

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G280		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/02/2011	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 2820 BENHAM AVE ELKHART, IN46517			
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 28, 29, 30, and December 1 and 2, 2011.</p> <p>Facility number: 000800 Provider number: 15G280 AIM number: 100243460</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-16-11 C. Neary, Program Coordinator.</p>	W0000					
W0104	<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 to maintain operating direction over the group home for 6 of 6 clients in the home at the time of the survey (clients #1, #2, #3, #4, #5, and #6) by failing to establish a system to ensure maintenance and repairs were completed.</p> <p>Findings include:</p> <p>Observations were conducted at the group</p>	W0104	<p>In regards to evidence cited by the medical surveyor, the following repairs were scheduled to be completed by 1/1/12: The shower door in the small restroom, removal of two screws sticking out of the wall tiles next to the sink, the ceramic towel bar, the loose handrail, the loose fire plate, and the touch up paint through the facility.</p> <p>Additionally, all facility staff were retrained on or before 1/1/12 on completing maintenance requests to assure the maintenance and</p>	01/01/2012			

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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	<p>home on 11/29/11 from 6:56 A.M. until 9:05 A.M.. During the observation period the following repair needs were noted:</p> <p>The shower door in the small restroom was stuck, and unable to be opened. There were two large screws sticking out of the wall tiles beside the sink. The ceramic towel bar by the sink was broken. The living room wall had two areas where the paint was worn off. One area was 1' (one foot) by 1' in size and the other area was 6" (six inches) by 8" (eight inches). The back room had an area of worn paint 2' (two foot) by 6" (six inches) to the left of the window. Both of the large bathrooms had plaster damage on the wall by the tub/shower. The bathroom connected to client #2's and #6's bedroom had worn and scraped paint on the door and the walls. The handrail surrounding the commode in the bathroom was loose and wobbly. The lock plate on the fire door in the hallway was loose and hanging down by one screw.</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 11/30/11 at 10:35 A.M.. When asked about the repair issues at the home the QMRP indicated she was aware of the worn paint and damaged plaster by the showers.</p>		<p>repairs are completed in a timely fashion.</p> <p>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 furniture is in sufficient condition.</p> <p>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. As a part of this visit, each manager assures all maintenance and repairs are completed in a timely fashion.</p>		

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W0331	<p>A work order dated 11/16/11 was reviewed on 11/30/11 at 10:30 A.M. and indicated the shower was in need of repair and a sink faucet needed to be replaced.</p> <p>9-3-1(a) The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review, observation and interview, the facility failed to ensure 2 of 2 clients who utilized wheelchairs as their main form of mobility (clients #2 and #6) had client specific wheelchair usage protocols and client specific transfer protocols.</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/28/11 at 3:02 P.M. including Bureau of Developmental Disabilities Service (BDDS) Reports and the incident accident (I & A) reports for the time frame between 12/18/10 and 11/28/11. The reports indicated the following:</p> <p>-an I & A dated 9/20/11 for client #6 indicated she had a bruise on her left thigh caused by hitting her leg on the arm of the wheelchair.</p> <p>-an I & A dated 4/30/11 indicated client #2 had black and blue lines on her left thigh from the table on her wheelchair.</p>	W0331	<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. On 12/28/11, the facility QIDP drafted a Lift and Transfer Protocol and a Wheel Chair Usage Protocol for both clients cited. Additionally, on or before 1/1/2012, all facility staff received training on Lift and Transfer Protocol and a Wheel Chair Usage Protocol for both client #2 and #6. 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 (QIDP), and agency Registered Nurse. During this visit each assures all residents utilizing wheelchairs as their main form of mobility have and benefit from client specific wheelchair usage protocols as well as client specific transfer protocols.</p>	01/01/2012	

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	<p>Client #2's record was reviewed on 11/29/11 at 11:40 A.M.. Client #2's record indicated she utilized a wheelchair with a tray table. Client #2's record indicated she had a wound care management plan dated 4/2011. Client #2's record did not indicate when she was to be out of her wheelchair, repositioned, or how she was to be transferred.</p> <p>Client #6's record was reviewed on 12/1/11 at 2:38 P.M.. Client #6's record indicated she utilized a wheelchair. Client #6's record did not indicate when she was to be out of her wheelchair, repositioned, or how she was to be transferred.</p> <p>Observations were conducted at the group home on 11/28/11 from 4:57 P.M. until 6:48 P.M.. Client #2 and client #6 were observed to be in their wheelchairs during the observation period.</p> <p>Observations were conducted at the group home on 11/29/11 from 6:56 A.M. until 9:05 A.M.. Client #2 and client #6 were observed to be in their wheelchairs during the observation period.</p> <p>Observations were conducted at the day program on 11/29/11 from 2:03 P.M. until 2:46 P.M.. Client #2 and client #6 were observed to be in their wheelchairs during</p>				

