

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2011
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN46514
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: October 11, 12, 13, and 14, 2011</p> <p>Facility Number: 000772 Provider Number: 15G252 AIM Number: 100234940</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 11/3/11 by Chris Greeney, Medical Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>In response to the health survey conducted on October 14, 2011, please review the subsequent plan of correction required to meet compliance for the deficiencies identified at 1319 Lawn Ave, Elkhart, IN (15G252). We sincerely appreciate the help and support you have provided our agency in completing our recertification and state licensure survey. Please contact me at (574) 675-0726 if you have any concerns or questions regarding the documentation enclosed.</p>	
W0112	<p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients (client #4) to keep appointment records</p>	W0112	<p>In regards to the evidence cited by the medical surveyor on 10/14/2011, the doctor appointment card with client #4's</p>	10/21/2011

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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W0125	<p>confidential in his client record.</p> <p>Findings include:</p> <p>On 10-11-11 from 3:15 until 5:10 p.m. an observation at the home of client #4 was conducted. At 4:10 p.m. a bulletin board in the kitchen for all to see, was observed to have a doctor's appointment card with client #4's name, the date of the appointment, and the time of the appointment.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director (AD) indicated client #4's appointment card was posted in the kitchen and client records should be kept confidential.</p> <p>9-3-1(a)</p> <p>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. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure a legally sanctioned representative was available to assist him with his medical and financial needs per his assessments and for 7 of 8 clients (clients #2, #3, #4, #5, #6, #7, and #8) who lived in the group</p>	W0125	<p>name was removed. Additionally, the facility conducted an immediate review of of the facility to assure all information contained in client records was stored in a confidential manner. The facility conducted an in-service with all facility staff on 10/21/11 to insure all information contained in clients' records remains confidential and is stored in a secure location at all times. To assure this deficiency does not recur, per policy and procedure, Mosaic conducts weekly audits of the facility. As a part of this audit, Mosaic staff make on site observations to assure no confidential information is posted in a public place in the facility.</p> <p>In response to the evidence identified by the Medical Surveyor, the lock on the bathroom door was removed on 11/15/11. All clients in facility have access to this bathroom. Additionally, to assure there were no further rights violations, the program coordinator and direct support manager audited the</p>	11/15/2011	

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	<p>home, to ensure they had unimpeded access to the bathrooms in their home.</p> <p>Findings include:</p> <p>1. On 10-12-11 at 11:15 a.m. a record review for client #4 was conducted. The ISP (Individual Support Plan) dated 7-22-11 indicated client #4 was an emancipated adult. Client #4's CFA (comprehensive functional assessment) dated 7-11 indicated he needed complete assistance from staff to administer his medications, identify or name his medications, identify the side effects of his medications, understand his diagnosis, to follow medical /professional orders and to maintain his medications. His Personal Finances Assessment (PFA) dated 10-11-11 indicated client #4 needed "a guardian to give informed consent in the area of finances." The PFA indicated client #4 required complete assistance with setting a budget, keeping a budget, making personal expense decisions, using a checking/savings account, and to understand financial responsibility.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director (AD) indicated client #4 needed assistance in the areas of understanding his rights, his medications, and with his finances. The AD indicated client #4 did not have a</p>		<p>home to assure no additional rights violations were in place for the residents in the facility. To further assure this deficiency does not recur, Mosaic provides all staff training on the rights of each person served. This training is completed prior to employment as well as presented annually. The staff at this facility received retraining on October 21, 2011. Mosaic has policies and procedures to be sure to define and describe the rights of persons served. To promote the rights, interests, and well-being of all persons served and to specify how any individual or their guardian may seek enforcement of these rights on behalf of the individual. This 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. Finally, to assure this deficiency does not recur, either the facility program coordinator or direct support manager audit the facility on a weekly basis to ensure the rights of all clients are respected. In regards to the issue with client #4 who has been assessed as in need of a guardian in certain areas of his</p>		

