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| 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 12/13/2013 |
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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 an extended recertification and state licensure survey.</p> <p>Dates of Survey: November 5, 6, 8, 18, 22 and December 13, 2013.</p> <p>Facility number: 009969 Provider number: 15G676 AIM number: 200129000</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/26/13 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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| W000104 | <p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 4 of 4 clients (clients #1, #2, #3 and #4) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. Upon arriving at clients #1, #2, #3 and #4's home, the doorbell did not work.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. Upon arriving at the group home the doorbell did not work.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/8/13 at 10:25 A.M.. The QIDP indicated the doorbell sometimes worked and sometimes did not. No documentation was submitted for review to indicate when the doorbell would be repaired.</p> <p>9-3-1(a)</p> | W000104 | <p>In regards to evidence cited by the medical surveyor, the doorbell was repaired on 12/14/13. Additionally, Mosaic has a procedure to submit maintenance repairs on-line. Upon review, the request for repair was made on 12/13/13 at 3:30pm. Requests are made by the home manager. Given the delay in the repair request, Mosaic reviewed the procedure with the Direct Support Manager responsible for the home. The Direct Support Manager did note that they did not typically ring the doorbell when going to the facility and had not received a complaint regarding the malfunction. In order to assure that this deficiency does not recur in this facility, Per Mosaic policy and procedure, quarterly safety inspections are completed for each facility Mosaic operates. As a part of this inspection, Mosaic assures the property and its contents working properly. As a further means to assure this deficiency does not recur, Mosaic management conducts multiple weekly visits to each facility to assure the site is properly maintained.</p> | 12/13/2013 | |

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| W000125 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4) to have toilet paper readily accessible in the restroom.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group on 11/5/13 from 4:35 P.M. until 6:00 P.M.. During the entire observation period the main bathroom at the group home had no toilet paper.</p> <p>A morning observation was conducted at the group on 11/8/13 from 6:20 A.M. until 8:10 A.M.. During the entire observation period the main bathroom at clients #1, #2, #3 and #4's home had no toilet paper available for use.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/8/13 at 10:25 A.M.. The QIDP indicated there should be toilet paper available in the bathroom for clients to use.</p> | W000125 | Mosaic has policies and procedures in place to define and describe the rights of people served. Mosaic also works to promote the rights, interests, and well-being of all people served and to specify how any individual or their guardian may seek enforcement of these rights on behalf of the individual. The agency policy and procedure explains how all residents are educated on their rights and will describe how every individual served has the right to independent personal decisions and knowledge of available choices. Each client and guardian signs a receipt which documents the annual review of the rights of each person served by Mosaic. Mosaic provides all staff training on the rights of each person served. This training is completed prior to employment as well as annually. The staff at this facility will be retrained on or before 1/10/14. In response to the evidence identified by the Medical Surveyor, toilet paper was available in the bathroom. It was located under the sink. Client #2 has a Behavior Support | 01/12/2014 | | | |

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| | 9-3-2(a) | | Plan that addresses shredding paper, specifically toilet paper. It doesn't restrict his access, rather, it places it out of sight (the cabinet is unlocked). The plan has been approved by the agency HRC. To further assure other consumers rights are not being restricted, the practice of placing the toilet paper in the cabinet will be reviewed by the agency HRC on 1/9/14. To further assure this deficiency does not recur, the facility QIDP or home manager conducts multiple visits to the facility to assure the rights of all clients are protected. Specifically, staff assure the facility is free from unnecessary restrictions. | | |

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| W000137 | <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.</p> <p>Based on observation and interview, the facility failed to provide age appropriate activities for 1 of 2 sampled clients (client #2).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. At 5:20 P.M., Direct Support Professional (DSP) #3 handed client #2 a plastic children's see and say toy and a stuffed animal. DSP #3 placed a plastic light up musical toy, on the table in front of client #2. DSP #3 prompted client #2 to play with the toys. Client #2 was not provided any other activities during the observation.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 7:40 A.M., DSP #5 handed client #2 a plastic children's see and say toy. DSP #5 placed a wooden children's puzzle and a plastic light up musical toy, on the table in front of client #2. DSP #5 prompted client #2 to play with the toys. Client #2 was not</p> | W000137 | In regards to evidence cited by the medical surveyor, it is Mosaic policy to assure the rights of all clients are protected. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possession and activities. Direct Support staff will be retrained on the need to monitor client's possessions to assure clients have age appropriate options based on personal choice and need. Retraining on age appropriate activities and choices will be provided on or before 1/12/14 by the facility QIDP. This training session specifically identifies the active treatment and support training for each client as it relates to providing age appropriate activities. Furthermore, staff were retrained on using all formal and informal opportunities in order to implement a continuous active treatment program, specifically as it relates to providing a variety of age appropriate activities. To further assure this deficiency does not recur, the QIDP and Direct Support Manager will conduct routine weekly observations during multiple shifts and varying times of active | 01/12/2014 | | | |

