staff receive "med points" based on the facility policy which is based on severity of the medication administration error. The facility nurse stated, "Yes, it's terrible we have that many med errors." The facility nurse indicated she continues "to emphasize the importance" to staff of passing medications per the physician's orders.</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (Client #2) to serve a diet as prescribed by the physician.</p>	W000460	In regards to evidence cited by the medical surveyor, Mosaic's Dietary Policy and Procedure states that each client must receive a balanced diet which may include modified and	02/04/2014			

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	<p>Findings include:</p> <p>On 12/11/13 between 4:30 PM and 6:01 PM, group home observations were conducted. Between 4:47 PM and 5:20 PM, dinner was served. Dinner consisted of tomato soup with crackers, chicken, milk, juice, and water. Client #2 was served soup and chicken which had been cut up into bite size pieces which she ate with her fingers. During the dinner observation, Client #2 was offered a second portion of chicken and was again served the chicken cut up into bite size pieces.</p> <p>On 12/12/13 at 2:06 PM, record review indicated Client #2 had an annual diet assessment on 9/22/13 which indicated Client #2 was on a "mechanical soft with ground meats."</p> <p>Record review indicated a "Choking and Aspiration Management Plan" dated 10/2013 which indicated Client #2 "is at risk for choking/aspiration as she doesn't have any teeth to grind food up on her own." The choking plan indicated "all food must be cut into small pieces and meat ground (mechanical soft)."</p> <p>During an interview on 1/3/14 at 1:34 PM, the House Manager (HM) stated Client #2 "usually gets bite size pieces of meat" and indicated staff did not usually serve Client #2 with her meat ground. The HM indicated she did not know Client #2's meat was to be served with a ground texture.</p> <p>9-3-8(a)</p>		<p>specially prescribed diets as identified by the agency Registered Dietician. On 2/4/2014, Mosaic staff received retraining on client #2's Diet as specified in the IPP and the Annual Nutritional Assessment. The staff were also retrained on each client's dietary plan to assure all residents in the facility receive nourishing, well balanced meals that are prepared as defined in their plan. Additionally, Mosaic reviewed the available resources found throughout the facility that help describe how various food consistencies are to be prepared. Specifically, staff were trained on preparing food in a manner with a ground texture consistency. 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 that direct care staff provides nourishing, well balanced meals in accordance with each individual's dietary plan.</p>				

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who resided in the group home, the facility failed to encourage and include clients in meal preparation.</p> <p>Findings include:</p> <p>On 12/11/13 between 6:11 AM and 8:23 AM, group home observations were conducted. At 6:23 AM, DSP (Direct Support Professional) #1 was in the kitchen. DSP #1 poured the same type of cereal in each bowl on the kitchen counter with no clients present in the kitchen. DSP #1 also pureed cereal in the kitchen with no clients present. At 6:38 AM, DSP #1 put the prepared cereal bowls onto the dining room table. At 6:42 AM, Client #5 was the only client seated at the dining room table and DSP #1 poured her milk into the cereal bowl. Between 6:23 AM and 8:23 AM, Client #1, #2, #3, #4, #5, #6, and #7 were served breakfast as they were ready for the day.</p>	W000488	<p>Mosaic's Dietary Policy and Procedure states that each individual served should participate in the preparation and service during all meals. On February 4, 2014, All facility staff received training on conducting meal time goals and objectives in accordance with each individual's Individual Program Plan. Additionally, the Direct Support Manager responsible for assuring family style dining received disciplinary action for failing to assure people supported were involved in meal preparation. 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.</p>	02/04/2014			

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	<p>During an interview on 12/12/13 at 3:29 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated clients (#1, #2, #3, #4, #5, #6, and #7) should assist in meal preparation to the best of their abilities.</p> <p>9-3-8(a)</p>			