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	<p>legally sanctioned representative.</p> <p>2. On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of clients #2, #3, #4, #5, #6, #7, and #8 was conducted. At 3:45 p.m. 2 of 3 bathrooms in the home were observed to be locked. Direct care staff #3 (DCS) did not have a key to open the bathroom at the end of the hall but he did have a key to unlock the bathroom off of the kitchen. DCS #3 indicated the bathrooms are kept locked because client #1 had a behavior of breaking glass.</p> <p>On 10-12-11 at 10:00 a.m. a record review for client #2 was conducted. The Individualized Support Plan (ISP) dated 9-29-11 did not indicate client #2 had a need for his bathrooms to be locked.</p> <p>On 10-12-11 at 10:45 a.m. a record review for client #3 was conducted. The ISP dated 5-27-11 did not indicate the need for his bathrooms to be locked.</p> <p>On 10-12-11 at 11:15 a.m. a record review for client #4 was conducted. The ISP dated 7-22-11 did not indicated the need for his bathrooms to be locked.</p> <p>On 10-12-11 at 11:30 a.m. a record review for client #7 was conducted. The Comprehensive Functional Assessment</p>		<p>life, The two areas requiring support were managing his health care and financial resources. The IDT met and arranged for his parent to act as Health Care Representative. Additionally, Mosaic has taken on the role as Representative Payee. The IDT further agreed that a full time guardian was not needed for client #4.</p>		

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W0149	<p>dated 1-12-11 did not indicate the need for his bathroom to be locked.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director (AD) indicated the Human Rights Committee had approved the locked bathrooms but there was no assessed need for clients #2, #3, #4, #5, #6, #7 or #8 to have 2 of 3 of their bathroom locked in their home. The AD indicated the bathrooms were kept locked due to client #1 breaking glass.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, the facility failed for 2 of 8 clients living at the group home (clients #5 and #6), to implement policy which investigated reports of client to client aggression in order to rule out neglect, or to determine what additional supports and services were required to keep clients free from abuse and/or neglect.</p> <p>Findings include:</p> <p>A review of the facility's Incident/Accident Reports was conducted</p>	W0149	In regards to evidence cited by the medical surveyor, per policy an 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. As the incident occurred on 10/11/11, Mosaic does not feel it can conduct a sufficient investigation at this time. In response to this, all facility staff, the facility program coordinator, direct support manager, day service staff, and day service direct	10/24/2011	

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	<p>at the facility's administrative office on 10-11-11 at 11:55 a.m. Review of the reports dated 2-11 to 10-11-11 indicated the following incident:</p> <p>On 10-4-11 at 11:40 a.m. in the lunch room at the facility owned day program, client #6 hit client #5 in the arm 2 times because client #5 used the words "shut up."</p> <p>A review of the facility's "Investigations and Inquiries" dated 7-1-08 was completed at the facility's administrative office on 10-11-11 at 1:30 p.m. The policy indicated investigations may involve issues related to abuse/neglect but did not address actions needed to be taken to rule out neglect when one client was aggressive to another.</p> <p>A review of the facility's "Abuse, Neglect, Exploitation or Mistreatment Policy and Procedure" dated 1-8-08 was completed at the facility's administrative office on 10-11-11 at 1:30 p.m. A review of the facility's policy indicated any abuse, neglect, exploitation or mistreatment of clients was strictly prohibited.</p> <p>The AD was interviewed at 10-11-11 at 1:40 p.m. When asked if the information of the incident management system used by the provider included information</p>		<p>support manager were retrained on the agency Abuse, Neglect, Mistreatment, and Exploitation Policy on 10/21/11. Additionally, facility supervision (the program coordinator and direct support manager) were retrained on this policy on 10/24/11. 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. Finally, to further reassure this deficiency does not recur, the agency investigations coordinator reviews each incident to assure any action was properly investigated.</p>		

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	about which clients were aggressive to other clients and/or which clients were aggressed against one another, the AD indicated every client who exhibited aggressive behavior had a behavior management plan, or medication, and the facility tracked targeted behaviors. The AD indicated there were no investigations for clients #5 and #6. 9-3-2(a)				
W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review, the facility failed for 2 of 8 clients living at the group home (clients #5 and #6), to thoroughly investigate a client to client	W0154	As identified in W0149, In regards to evidence cited by the medical surveyor, per policy an each incident of suspected client abuse, neglect, mistreatment and	10/24/2011	