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| | <p>provided any other activities during the observation.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/8/13 at 1:25 P.M.. The QIDP indicated client #2 should be offered age appropriate activities.</p> <p>9-3-2(a)</p> | | <p>treatment sessions on an ongoing basis to assure people supported are offered a variety of activities reflecting personal choice which will enhance opportunities for growth.</p> | | |

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| 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. Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2), the facility neglected to implement written policy and procedures to conduct thorough investigations in regards to unknown injuries and an allegation of neglect.</p> <p>Findings include:</p> <p>A request for investigation records for this group home from 10/12 to current was made on 11/6/13 at 1:50 P.M.. No investigations were submitted for review. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 11/6/13 at 1:50 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 11/25/12 indicated client #1 had a bump on his eye. The cause of injury was unknown. No investigation record was submitted for review in regard to this incident.</p> <p>-BDDS report dated 12/18/12 indicated client #2 had a brown bruise. The cause of injury was unknown. No investigation record was submitted for review in regard to this incident.</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 have been immediately reported and consequently investigated within 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. On 1/6/14, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation, specifically as it relates to injuries of unknown origin. | 01/06/2014 | |

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| | <p>-BDDS report dated 1/19/13 indicated client #2 had a bruise. The cause of the injury was unknown. No investigation record was submitted for review in regard to this incident.</p> <p>-BDDS report dated 10/8/13 indicated: "On 10/8/13, [client #1] was eating his lunch, which had been sent in pureed for him by his home staff. After a few bites he began coughing and turning red. Staff told him to keep coughing. As he did, he vomited. Mixed in with the emesis was a whole piece of bone. The piece of bone appeared to be a pork chop bone, approximately 1 3/4 inches long by approximately 3/8 inch wide at one end tapering down to a sharp point. The bone was approximately 3/8 inch thick and the edges were rough and sharp...." No investigation record was submitted for review in regard to this incident.</p> <p>A review of the facility's abuse/neglect policy dated 7/1/08 was conducted on 11/18/13 at 4:50 P.M. and indicated:</p> <p>"Mosaic investigates in a timely manner any Incident/Allegation which places anyone associated with Mosaic or the organization as a whole at risk. Investigations may involve but are not limited to issues related to abuse/neglect,</p> | | | | | | |

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| | <p>mistreatment, exploitation, finance, criminal activity and employee misconduct. Agencies are required to report incidents or allegations according to their agency's regulatory reporting requirements.</p> <p>Inquiries and investigations should be commenced within 24 hours of Mosaic's notification of the Incident/Allegation.</p> <p>Inquiries must be completed within 5 working days."</p> <p>An interview with the Program Director (PD) was conducted on 11/6/13 at 3:50 P.M.. When asked if there was documentation to indicate investigations were conducted in regards to the mentioned incidents, the PD stated "No."</p> <p>9-3-2(a)</p> | | | | |

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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 for 4 of 4 incidents, involving 2 of 2 sampled clients (clients #1 and #2), the facility failed to provide written evidence investigations were conducted of unknown injuries and an allegation of neglect.</p> <p>Findings include:</p> <p>A request for investigations for this group home from 10/12 to current was made. No investigations were submitted for review. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 11/6/13 at 1:50 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 11/25/12 indicated client #1 had a bump on his eye. The cause of injury was unknown. No investigation record was submitted for review in regard to this incident.</p> <p>-BDDS report dated 12/18/12 indicated client #2 had a brown bruise. The cause of injury was unknown. No investigation record was submitted for review in regard to this incident.</p> | W000154 | In regards to evidence cited by the medical surveyor, per policy and procedure, each incident of suspected client abuse, neglect, mistreatment and exploitation should have been immediately reported and consequently investigated within 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. On 1/6/14, the Program Coordinator and Investigation Coordinator for the facility received training on conducting an investigation, specifically as it relates to injuries of unknown origin. | 01/06/2014 | |

