

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G676	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2014
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 WOODMONT DR SOUTH BEND, IN 46614
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W000000	<p>This visit was for a fundamental recertification and state licensure survey and the investigation of complaint #IN00157540.</p> <p>Complaint #IN00157540: Substantiated; no deficiencies related to the allegations are cited.</p> <p>Dates of Survey: November 12, 13, 14, and 17, 2014.</p> <p>Facility number: 009969 Provider number: 15G676 AIM number: 200129000</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on November 20, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to</p>	W000104	In response to the issue identified by the medical surveyor, Mosaic has implemented the following	11/21/2014

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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W000137	<p>exercise general operating direction over the facility by failing to assure 1 of 2 additional clients (client#5), had a curtain on his bedroom window.</p> <p>Findings include:</p> <p>The group home where client #5 resided was inspected during the 11/13/14 observation period from 3:18 P.M. until 5:30 P.M. The window in client #4's bedroom was covered with a bed sheet.</p> <p>House manager #1 was interviewed on 11/14/14 at 10:03 A.M. House manager #1 stated, "He (client #5) pulled the curtain off. We (the facility) need to buy a new curtain for his (client #5's) room."</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview, the facility failed to assure 1 of 3 sampled</p>	W000137	<p>protocols: In response to concerns over the failure to maintain the bedroom curtains. Mosaic policy and procedure assures regular inspections take place assuring Compliance with sanitation, health and environmental safety codes. On November 21, 2014, new curtains were hung in the bedroom . Furthermore, on October 21, 2014 all staff at the facility were retrained on environmental safety procedures, specifically regarding identifying and resolving home maintenance needs using the online system. In addition, to assure this deficiency does not recur,each home is inspected by a member of Mosaic's safety committee for the purpose of assuring the home is in Compliance with sanitation, health and environmental safety codes In order to further assure both deficiencies do not recur in this facility, per Mosaic policy and procedure, Mosaic management conducts multiple visits to each facility to assure the home meets all sanitation, health and environmental safety codes.</p> <p>In regards to evidence cited by the medical surveyor, Mosaic has</p>	11/21/2014			

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	<p>clients (client #2), wore a belt to hold his pants up.</p> <p>Findings include:</p> <p>Client #2 was observed during the 11/13/14 observation period from 3:18 P.M. until 5:30 P.M., and the 11/14/14 observation period from 6:46 A.M. until 8:15 A.M. During the observation periods, client #2 was not wearing a belt and his pants were sliding down off of his hips and he was walking on his lower pants legs. During the observation periods, direct care staff #1, #2, #3, #4, and #5 did not prompt or assist client #2 to put on a belt.</p> <p>House manager #1 was interviewed on 11/14/14 at 10:03 A.M. House manager #1 stated, "[Client #2] should wear a belt and staff (direct care staff) should have helped him (client #2) put a belt on."</p> <p>9-3-2(a)</p>		<p>developed a plan that clearly defines the information and supports for both facility staff and client #4 to teach how to properly manage his safety needs of wearing his clothes properly and with a belt. Retraining on the supports has been completed 11/21/2014 for all facility staff and the fall plan was updated to include wearing a belt. This training was conducted by the QIDP. To assure this deficiency does not recur in the facility, Mosaic has Policies and Procedures stating that each client served must have an individual program plan. This plan includes needed interventions and services to support achievement of goals and objectives identified in the plan through ongoing active treatment. 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 achieve each goal and objective 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)and the Program Coordinator (QIDP). During this visit, each assures that direct care staff provides continuous active treatment specifically that each client receives interventions and services insufficient number</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. Based on observation, record review, and interview, the facility failed to assure nursing services clarified the administration directions of Reguloid Powder (stool softener) for 1 of 1 additional clients who required nectar thick liquids (client #4).</p> <p>Findings include:</p> <p>Client #4 was observed receiving prescribed medications during the 11/14/14 observation period from 6:46 A.M. until 8:15 A.M. At 6:57 A.M., direct care staff #3 mixed Reguloid powder (stool softener medication) into a glass of water and prompted client #4 to drink the mixture. After several minutes of prompting, client #4 began to drink the Reguloid mixture. As the client began drinking the mixture he began to cough. Direct care staff #3 patted the client on his back and continued to prompt the client to drink the Reguloid mixture. The mixture was noted to be separated with thin, water consistency liquid in the top two thirds of the glass and a thicker</p>	W000331	<p>and frequency to support the achievement of goals and objectives.</p> <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 incident cited by the medical surveyor, on 11/14/14, all facility staff were trained on the medication administration policy and dietary orders for client #4.. Additionally, on 10/21/2014, all facility staff received training on client #4 Choking and Aspiration Plan. To further ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple visits to every facility by the house manager (Direct Support Manager), the Program Coordinator (QDDP), Associate Director and agency Registered Nurse. During this visit each assures nursing services are both properly provided and documented in the Health Care T Logs in THERAP. Furthermore, the agency Registered Nurse, Associate Director, and Program Coordinator conducts monthly reviews. During this time, the each reviews the agency Health Care T Log. Any potential concern identified is immediately</p>	11/21/2014			