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	<p>aggression incident.</p> <p>Findings include:</p> <p>A review of the facility's Incident/Accident Reports was conducted at the facility's administrative office on 10-11-11 at 11:55 a.m. Review of the reports dated 2-11 to 10-11-11 indicated the following incident:</p> <p>On 10-4-11 at 11:40 a.m. in the lunch room at the facility owned day program, client #6 hit client #5 in the arm 2 times because client #5 used the words "shut up."</p> <p>The AD was interviewed at 10-11-11 at 1:40 p.m. The AD indicated there were no investigations for client #5 and #6.</p> <p>9-3-2(a)</p>		<p>exploitation should have been immediately reported and consequently investigated within 24 hours of the allegation as stipulated in agency policy. As the incident occurred on 10/11/11, Mosaic does not feel it can conduct a sufficient investigation at this time. In response to this, all facility staff, the facility program coordinator, direct support manager, day service staff, and day service direct support manager were retrained on the agency Abuse, Neglect, Mistreatment, and Exploitation Policy on 10/21/11. Additionally, facility supervision (the program coordinator and direct support manager) were retrained on this policy on 10/24/11. 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. Finally, to further reassure this deficiency does not recur, the agency investigation coordinator reviews each incident to assure any action was properly investigated.</p>		

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W0249	<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 for 4 of 4 sampled clients (clients #1, #2, #3, and #4) to ensure their medication goals were implemented per their Individualized Support Plan (ISP) and for 1 of 4 sampled clients (client #1) to ensure his dining goal was implemented per his ISP.</p> <p>Findings include:</p> <p>1. On 10-12-11 from 7:15 a.m. until 8:45 a.m. an observation at the home of clients #1, #2, #3, and #4. From 7:30 a.m. until 8:20 a.m. a medication administration for clients #1, #2, #3, and #4 was observed. At 7:30 a.m. direct care staff #6 was observed to punch the medications into a medication cup and give them to client #2. Client #2 took his pills with water. At 7:42 a.m. client #4 was observed during his medication administration.</p>	W0249	<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 October 21, 2011 for all facility staff. This training was conducted by the facility QMRP and the Associate Director. This training session specifically identified the active treatment and support training for each client in medication administration. Specifically, the facility staff was trained on the Individual Program Plan for client #1, #2, #3 and #4. Staff reviewed both the formal in informal objectives in each individual's IPP regarding medication administration. 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 medication administration. To further assure this deficiency was resolved, the</p>	10/21/2011	

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	<p>Client #4 came to the medication room, waited while DCS #6 punched his pills, told him what the pills were for, and asked him if he had used the restroom. Client #4 was observed to take his medications with water. At 7:50 a.m. client #3 was observed during his medication administration. Client #3 was observed to bring his refrigerated locked insulin box to the medication room, prepare for his insulin injection, inject himself, then he waited for DCS #6 to finish punching out his medications from the bubble packs. Client #3 then took his medication with water. At 8:13 a.m. client #1 was observed during his medication administration. Client #1 was observed to put his sandwich on the plate, go to the medication administration area, and wait for DCS #6 to punch out his medication from the bubble packs. DCS #6 named the pills and side effects for client #1.</p> <p>On 10-12-11 at 9:20 a.m. a record review for client #1 was conducted. The ISP dated 12-21-10 indicated client #1 had a medication goal to identify his medication box. DCS #6 was not observed to ask client #1 to identify his medication box.</p> <p>On 10-12-11 at 10:00 a.m. a record review for client #2 was conducted. The ISP dated 9-29-11 indicated client #2 had</p>		<p>facility direct support manager observed medication administration by facility staff for all residents to assure this finding was sufficiently resolved for each person living in the facility. 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 (QMRP). 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>medication goal to hold his medication cup while staff pushed out the medications. Client #2 was not observed to be prompted to hold his medication cup.</p> <p>On 10-12-11 at 10:45 a.m. a record review for client #3 was conducted. The ISP dated 5-27-11 indicated client #3 had a medication goal to identify one of his medications. Client #3 was not observed to identify one of his medication to DCS #6.</p> <p>On 10-12-11 at 11:15 a.m. a record review for client #4 was conducted. The ISP dated 7-22-11 indicated client #4 had a medication goal to identify 2 medications (or state the names since his vision has decreased). Client #4 was not observed to identify or state the names of 2 of his medications.</p> <p>2. On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of client #1 was conducted. During the observation client #1 was not observed to assist with any part of the meal preparation. He did ride along with direct care staff #1 to pick up the pizza and bread sticks. Direct care staff #4 was observed to get the salad mix from the refrigerator, open the bags, pour the bags into a bowl, then get the salad dressings</p>				