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| | <p>-BDDS report dated 1/19/13 indicated client #2 had a bruise. The cause of injury was unknown. No investigation record was submitted for review in regard to this incident.</p> <p>-BDDS report dated 10/8/13 indicated: "On 10/8/13, [client #1] was eating his lunch, which had been sent in pureed for him by his home staff. After a few bites he began coughing and turning red. Staff told him to keep coughing. As he did, he vomited. Mixed in with the emesis was a whole piece of bone. The piece of bone appeared to be a pork chop bone, approximately 1 3/4 inches long by approximately 3/8 inch wide at one end tapering down to a sharp point. The bone was approximately 3/8 inch thick and the edges were rough and sharp...." No investigation record was submitted for review in regard to this incident.</p> <p>An interview with the Program Director (PD) was conducted on 11/6/13 at 3:50 P.M.. When asked if there was documentation to indicate investigations were conducted in regards to the mentioned incidents, the PD stated "No."</p> <p>9-3-2(a)</p> | | | | | | |

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| W000227 | <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 2 sampled clients (client #2), the client's Individual Support Plan (ISP) failed to address the client's identified communication needs.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. During the entire observation period, client #2 was not able to communicate his wants and needs in that he did not speak.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. During the entire observation period, client #2 was not able to communicate his wants and needs in that he did not speak.</p> <p>A review of client #2's records was conducted on 11/8/13 at 3:00 P.M.. A review of the client's 1/19/13 ISP indicated he was non-verbal and failed to indicate a communication training objective to teach him to communicate</p> | W000227 | <p>In regards to evidence cited by the medical surveyor, Mosaic reviewed the assessment conducted on client #2 and agrees that a communication program was needed, however, one was not implemented. On or before 1/12/14, a goal addressing the communication needs of client #2 was crafted. Training on the communication goal will be conducted on 1/10/14 for all facility staff. The training will be conducted by the facility QIDP. This training session specifically identified the communication goal and objectives for Client #2. Additionally, the QIDP reviewed both the formal in informal objectives for Client #2's communication goal. Furthermore, staff were retrained on using all formal and informal opportunities in order to implement goals and objectives. 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.</p> | 01/10/2014 | | | |

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| | <p>with others about his wants and needs.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/8/13 at 3:30 P.M.. The QIDP indicated client #2 did not have a communication training objective in his plan and further indicated he did need one implemented into his program.</p> <p>9-3-4(a)</p> | | <p>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 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 in sufficient number and frequency to support the achievement of goals and objectives as it relates to communication.</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 to implement written objectives during times of opportunity for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. During the entire observation period, clients #2 and #4 sat in the dining room. Clients #1 and #3, who used a wheelchair for mobility, wheeled back and forth from the bedroom hallway to the dining room. Direct Support Professionals (DSP) #1, #2 and #3 would occasionally walk through and visually check on clients #1, #2, #3 and #4 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20</p> | W000249 | <p>In regards to evidence cited by the medical surveyor, retraining on the specific goals identified in the evidence pertaining active treatment was conducted again on 1/10/14 for all facility staff. Specifically, the facility staff was trained on the Individual Program Plan for client #1, #2, #3 and #4. This training was conducted by the facility QIDP. This training session specifically identified the active treatment and support training for each client. Staff reviewed both the formal in informal objectives in each individual's IPP. Furthermore, staff were retrained on using all formal and informal opportunities in order to implement a continuous active treatment program. Additional review by agency leadership noted this was a pervasive issue and not an isolated incident. Direct Support Staff and the facility Direct Support Manager received disciplinary action for failing to complete duties as assigned. To assure this deficiency does not recur in the facility, Mosaic has Policies and Procedures</p> | 01/10/2014 | |