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	<p>substance in the bottom third of the glass. Direct care staff #3 continued to prompt client #4 to drink the mixture. Client #4 continued to cough, with direct care staff #3 patting him on the back, as the client took sips of the Reguloid mixture until he drank down to the lower third (thicker substance) of the mixture.</p> <p>Client #4's record was reviewed on 11/14/14 at 7:20 A.M. Review of the client's 10/7/14 Choking/Aspiration Risk Plan indicated the client was to have nectar thick liquids.</p> <p>Client #4's 11/14 Medication Administration Record was reviewed on 11/14/14 at 8:07 A.M. The review indicated the following administration information for client #4's Reguloid powder: "Reguloid Powder Orange, mix with water and give orally 2x (two times) a day."</p> <p>Client #4's record was further reviewed on 11/14/14 at 8:47 A.M. Review of the client's record failed to indicate the facility's nurse reviewed administration instructions to assure client #4 received his Reguloid powder mixture in a nectar thick consistency to avoid aspiration and/or choking.</p> <p>House manager #1 was interviewed on</p>		reported to the facility Administrator.				

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W000436	<p>11/14/14 at 10:03 A.M. House manager #1 stated, "We sometimes mix his (client #4's) Reguloid with Thick-It (thickening agent) to make it (Reguloid mixture) thicker. [Direct care staff #3] must not have done that."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to maintain in good repair a wheelchair for 1 of 2 clients in the home who utilized a wheelchair (client #4).</p> <p>Findings include:</p> <p>Client #4 was observed during the 11/13/14 observation period from 3:18 P.M. until 5:30 P.M., and the 11/14/14 observation period from 6:46 A.M. until 8:15 A.M. During the observation periods, client #4 was sitting in a wheelchair. The wheelchair's front</p>	W000436	In regards to evidence cited by the medical surveyor, At the time of the survey, the wheelchair for client #4 had a broken tire. A follow up from NuMotion was completed on 11/20/2014 and the wheel of the chair was repaired. To assure this deficiency does not recur in the facility, Mosaic ha Policies and Procedures stating that each client served must have an individual program plan as well as the proper adaptive equipment needed to support the individual. To further ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple visits each week to every facility by the	11/20/2014			

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	<p>wheels had shredded rubber tires.</p> <p>Client #4's record was reviewed on 11/14/14 at 8:47 A.M. The review failed to indicate the client's wheelchair had been examined for repair of the front wheels/tires.</p> <p>Executive Director #1 was interviewed on 11/14/14 at 9:08 A.M. Executive Director #1 stated, "I was not aware [Client #4's] wheelchair wheels (tires) were in need of repair. Staff (direct care staff) are to let the manager (house manager) know when his (client #4's) wheelchair needs repair."</p> <p>9-3-7(a)</p>		<p>house manager (Direct Support Manager) and the Program Coordinator (QDDP). During this visit, each assures that direct care staff provides continuous active treatment specifically that each client receives interventions and services in sufficient number and frequency to support the achievement of goals and objectives.</p>		