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W0262	<p>out of the refrigerator.</p> <p>On 10-12-11 at 9:20 a.m. a record review for client #1 was conducted. The ISP dated 12-21-10 indicated client #1 had a goal to help prepare a side dish for dinner. Client #1 was observed to sit at the dinner table and eat his prepared meal at 4:30 p.m.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director (AD) indicated clients #1, #2, #3, and #4's medication goals should be implemented per their ISP. The AD also indicated client #1's dining goal should be implemented per his ISP.</p> <p>9-3-4(a)</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview the facility failed for 1 of 4 sampled clients (client #2) to ensure the Human Rights Committee (HRC) met to review and sign approvals at a time when all members</p>	W0262	In regards to evidence cited by the medical surveyor, the facility presented client #2 's behavior plan to the agency Human Rights Committee on 11/10/11. The plan was approved by the	11/10/2011	

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W0383	<p>were present or able to have discussions regarding the behavior plan.</p> <p>Findings include:</p> <p>On 10-12-11 at 10:00 a.m. a record review for client #2 was conducted. The review indicated client #2 had behavior plan approvals which included medication restrictions which was sent out via email. The approvals were dated and signed by HRC members on different days and at different times. The HRC did not meet when all members were able to have discussion regarding this behavior plan.</p> <p>On 10-12-11 at 11:45 a.m. an interview with Associate Director (AD) indicated this approval was sent out via email and HRC members would sign and return them if they approved with the plan. The AD did indicate HRC does have meetings where they all meet and have discussions.</p> <p>9-3-4(a)</p> <p>Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived</p>	W0383	<p>committee. A copy of the signature page documenting the approval is located in the client file. To assure the standards regarding Human Rights Committee review of all behavior support plans was in compliance for all facility residents, an audit was conducted by the program coordinator and direct support manager to assure each plan had been reviewed by the agency HRC. In order to assure this deficiency does not recur, Mosaic policy and procedure requires all Behavior Management Plans which incorporate restrictive measures to be reviewed by the Human Rights Committee prior to implementation. On 10/24/11, all agency QMRPs were received training on this policy and procedure. In addition to these measures Mosaic conducts a records review on a quarterly basis. A 10% sample of client records are reviewed to assure the file is up to date and accurate. This audit assures that all behavior management plans are current and all plans reviewed have received Human Rights Committee approval.</p> <p>In regards to evidence cited by the medical surveyor Mosaic policy and procedure specifies all medication must be kept in a</p>	10/21/2011	

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	<p>in the home, to ensure only authorized persons had access to the keys to the drug storage area.</p> <p>Findings include:</p> <p>On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, #7, and #8 was conducted. At 4:15 p.m. the medication keys were observed to hang on a hook on the wall in the kitchen with access to anyone who walked by.</p> <p>On 10-12-11 from 7:15 a.m. until 8:45 a.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, #7, and #8 was conducted. At 7:15 a.m. the medication keys were observed to hang on a hook on the wall in the kitchen with access to anyone who walked by. At 7:20 a.m. direct care staff (DCS) #6 was observed to get the key from the hook and head to the medication room. DCS #6 was observed to pass medications from 7:30 a.m. until 8:20 a.m. DCS #6 continued to pass medications to other clients not observed from 7:30 until 8:20 a.m. At 8:45 a.m. DCS #6 was observed to hang the medication keys back on the hook in the kitchen with access to anyone who walked by.</p> <p>On 10-12-11 at 11:45 a.m. an interview</p>		<p>secured location. This includes assuring only authorized people have access to the keys to the drug storage area. All Mosaic Staff are trained on this policy at new staff orientation and updated annually or as needed. In regards to the keys in question, they are now kept in a locked area and facility staff carry a key to access it as needed. Additionally, the facility direct support manager conducted multiple facility visits in the following weeks to assure the key was maintained in a secure location. To assure this deficiency does not recur, Mosaic trained all facility staff including the facility program coordinator and direct support manager on 10/21/11 on the agency medication administration policy and procedure specifically as it pertains to assuring only authorized personnel have access to the keys to the drug storage area. 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. During this visit, the manager assures medications are secured. Furthermore, the agency Registered Nurse conducts monthly reviews. During this time, the RN reviews the facility's storage practices. Any potential concern identified is immediately</p>		

