

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G411	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 7933 E CHANDLER AVE TERRE HAUTE, IN 47803
--	---

(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 #IN00147515.</p> <p>Complaint #IN00147515 - Substantiated; Federal/state deficiency related to the allegation is cited at W331.</p> <p>Survey Dates: April 24 and 25, 2014.</p> <p>Facility Number: 000925 Aim Number: 100244480 Provider Number: 15G411</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 May 2, 2014 by Dotty Walton, QIDP.</p>	W000000		
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, the facility failed to ensure nursing services monitored current medical needs for 1 of 4 sampled clients (B). The facility failed to ensure client B's follow up care until an injury was resolved</p>	W000331	<p>POC EG Complaint 4/25/14 1.All Direct Support Staff who workat the East Glenn location will be retrained on timely, accurate andongoing Health Note/T-Log Documentation, ensuring appropriatedocumentation will be</p>	05/16/2014

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: 15G411		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2014	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 7933 E CHANDLER AVE TERRE HAUTE, IN 47803			
(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>(injury to face) was documented.</p> <p>Findings include:</p> <p>The facility's incident reports were reviewed on 4/24/14 at 10:08a.m. Client B had an incident report on 4/21/14. The report indicated client B had a behavior and hit his left eyebrow area on the floor. The report indicated client B had a 1/4" (inch) open area by his left eyebrow with some bleeding. The report indicated first aid was applied to his eyebrow and the bleeding stopped.</p> <p>Client B's record was reviewed on 4/24/14 at 1:00p.m. Client B's nursing notes were reviewed. There was no documentation in regards to the area on client B's left eyebrow and if the area was resolved. There were no nursing measures or treatment plan in place. Client B had a 2/7/14 "Fall Protocol." The protocol indicated staff were to document the falls in the nursing notes.</p> <p>Professional staff #1 and professional staff #2 (nurse) were interviewed on 4/24/14 at 1:34p.m. Staff #2 indicated she was aware of the area on client B's left eyebrow. Staff #2 indicated there was nothing documented about the care, treatment and how the area (left eyebrow area) was</p>		<p>continued until health issues are resolved.</p> <p>2. Client B's "Fall Risk Protocol" will be updated by the agency Nurse/RN to include procedures regarding head injury as a result of a fall. All Staff who work with Client B will be trained on this updated "Fall Risk Protocol". (See Attached Updated Fall Risk Protocol for Client Band staff training documentation)</p> <p>3. All clients receiving services at Mosaic/Terre Haute agency who currently have a "Fall Risk Protocol", will receive updates to the protocol to include procedures regarding head injury as a result of a fall. (See Attached Updated Fall Risk Protocols and staff training documentation)</p> <p>4. Mosaic of Terre Haute will update its "Medical Emergencies Policy and Procedure" to include new information regarding specific instructions for the procedures and documentation of incidents involving head injuries. In addition this update will include instructions for the treatment and monitoring of individuals in service who have sustained a head injury. (See attached Updated Medical Emergency Policy and Procedures and New Head Injury Tracking Form)</p> <p>5. All staff employed at Mosaic of Terre Haute will be trained on the updated "Medical Emergencies Policy and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G411	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2014
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 7933 E CHANDLER AVE TERRE HAUTE, IN 47803		
(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>healing. Staff #2 indicated there should have been documentation of the care of the injury until the injury was resolved.</p> <p>This federal tag relates to complaint #IN00147515.</p> <p>9-3-6(a)</p>		<p>Procedure" including the specific instructions for the procedures and documentation of incidents involving all head injuries. In addition all will be trained on following instructions for the treatment and monitoring of individuals in service who have sustained a head injury.</p> <p>6. All corrections will be completed and submitted no later than 5/25/14.</p>		