STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G227		03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC	723 CHERRY TREE LN SOUTH BEND, IN 46617

(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
W 0000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: February 29, and March 2, 3, and 4, 2016 Facility number: 000751 Provider number: 15G227 AIM number: 100248910 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/10/16.	W 0000		
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview, the facility failed to implement a dental hygiene objective for 1 of 2 sampled clients with a dental hygiene	W 0249	In regards to evidence cited by the medical surveyor, retraining on the specific goals identified in the evidence pertaining active treatment and all opportunities to	03/16/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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	objective (client #1). Findings include: Client #1 was observed at the group home during the 3/3/16 observation period from 6:38 A.M. until 8:15 A.M. During the observation period, direct care staff #2 prompted client #1 to brush his teeth. Client #1 entered the bathroom and closed the door. Direct care staff #2 entered the bathroom a few minutes later and asked the client, "Did you brush your teeth?" Client #1 stated, "Yes." Direct care staff #2 did not observe client #1 brushing his teeth and did not prompt the client to brush his teeth for two minutes. Client #1's record was reviewed on 3/3/16 at 8:46 A.M. A review of the client's 1/4/16 Individual Program Plan indicated the client had the following dental hygiene objective, "With unlimited verbal prompts, [client #1] will brush his teeth twice a day for 2 minutes." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 3/3/16 at 10:40 A.M. QIDP #1 stated, "Staff (direct care staff) should have implemented (client #1's) objective." 9-3-4(a)		run goals was conducted again on March 16, 2016 for all facility staff. This training was conducted by the facility Manager. This training session specificallyidentified the active treatment and support training for each client in oral hygiene. Staff reviewed both the formal and informal objectives in each individual's IPP regarding hygiene.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 hygiene. To assure this deficiency does not recur in the facility, Mosaic has Policies andProcedures 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	

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			that direct care staff provides continuous active treatment specifically that each individual receives interventions and services in sufficient number and frequency to support the achievement of goals and objectives.	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 of 3 additional clients (clients #4, #5, and #6). Findings include: Clients #1, #2, #3, #4, #5, and #6 were observed during the group home observation period on 3/3/16 from 6:38 A.M. until 8:15 A.M. Upon entering the group home, direct care staff #1 was in the dining room talking to client #5. In the medication room, medications were noted to be open on the counter. At 6:50 A.M., direct care staff #1 prepared medications for client #1. While preparing the medications, direct care staff #1 left the medication room three times to get water, applesauce and to	W 0382	In regards to evidence cited by the medical surveyor Mosaic policy and procedure specifies all medication must be kept in a secured location. All Mosaic Staff are trained on this policy at new staff orientation and updated annually or as needed. To assure this deficiency does not recur, Mosaic trained all facility staff were retrained on the agency medication administration policy and procedure on 3/16/2016. Training was focused on keys and assuring medications are properly secured at all times. To further ensure Mosaic prevents recurrence of this deficiency, the agency also conducts multiple visits each week to every facility by the house manager (DirectSupport Manager) and the Program Coordinator (QIDP). During this visit, the manager assures medications are secured. Furthermore, the agency Registered Nurse conducts	03/16/2016

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	wash his hands. Medications were left open and on the counter and were accessible to all clients in the facility (clients #1, #2, #3, #4, #5, and #6). QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 3/3/16 at 10:40 A.M. QIDP #1 stated, "Medications are to be locked when they aren't being administered." 9-3-6(a)		monthly reviews. During this time, the RN reviews the facility's storage practices. Anypotential concern identified is immediately reported to the facility QIDP.	