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W0436	<p>with the Associate Director indicated the keys to the medication administration cabinet were kept on a hook in the kitchen with access to anyone who walked by.</p> <p>9-3-6(a)</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 4 sampled clients (client #3) to ensure his Individualized Support Plan (ISP) had an objective to teach him the importance of wearing his hearing aids.</p> <p>Findings include:</p> <p>On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of client #3 was conducted. During the entire observation client #3 was not observed to wear his hearing aids. Direct care staff</p>	W0436	<p>reported to the facility QMRP.</p> <p>In regards to evidence cited by the medical surveyor, at the time of the survey, the hearing aids for client #3 were found to be broken. They were immediately sent to the Elkhart Clinic Hearing Center for repair. 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. On 10/21/11, all facility staff were trained on the importance of assuring and encouraging, facility</p>	11/11/2011	

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	<p>(DCS) #1, #2, #3, or #4 did not prompt him to wear his hearing aids.</p> <p>On 10-12-11 from 7:15 a.m. to 8:45 a.m. an observation at the home of client #3 was conducted. At 7:50 a.m. client #3 was observed during a medication administration. Client #3 was asked questions pertaining to his administering himself his insulin. Client #3 did not respond to the questions and was observed to be standing 1 foot from surveyor. Client #3 did not have his hearing aids in. DCS #6 did not prompt client #3 to wear his hearing aids.</p> <p>On 10-12-11 at 10:45 a.m. a record review for client #3 was conducted. The annual physical dated 6-10-11 indicated client #3 wore hearing aids. His ISP dated 5-27-11 did not indicate client #3 had a goal in place to teach him the importance of wearing/taking care of his hearing aids.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director indicated client #3 wore his hearing aids when he chose to and he did not have a goal in place to assistance him with wearing them.</p> <p>9-3-7(a)</p>		<p>residents to use and make informed choices about wearing hearing aids, using glasses, etc. 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. 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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W0449	<p>The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review, and interview, the facility failed for 1 of 8 clients (client #7) who lived in the home, to ensure problems with drills were investigated and corrective action was taken.</p> <p>Findings include:</p> <p>On 10-11-11 at 12:50 p.m. a record review of the evacuation drills for client #7 was conducted. The review indicated client #7 refused to participate in the emergency drills on 6-8-11, 3-1-11, 2-22-11, 12-6-10, 12-4-10, 12-14-10, 11-12-10, 10-2-11, 10-7-10, and 10-16-10.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director (AD) indicated client #7 has had a goal in the past for refusals of drill but it was discontinued due to no success. The AD indicated client #7 has continued to refuse to participate in emergency drills and there was no plan in place available for review.</p> <p>9-3-7(a)</p>	W0449	<p>In regards to the evidence provided by the medical surveyor, per policy and procedure, staff are expected to take corrective action and run the program plan developed for client #7 in the event he refuses to participate in drills. On 10/19/11, client #7's IPP was reviewed and an evacuation guideline was drafted, reviewed and approved by the IDT that addressed the evacuation issue. On 10/21/11, all facility staff were retrained on client #7's Individual Program Plan as well as Mosaic procedures regarding drills. In order to assure that this deficiency does not recur in this facility, Per Mosaic policy and procedure, quarterly reviews of safety drills are completed for each facility Mosaic operates. As a part of this inspection, Mosaic assures any problems with evacuation drills are resolved with corrective action. As a further means to assure this deficiency does not recur, Mosaic management conducts multiple weekly visits to each facility to assure any problems with evacuation drills are resolved with corrective action. In response to the follow up questions posed by the Medical Surveyor on 11/18/11, based on assessments completed, client #7 knows the difference between an actual fire</p>	10/21/2011	

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W0455	<p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) to encourage hand washing at meal times and medication administration.</p> <p>Findings include:</p> <p>On 10-12-11 from 7:15 a.m. until 8:45 a.m. an observation at the home of clients #1, #2, #3, and #4. From 7:30 a.m. until 8:20 a.m. a medication administration for clients #1, #2, #3, and #4 was observed. At 7:30 a.m. direct care staff #6 was observed to punch the medications into a medication cup and give them to client #2. Client #2 took his pills with water. At 7:42 a.m. client #4 was observed during his medication administration.</p>	W0455	<p>and a drill. Client #7 actively participates in all day drills both at home and at his day program. In the event of an actual fire, it is expected that client #7 will leave the facility. If client #7 refuses to leave when there is an actual fire, staff will physically escort him from the facility per his implemented evacuation plan. All staff have received training on this plan. The facility has not tested the practice of physically escorting him during a drill as it would be a violation of his rights.</p> <p>In regards to evidence cited by the medical surveyor, Mosaic's Infection Control Policy and Procedure stipulates that each client and staff within the facility must be encouraged to wash their hands to minimize the risk of exposure to and transmission of communicable diseases. On October 21,2011 Mosaic staff received retraining on infection control procedures. Specifically, facility staff were trained on assuring all facility residents need to wash their hands prior to medication administration and eating. Additionally, upon being informed of this finding, the facility direct support manager conducted multiple observations of the staff and residents to assure ongoing supports were provided to assure residents washed their hands prior to food</p>	10/21/2011	