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W0368	<p>the observation period.</p> <p>The facility RN and Qualified Mental Retardation Professional (QMRP) were interviewed on 11/30/11 at 11:40 A.M.. When asked if there were client specific protocols in place for client #2's and #6's wheelchair usage and transfers to help maintain their skin integrity. The RN and the QMRP stated. "No."</p> <p>9-3-6(a) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review and interview, the facility failed to administer 1 of 6 medications administered to client #2 in compliance with the physician's orders (PO).</p> <p>Findings include:</p> <p>Observations of the morning medication administration to client #2 was conducted on 11/29/11 at 7:35 A.M.. Client #2 was given the following medication, Exemestane (anti-cancer medication) 25 mg (milligrams) 1 tablet (crushed and mixed in a liquid medication cup of applesauce along with her other crushed 7:00 A.M. medications). The prescription label on the medication card indicated the medication was to be given orally after a</p>	W0368	In regards to evidence cited by the medical surveyor, Mosaic policy and procedure specifies all medication administered are administered in compliance with the physicians orders and without error. 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. Mosaic retrained all facility staff on the agency medication administration policy and procedure on or before 1/1/12. Specifically, staff were retrained on assuring all medications are dispensed as ordered. This includes dispensing the medication after a meal when prescribed. To further ensure Mosaic prevents recurrence of this deficiency, the agency continues to conduct	01/01/2012	

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	meal. Client #2 began to eat her breakfast at 8:14 A.M.. Client #2's 90 day PO signed/dated on 9/1/11 by her physician for the date of 9/2011 was reviewed on 11/29/11 at 11:40 A.M.. Client #2's PO indicated "Exemestane 25 mg give 1 tablet orally daily after meal. (anti cancer medication)." Client #2's PO dated for 10/2011 indicated "Exemestane 25 mg give 1 tablet orally daily after meal." The Qualified Mental Retardation Professional (QMRP) was interviewed on 11/30/11 at 11:50 A.M.. When asked if client #2's medication was administered according to her PO the QMRP stated. "It should have been given after the meal." 9-3-6(a)		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 the physicians orders and with Mosaic policy and procedure.		
W0454	The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview, the facility failed to provide a sanitary environment for 2 of 6 clients in the home (clients #2 and #6) by not ensuring shower equipment was free from bodily waste. Findings include:	W0454	In regards to evidence cited by the medical surveyor, Mosaic's Infection Control Policy and Procedure stipulates that must maintain a sanitary environment to avoid any and all sources and transmission of infections. Upon discovery, the shower equipment was sanitized. Additionally, the Program Coordinator (QIDP) drafted a shower equipment	01/01/2012	

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W9999	<p>Observations were conducted at the group home on 11/29/11 from 6:56 A.M. until 9:05 A.M.. During the observation period at 8:25 A.M. the shower chair located behind the closed shower curtain in the bathroom connected to client #2 and #6's bedroom was observed to have chunks of feces on the footrest. Client #2 and #6 had completed their showers for the morning.</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 12/1/11 at 12:27 P.M.. When asked who used the shower/shower chair, the QMRP indicated client #2 and #6. When asked about a sanitation protocol for the shower equipment, the QMRP stated. "Not supposed to have feces on it. It should be cleansed and sanitized after each use."</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>431 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties</p>	W9999	<p>sanitation protocol for all facility staff to follow to assure the facility maintains a sanitary environment. On or before 1/1/12, Mosaic staff received retraining on infection control procedures as well as in the shower equipment sanitation protocol. 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, both assure the facility provides a sanitary environment.</p> <p>In regards to evidence cited by the medical surveyor, the direct care staff completed a chest X-Ray and the results were provided to the agency Human Resources Manage. Results can be found in the personnel file for staff #9. To assure recurrence of this deficiency does not recur, Mosaic has hiring practice policy and procedure that specifically</p>	01/01/2012	

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	<p>and annually thereafter, each residential staff person shall submit written evidence that a Mantou (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten(10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 staff (staff #9) reviewed and who worked in the home had a negative mantoux test in accordance with state law.</p> <p>Findings include:</p> <p>Facility records reviewed on 11/30/11 at 11:05 A.M. indicated staff #9 on 1/12/09 had a positive mantoux test (18 millimeters of induration). This was prior to her employment with the facility. Staff #9 was sent to the local County Health Department on 5/6/2011 as a pre-employment requirement. Staff #9</p>		<p>identifies a tuberculosis mantoux test must be completed prior to employment and annually. In addition to this practice, the Mosaic Human Resources Department has developed a tracking system to assure staff are notified 30 days in advance of when their tuberculosis skin test is due to assure ample time is given for staff to complete the test. All records are maintained in the staff personnel file. In order to assure the agency meets this standard, Mosaic conducts quarterly audits of a 10% random sample of employee files to assure all required personnel documents are maintained.</p>		

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	<p>completed a TB Exposure Risk Assessment and the local County Health Department indicated staff #9 did not need a chest x-ray (CXR). There was no indication in staff #9's record she had a negative mantoux or a CRX prior to her working in the group home.</p> <p>An interview with The Executive Director (ED) was conducted on 11/30/11 at 12:30 P.M.. When asked about staff #9's mantoux test/CRX, the ED indicated he understood the staff needed a negative mantoux/CRX upon initial employment, and then a yearly TB risk assessment could be completed.</p> <p>9-3-3(e)</p>				