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| | <p>A.M. until 8:10 A.M.. During the entire observation period, clients #2 and #3 sat in the dining room. Clients #1 and #3, who used a wheelchair for mobility, wheeled back and forth from the bedroom hallway to the dining room. Direct Support Professionals (DSP) #2, #4 and #5 would occasionally walk through and visually check on clients #1, #2, #3 and #4 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A review of client #1's records was conducted on 11/8/13 at 1:55 P.M.. A review of the client's 2/7/13 Individual Support Plan (ISP) indicated the following objectives which could have been implemented during the observation periods: "Will pack items into his lunch box...Will participate in Range of Motion Exercises daily while out of his chair...Will participate in the life of the community activities...Will connect with his Natural Supports, namely his cousins via telephone, letters or visits."</p> <p>A review of client #2's records was conducted on 11/8/13 at 3:00 P.M.. A review of the client's 1/19/13 ISP indicated the following objectives which could have been implemented during the observation periods: "Will prepare his applesauce before taking his</p> | | <p>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 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 in sufficient number and frequency to support the achievement of goals and objectives.</p> | | |

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| | <p>medications...will place items into his lunch box...Will participate in gross motor activities...Will participate in the life of the community through outings."</p> <p>A review of client #3's records was conducted on 11/8/13 at 3:30 P.M.. A review of the client's 5/29/13 ISP indicated the following objectives which could have been implemented during the observation periods: "Will improve his communication skills by answering questions with verbal prompts...Will increase his interaction with the community with more activity involvement...Will participate in household task of taking his plate to the kitchen when done...Will participate in Range of Motion exercises."</p> <p>A review of client #4's records was conducted on 11/8/13 at 4:10 P.M.. A review of the client's 4/18/13 ISP indicated the following objectives which could have been implemented during the observation periods: "Will pack items in his lunch box...Will participate in a physical activity...Will communicate his drink preference using sign language and pictures."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/8/13 at 3:30 P.M.. The QIDP stated</p> | | | | | | |

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| | <p>client objectives should be implemented "during all times of opportunity." The QIDPD further indicated clients #1, #2, #3 and #4 should have been provided with meaningful active treatment activities during the observation periods.</p> <p>9-3-4(a)</p> | | | | |

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| W000331 | <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 1 deceased client (client #5), the facility's nursing services failed to meet the needs of the client in regard to assessing client #5 in regards to his high blood pressure. The facility's nursing services failed to develop a hypertension plan for client #5, who was diagnosed with hypertension. The facility's nursing services failed to ensure client #5's prescribed medication was available at the group home.</p> <p>Findings include:</p> <p>Review of client #5's record was conducted on 11/18/13 at 2:00 P.M.. Review of client #5's record indicated he was diagnosed with hypertension. Review of client #5's record did not indicate an assessment by the nurse in regards to his high blood pressure reading. The record did not indicate a plan that gave staff guidance on signs and symptoms of hypertension and directed staff on when they should notify the nurse. Review of his Medication Administration Record (MAR) dated 2/13 indicated: "6/8/12...Blood Pressure every Monday, Wednesday and Friday call for >180/100 or <80/50." Further review of the MAR</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. Additionally, Risk plans are developed by the IDT and reviewed by the agency RN as needed. Furthermore, medication is to be in the group home as prescribed. In response to the incident cited by the medical surveyor, the agency RN failed to develop a clear protocol regarding Client #5's hypertension diagnosis. Although, Client #5 did not have an active diagnosis of hypertension prior to his hospitalization (there was one several years prior, however, the medication used caused dizziness and falls and the primary care physician discontinued the medication and eliminated the hypertension diagnosis), the agency elected to monitor client #5's blood pressure on the MAR with instructions to contact the RN if a reading fell outside of specific parameters. A formal hypertension plan should have been put into place to assure all direct support staff were aware of steps to take in the event a blood pressure reading was outside of prescribed parameters. Mosaic is reviewing</p> | 01/12/2014 | |