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	<p>Client #4 came to the medication room, waited while DCS #6 punched his pills, told him what the pills were for, and asked him if he had used the restroom. Client #4 was observed to take his medications with water. At 7:50 a.m. client #3 was observed during his medication administration. Client #3 was observed to bring his refrigerated locked insulin box to the medication room, prepare for his insulin injection, inject himself, then he waited for DCS #6 to finish punching out his medications from the bubble packs. Client #3 then took his medication with water. At 8:13 a.m. client #1 was observed during his medication administration. Client #1 was observed to put his sandwich on the plate, go to the medication administration area, and wait for DCS #6 to punch out his medication from the bubble packs. DCS #6 named the pills and side effects for client #1. Direct care staff #6 did not prompt clients #1, #2, #3, or #4 to wash their hands before a medication administration.</p> <p>2. On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of client #2 was conducted. At 4:30 p.m. client #2 was observed to run his hands through his hair then eat his pizza and breadsticks with his hands. At 4:35 p.m. client #2</p>		<p>consumption, preparation and medication administration. 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 (QMRP). During this visit, each assures that direct care staff provides both formal and informal opportunities to teach clients on proper infection control procedures. Furthermore, the Direct Support Manager and Program Coordinator routinely observe staff to assure a active program for the prevention and control of communicable diseases is implemented specifically as it pertains to meal preparation and medication administration.</p>		

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	<p>was observed during the supper meal to run his hands through his hair then pick up his pizza and breadsticks and eat them. Direct care staff #1 and #4 were observed to sit at the table with client #2 but they did not prompt him to wash his hands at any time during the supper meal.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director (AD) indicated clients #1, #2, #3, and #4 should be prompted to wash their hands before medication administration. On 10-13-11 at 9:30 a.m. an interview with the AD indicated client #2 should be prompted to wash his hands when touching his hair then eating with his hands.</p> <p>9-3-7(a)</p>				
W0484	<p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation, record review, and interview, the facility failed for 8 of 8</p>	W0484	Mosaic's Dietary procedure stipulates that each individual	10/21/2011	

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	<p>clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) to ensure a full set of silverware was offered at meal times.</p> <p>Findings include:</p> <p>On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, #7, and #8. At 4:00 p.m. direct care staff (DCS) #4 was observed to set the napkins and forks on the table. At 4:30 p.m. clients #1, #2, #3, #4, #5, #6, and #8 were observed to sit at the dinner table to eat. The supper meal consisted of pizza, breadsticks, tossed salad, and fruit cocktail. At 4:45 p.m. client #4 was observed to eat his salad with his hands, he then tried to use his fork to eat his fruit cocktail and the fruit fell off the fork. Client #4 then used his hands to eat his fruit cocktail. At 5:00 p.m. client #7 was observed to come to the supper table. A fork was the only silverware available to him.</p> <p>On 10-12-11 at 9:20 a.m. a record review for client #1 was conducted. The ISP dated 12-21-10 did not indicate client #1 could not use a full set of silverware at mealtimes.</p> <p>On 10-12-11 at 10:00 a.m. a record review for client #2 was conducted. The ISP dated 9-29-11 did not indicate client</p>		<p>served should have the proper equipment, eating utensils, etc. that would meet both the developmental and dietary needs of each person served. On 10/21/11, facility staff were retrained on this policy, specifically on assuring each client had a full set of silverware available at every meal. Additionally, upon being informed of this finding, the facility direct support manager conducted multiple observations of the staff and residents to assure each client had a full set of silverware available at every meal. To 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. During this visit, each assures that clients have the proper dishes, utensils and other equipment available to meet their dietary needs. Furthermore, during their observation, each assures direct support staff encourage clients to use utensils, glasses, and other equipment.</p>		

