

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  06/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>This visit was for the investigation of complaint #IN00148708.</p> <p>Complaint #IN00148708 - Substantiated. Federal/State deficiencies related to the allegations are cited at W157.</p> <p>Dates of Survey: May 28, 29, 30 and June 2, 2014</p> <p>Provider Number: 15G373 Aims Number: 100249240 Facility Number: 000887</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed June 6, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000157	<p>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 for 1 of 1 investigations of alleged neglect/abuse reviewed (an unapproved restraint used on client A), to ensure appropriate corrective action was identified.</p>	W000157	<p>Plan of Correction for Survey Event ID 84JP11 6-2-14 W0157</p> <p>1. As a result of state citation W157, All Mosaic Terre Haute Agency staff working direct care have been retrained on appropriate documentation regarding Incident Reports/General Event Reports</p>	06/19/2014

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.

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  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>Findings include:</p> <p>Review of the facility's incident/investigations was done on 5/28/14 at 3:42p.m. The following 5/1/14 facility investigation indicated: On 4/17/14 client A had a behavior on a facility van which included physical aggression and self injurious behavior. A 4/17/14 facility incident report, filled out by the staff that had intervened with the behavior, indicated a Mandt physical restraint had been used on client A. There was no further detail as to what type of Mandt restraint was used during the behavior intervention on 4/17/14 with client A. The 5/1/14 investigation indicated it was started on 5/1/14 due to the fact that the staff that had applied the physical restraint had described the technique used to other staff. The other staff then reported the physical restraint style used to administrative staff and an investigation began. The investigation determined an unapproved physical restraint had been used with no injury to client A. The investigation summary did not indicate the facility staff were in need of retraining on incident reporting (describing type of Mandt restraint used) and incident report reviews (review staff did not question type of restraint used).</p> <p>Professional staff #1 was interviewed on</p>		<p>(GER) when a MANDT Behavioral Intervention is used. Staff were retrained to ensure the details/specifics as to which type of MANDT techniques were used when documenting the incident to inform all concerned. This retraining of this practice will ensure that the documentation surrounding these intervention techniques is thorough and complete, eliminating delays in possible future findings of abuse.</p> <p>2. All agency supervisory staff with responsibility over direct support staff and direct support managers have been retrained on Incident Report/General Event Report review involving MANDT intervention techniques to include ensuring the specifics as to which type of techniques was used in the intervention. In addition, all agency supervisory staff with responsibility over direct support staff and direct support managers have been retrained on our agency Incident Reporting Policy and Utilization of Restraints Policy.</p> <p>3. The executive and/or associate director will review all incidents involving MANDT intervention to ensure that the appropriate documentation has been completed upon final approval of Habilitation Coordinators.</p> <p>4. All trainings have been completed as of 6/19/14</p>				

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  06/02/2014	
NAME OF PROVIDER OR SUPPLIER  MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>5/30/14 at 11:14a.m. Professional staff #1 indicated the 4/17/14 incident report should have described the type of physical restraint used (not just Mandt used) and the review team should have questioned this omission of restraint type during their initial review. Professional staff #1 indicated the corrective action included: the staff was terminated, a second staff was added to van transports, behavior plan reviewed, assigned van seating addressed, staff trained on Mandt physical restraint techniques.</p> <p>Professional staff #1 indicated the facility's corrective action for the 4/17/14 allegation of abuse/neglect with client A had not identified the need to retrain facility staff on incident/restraint reporting and reviews of incident reports.</p> <p>This federal tag relates to complaint #IN00148708.</p> <p>9-3-2(a)</p>						