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| | <p>indicated:</p> <p>"2/8/13: 157/100 2/21/13: 128/100."</p> <p>Written Statement by Qualified Intellectual Disabilities Professional (QIDP) dated 6/14/13 indicated: "On the Friday of the 31st of May, I spoke with [Day Program Nurse] regarding [client #5] being picked up from [Day Program] because he was sick and vomiting with flu like symptoms. He went home and was given juice and water. He was better by the weekend."</p> <p>Written Statement by Direct Support Professional (DSP) #10 dated 6/12/13 indicated: "Wednesday 6/5 and Thursday 6/6 [Day Program] informed us [client #5] was not eating. It was not normal of [client #5]. I sent the Nurse an SComm (electronic note) out of concern after taking his vitals during my shift."</p> <p>Written Statement by DSP #11 dated 6/12/13 indicated: "During the week of June 31st (sic) [client #5] was showing flu like symptoms. On Friday the 31st he had a slight temperature of 99 degrees. PRN (as needed) medication was given. Through out the week of June 7th [client #5] was showing signs of sluggishness and not eating a lot. This was not an</p> | | <p>hypertension tracking procedures across the agency and identifying people supported that would benefit from a hypertension plan. Clients identified as needing a plan will have a plan drafted and a subsequent review by the IDT prior to implementation. In response to the second issue cited by the Medical surveyor, The issue of the undelivered medication was reviewed with the agency pharmacy at the time of the incident. Omnicare has reviewed its practices and changes in delivery procedures to reduce late or failed deliveries has occurred. 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 Coordinator (QIDP). Additional visits are conducted by the agency Registered Nurse on a monthly basis (or more if needed). During this visit each assures nursing services are both properly provided and documented in the Health Care Notes. Furthermore, the agency Registered Nurse and Program Coordinator conduct monthly reviews of all health care services. During this time, the RN and PC review the agency Health Care Coordination T-logs (Therap documents). Any potential concern identified is immediately reported to the facility</p> | | | | |

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| | <p>alarm to staff as [client #5] is picky eater. On Friday, June 7th, staff called stating [client #5] did not want to get up. He would not eat or drink anything and they had taken his blood pressure and it was high. They (day program) asked someone to pick [client #5] up. I called [client #5]'s doctor to get him in...The doctor took his blood pressure and listened to his lungs and heart. He felt there were enough high blood pressures to merit blood pressure medicine. He faxed a prescription to [Pharmacy] and medication was to start at 7 A.M. the following day."</p> <p>Further review of the record indicated client #5's prescribed Lisinopril 10 mg (milligram) tablet...1 tablet orally once a day at 7:00 A.M., was not available on 6/8/13. Review of the record indicated client #5 expired on 6/10/13. The record indicated:</p> <p>"Discharge Summary dated 6/10/13...Discharge Diagnosis:</p> <ol style="list-style-type: none"> 1. Brain death due to left cerebral subdural hematoma and subarachnoid hemorrhage with possible cerebral tonsil herniation. 2. Pneumonia. 3. Hypertension." | | Administrator. | | | | |

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| | <p>A Memo no date noted indicated: "During the investigation of [client #5]'s death there were a few communication break downs that this investigator found worth noting. First the lack of a timely T-Log or Scomm (electronic communication) to staff about the appointment with [client #5]'s PCP (Doctor) for his high blood pressure and medication change as most of the staff interviewed had no information of either unless they were told directly. The second communication break down was that the PC (Program Coordinator) was on call for the weekend of June 8th during an issue with the medication not showing up during the overnight and [client #5] heading to the hospital the on call was not notified until 8 P.M. Saturday night. At that point there was still no mention to the on call about the medication not being delivered or administered on time. The last issue was the IR (Internal Report) being done by the on call and not the management staff who had dealt with and had discussed directly with the staff [client #5] being admitted to the Emergency Room."</p> <p>Review of client #5's record did not indicate an assessment by the nurse in regards to his blood pressure reading on 2/8/13 and 2/21/13. The record did not indicate a plan that gave staff guidance on</p> | | | | |

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| | <p>signs and symptoms of hypertension and directed staff on when they should notify the nurse. Further review of client #5's MAR dated 6/13 indicated he received his Lisinopril 10 mg tablet at 7:00 A.M. on 6/8/13.</p> <p>An interview with the Nurse was conducted on 11/22/13 at 12:20 P.M.. The nurse indicated client #5 was diagnosed with hypertension years ago. She indicated the facility checked his blood pressure on Mondays, Wednesdays and Fridays. The Nurse indicated client #5's doctor discontinued his blood pressure medication before she was employed at the facility due to him having repeated falls over three years ago. When asked if she assessed him after the documented high reading in 2/13, she indicated she did not. When asked if a hypertension protocol was developed for client #5 due to his diagnosis of hypertension, she indicated no. When asked if the facility's nursing services checked to ensure client #5's prescribed blood pressure medication was available for him to take at 7:00 A.M., she indicated no. When asked if client #5 took his 7:00 A.M. dosage of Lisinopril on 6/8/13, she indicated he did not. When asked how client #5 expired, the Nurse stated "Bleeding of the brain."</p> | | | | |

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| W000336 | <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 1 of 2 sampled clients (client #1), the facility's nursing services failed to conduct quarterly nursing assessments of the client's health status and medical needs.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/8/13 at 1:11 P.M.. Client #1's record indicated nursing quarterlies were completed on 11/25/12, 2/25/13 and 8/26/13. Client #1's most current annual physical was dated 1/31/13. Client #1's 11/13 physician orders indicated client #1 received routine medications. There was no documentation to indicate a nursing quarterly was completed in 5/13.</p> <p>An interview with the Nurse was conducted on 11/22/13 at 12:20 P.M.. The Nurse indicated nursing quarterlies are to be completed every three months.</p> <p>9-3-6(a)</p> | W000336 | <p>The agency reviewed the nursing quarterlies for all clients in the facility. All Nursing Quarterlies were completed including client #1. Client #1's nursing quarterly dated 5/25/13 is attached to this Plan of Correction. It was on file both in Therap and in the program record. Please note that the date on the quarterly documented a February Date. On 6/14/13, the RN noted her error on Therap and completed a follow up report documenting the date error and change. The original hand written quarterly with date complete was also provided.</p> | 01/12/2014 | | | |

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| W000369 | <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 clients observed during the morning medication administration (clients #2 and #3) to ensure staff administered 2 of 13 of the clients' medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 6:45 A.M., Direct Support Professional (DSP) # 6 began administering client #2's prescribed oral medications. DSP #6 administered client #2's "Levothyroxine (hypothyroidism) 100 mcg (microgram) tablet...Aspirin 81 mg tablet chew (heart)...Docusate Sodium 100 mg capsule with applesauce. Client #2 was not prompted to chew his medication and did not chew his medication. Review of the bubble pack and Medication Administration Record (MAR) dated 11/1/13 to 11/30/13 indicated: "Levothyroxine 100 mcg tablet...1 tablet once a day...Take on an empty</p> | W000369 | 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. Upon review of the medication pass cited by the medical surveyor, it was determined DSP #6 was not able to adequately administer medications as prescribed. It was determined that DSP #6 would no longer administer medications until he completed Core A again and displayed sufficient competency in administering medications. Additionally, DSP #6 received a corrective action in accordance with agency policy. To further ensure Mosaic prevents recurrence of this deficiency the agency continues to conduct multiple visits each week to every facility by the house manager (Direct Support Manager) and the Program Coordinator (QIDP). During this visit, the manager assures medications are administered in accordance with Mosaic policy and procedure. | 01/10/2014 | |

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| | <p>stomach...Aspirin 81 mg tablet chew...Chew tablet before swallowing...Docusate Sodium 100 mg capsule...3 capsules orally once a day after supper...7 P.M.." At 7:40 A.M., DSP #6 administered client #3's prescribed oral medications. DSP #6 administered client #3's "Aspirin 81 mg (milligram) tablet with applesauce. Client #3 was not prompted to chew his medication and did not chew his medication. Review of the bubble pack and MAR dated 11/1/13 to 11/30/13 indicated: "Aspirin 81 mg (heart) tablet...1 tablet orally once a day...Chew before swallowing." Client #2 ate his breakfast at 7:00 A.M.. Client #2 did not take his medication on an empty stomach. Client #2 took his 7 P.M. medication at 6:45 A.M..</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/8/13 at 10:25 A.M.. The QIDP indicated client #2 and #3's medications should have been administered as directed on the label and MAR.</p> <p>An interview with the Nurse was conducted on 11/22/13 at 12:20 P.M.. The Nurse indicated client #2's medications should have been administered as directed on the label and MAR.</p> | | | | | | |

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| | 9-3-6(a) | | | | |

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| W000436 | <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 2 sampled clients and 1 additional client (clients #1 and #3) to ensure client #1's wheelchair was properly fit and client #3 used his adaptive spoon at meal times.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. At 5:40 P.M., client #3 ate dinner which consisted of roast beef and gravy, mashed potatoes, cream corn and carrots. Client #3 used a standard spoon to eat his meal. Client #3 had trouble gripping the spoon while eating. During the entire observation, client #1 kept sliding out of his wheelchair. Direct Support Professionals (DSPs) #1, #2 and #3 kept pulling him back into his wheelchair.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 7:30 A.M., client #3 ate his meal which consisted of</p> | W000436 | <p>In regards to evidence cited by the medical surveyor, Client #3 should have used adaptive silverware. Further investigation conducted by Mosaic found this to be a pervasive practice by facility staff. Mosaic gave a Corrective action for Direct Support Staff for failing to implement the recommendations identified in the ISP. Additionally, a corrective action was given to the Direct Support Manager for failing to assure recommendations from the nutritional assessment were implemented as identified in the ISP. In regards to the evidence cited by the medical surveyor, Mosaic scheduled an assessment of Client #1's wheelchair for January 10. Recommendations and adjustments will be implemented after the assessment is completed. 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 as well as the proper adaptive equipment needed to support the individual. To further ensure Mosaic</p> | 01/10/2014 | | | |

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| | <p>toast, oatmeal, cottage cheese and bananas. Client #3 used a standard spoon to eat his meal. Client #3 had trouble gripping the spoon while eating. During the entire observation, client #1 kept sliding out of his wheelchair. Direct Support Professionals (DSPs) #2, #5 and #6 kept pulling him back into his wheelchair.</p> <p>An interview with DSP #5 was conducted on 11/8/13 at 7:25 P.M.. DSP #5 indicated client #1 has been sliding out of his chair a lot the past couple of months.</p> <p>A review of client #1's record was conducted on 11/8/13 at 1:55 P.M.. Review of client #1's Individual Support Plan (ISP) dated 2/7/13 indicated he used a wheelchair for mobility at all times.</p> <p>A review of client #3's record was conducted on 11/8/13 at 3:30 P.M.. Review of client #3's most current Nutritional Assessment dated 7/10/13 indicated he should use adaptive silverware at meal times.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/8/13 at 10:25 A.M.. The QIDP indicated client #3 should use adaptive silverware at mealtimes. The QIDP further indicated</p> | | 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 and follows the support plan as defined in the ISP. Additionally, the visit reviews the facility and assures equipment is in good working order and is used as recommended. | | | | |

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| | client #1 may need to have his wheelchair assessed so he doesn't slide out of it. 9-3-7(a) | | | | |

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| W000455 | <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, during medication administration, for 1 of 2 sampled clients (client #2), whose oral medications were dispensed on to the unsanitized countertop/sink.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 6:45 A.M., Direct Support Professional (DSP) # 6 brought client #2 into the medication room. DSP #6 did not sanitize the counter top and sink prior to beginning medication administration. DSP #6 then punched each of client #2's medications from the bubble packets into a medication cup. DSP #6 dropped the medications onto the unsanitized countertop and they then fell into the unsanitized sink. DSP #6 then picked the medications up with his hands, placed them back into the cup and administered the medications to client #2.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on</p> | W000455 | <p>In regards to evidence cited by the medical surveyor, Mosaic policy and procedure specifies all medication administered should be administered without error and in a sterile, clean environment. All Mosaic Staff are trained on this policy in conjunction with Core A and Core B medication administration at new staff orientation as well as an annual retraining. This policy states that medication must be passed in a clean, sterile container. Upon review of the medication pass cited by the medical surveyor, Mosaic Administration determined DSP #6 was not able to adequately administer medications as defined in Core A Medication Administration procedures and that DSP #6 would no longer administer medications until he completed Core A again and displayed sufficient competency in administering medications. Additionally, DSP #6 received a corrective action in accordance with agency policy. To further ensure Mosaic prevents recurrence of this deficiency the agency continues to conduct multiple visits each week to every facility by the house manager (Direct Support Manager) and the Program Coordinator (QIDP).</p> | 01/10/2014 | | | |

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| | <p>11/8/13 at 10:25 A.M.. The QIDP indicated client #2's medications should have been administered directly from the paper cup and not from the counter top/sink.</p> <p>An interview with the Nurse was conducted on 11/22/13 at 12:20 P.M.. The Nurse indicated client #2's medications should have been administered directly from the paper cup and not from the counter top/sink.</p> <p>9-3-7(a)</p> | | <p>During this visit, the manager assures medications are administered in accordance with Mosaic policy and procedure.</p> | | |

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| W000460 | <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, interview and record review for 2 of 2 sampled clients (clients #1 and #2), the facility failed to assure the staff provided food in accordance with clients' diet order.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. At 5:40 P.M., clients #1, #2, #3 and #4 ate dinner which consisted of roast beef and gravy, mashed potatoes, cream corn and carrots. Client #1 and #2's mashed potatoes were not of a pureed consistency.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 7:00 A.M., clients #1 and #2 ate their meal which consisted of toast, oatmeal, cottage cheese and bananas. Clients #1 and #2's oatmeal was not of a pureed consistency.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 11/6/13 at 2:50 P.M.. Review of the reports indicated:</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 specially prescribed diets as identified by the agency Registered Dietician. On 1/10/2014, Mosaic staff received retraining on client #1 and #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. 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 puree 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 | 01/10/2014 | | | |

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| | <p>-BDDS report dated 10/8/13 indicated: "On 10/8/13, [client #1] was eating his lunch, which had been sent in pureed for him by his home staff. After a few bites he began coughing and turning red. Staff told him to keep coughing. As he did, he vomited. Mixed in with the emesis was a whole piece of bone. The piece of bone appeared to be a pork chop bone, approximately 1 3/4 inches long by approximately 3/8 inch wide at one end tapering down to a sharp point. The bone was approximately 3/8 inch thick and the edges were rough and sharp...."</p> <p>A review of client #1's record was conducted on 11/8/13 at 1:55 P.M.. Review of client #1's most current Nutritional Assessment dated 7/10/13 indicated: "Pureed diet."</p> <p>A review of client #2's record was conducted on 11/8/13 at 3:00 P.M.. Review of client #2's most current Nutritional Assessment dated 7/10/13 indicated: "Pureed diet."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/8/13 at 10:25 A.M.. The QIDP indicated staff should have followed each client's prescribed diet.</p> | | dietary plan. | | | | |

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| W000484 | <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the facility failed for 4 of 4 clients (clients #1, #2, #3 and #4) residing in the group home to provide condiments at the dining table.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. At 5:40 P.M., clients #1, #2, #3 and #4 ate their meal which consisted of roast beef, mashed potatoes, cream corn and carrots. There was no salt/salt substitute, pepper or butter available for clients #1, #2, #3 and #4 to use for their meal.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 7:00 A.M., clients #1, #2, #3 and #4 ate their meal which consisted of oat meal, cottage cheese, bananas and toast. There was no butter, jelly, sugar/sugar substitute available for clients #1, #2, #3 and #4 to use for their meal.</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p> | W000484 | In regards to evidence cited by the medical surveyor, Client #1, #2, #3 and #4 should have had condiments available. Facility direct support staff are scheduled to be retrained on 1/10/14 on assuring condiments are provided at each meal. 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 provides condiments at the dining table. | 01/10/2014 | | | |

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| | (QIDP) was conducted on 11/8/13 at 10:25 A.M.. The QIDP indicated condiments should be put on the table for the clients to use. 9-3-8(a) | | | | | | |

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| W000488 | <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed to assure 4 of 4 clients observed eating breakfast (clients #1, #2, #3 and #4) were involved in meal preparation and assisted in packing their lunches.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/5/13 from 4:35 P.M. until 6:00 P.M.. At 4:40 P.M., Direct Support Professional (DSP) #2 was in the kitchen preparing dinner which consisted of roast beef and gravy, mashed potatoes, cream corn and carrots. At 5:40 P.M., DSPs #1 and #2 put the prepared meal on the dining table where the clients sat. Clients #1, #2, #3 and #4 ate independently. Clients #1, #2, #3 and #4 did not assist in meal preparation.</p> <p>A morning observation was conducted at the group home on 11/8/13 from 6:20 A.M. until 8:10 A.M.. At 6:40 A.M., DSP #4 packed clients #2, #3 and #4's lunches into their lunch boxes, as the clients sat in the living area with no activity. Beginning at 7:15 A.M., Direct Support Professional (DSP) #2 put bread</p> | W000488 | Mosaic's Dietary Policy and Procedure states that each individual served should participate in the preparation and service during all meals. On or before November 8, 2013, 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. | 01/06/2014 | | | |

| 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 12/13/2013 | |
|--|---|---|---|---|--|---|--|
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| | <p>into the toaster and prepared oatmeal while clients #1, #2, #3 and #4 sat with no activity. At 7:30 A.M., DSPs #2 and #3 put the prepared meal on the dining table where the clients sat. Clients #1, #2, #3 and #4 ate independently. Clients #1, #2, #3 and #4 did not assist in meal preparation.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 11/8/13 at 10:25 A.M.. The QIDP indicated the clients were capable of assisting in meal preparation and further indicated they should be assisting in meal preparation at meal times.</p> <p>9-3-8(a)</p> | | | | | | |