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W0488	<p>#2 could not use a full set of silverware at meal times.</p> <p>On 10-12-11 at 10:45 a.m. a record review for client #3 was conducted. The ISP dated 5-27-11 did not indicate client #3 could not use a full set of silverware at meal times.</p> <p>On 10-12-11 at 11:15 a.m. a record review for client #4 was conducted. The ISP dated 7-22-11 did not indicate client #4 could not use a full set of silverware at meal times.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director indicated all the clients should be offered a full set of silverware at meal times.</p> <p>9-3-8(a)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #8)</p>	W0488	Mosaic's Dietary Policy and Procedure states that each individual served should participate in the preparation and service during all meals. On October 21, 2011, All facility staff received training on conducting meal time goals and objectives in	10/21/2011	

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	<p>Findings include:</p> <p>On 10-11-11 from 3:15 p.m. until 5:10 p.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, and #8 was conducted. At 4:00 p.m. direct care staff (DCS) #4 was observed to put the napkins and the forks on the table. DCS then took the salad mix from the refrigerator, cut the bags open, and poured the salad into a large bowl. DCS #4 then poured 3 drink pouches into a pitcher, added a tray of ice cubes, added water, and stirred the mixture. DCS #4 took the milk, ketchup, 2 salad dressings, parmesan cheese, and tropical punch and set them on the bar in the kitchen. Client #2 was observed to sit outside and clients #3 and #5 were in their room while DCS #4 prepared part of the evening meal. At 4:15 p.m. DCS #4 took the cups from the cabinet and set them on the counter. DCS #4 prompted clients #1 and #8 to put the items on the table that he had set on the bar. At 4:30 p.m. clients #1, #2, #3, #4, #5, #6, and #8 were observed to sit at the tables to eat. DCS #1 was observed to pour client #2's drink into his cup for him, DCS #2 served salad to client #4 and #2, and DCS #1 poured the salad dressing on the salad for clients #2 and #6. At 4:35 p.m. DCS #2 dished the fruit onto client #1's plate for him, DCS #1 served fruit to clients #5 and #6. At 4:45 p.m. DCS #2 dished the fruit for</p>		<p>accordance with each individual's Individual Program Plan. Additionally, upon being informed of this finding, the facility direct support manager conducted multiple observations of the staff and residents to assure all facility staff conducted meal time goals and objectives in accordance with each individual's Individual Program Plan. To 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. During this visit, each assures the facility encourages and teaches each client meal preparation tasks.</p>		

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	<p>client #4. DCS #1, #2, #3, and #4 did not have clients #1, #2, #3, #4, #5, #6, and #8 assist with meal preparation or serve themselves as independently as possible.</p> <p>On 10-12-11 at 9:20 a.m. a record review for client #1 was conducted. The ISP (Individualized Support Plan)/CFA (Comprehensive Functional Assessment) dated 12-21-10 indicated client #1 was able to help with meal preparation and to serve himself with prompts</p> <p>On 10-12-11 at 10:00 a.m. a record review for client #2 was conducted. The ISP/CFA dated 9-29-11 indicated client #2 was able to assist with meal preparation and to serve himself with prompts.</p> <p>On 10-12-11 at 10:45 a.m. a record review for client #3 was conducted. The ISP/CFA dated 5-27-11 indicated client #3 was able to assist with meal preparation and to serve himself with prompts.</p> <p>On 10-12-11 at 11:15 a.m. a record review for client #4 was conducted. The ISP/CFA dated 7-22-11 indicated client #4 was able to help with meal preparation and to serve himself with prompts.</p> <p>On 10-12-11 at 11:45 a.m. an interview</p>				

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NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 1319 LAWN AVE ELKHART, IN46514		
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W9999	<p>with the Associate Director indicated clients #1, #2, #3, #4, #5, #6, and #8 were all capable of assisting with meal preparation and to serve themselves.</p> <p>9-3-8(a)</p> <p>1. 460 IAC 9-3-2(a) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: Resident Protections</p> <p>(3) The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check and three references.</p> <p>This state rule is not met as evidenced by: Based on record review and interview the facility failed for 1 of 6 sampled facility staff (staff #15) to provide 3 references.</p> <p>Findings include: Facility personnel records were reviewed on 10-13-11 at 10:00 a.m. including the personnel record for staff #15. Staff #15's record did not include 3 references.</p>	W9999	<p>In reference to evidence cited by the medical surveyor, the facility human resources staff obtained the third and final reference for staff #15. References can be found in each staff's personnel file. Additionally, upon being informed of this finding, the facility human resources manager conducted a review of all facility staff to assure the personnel record maintained three references for each person. To assure recurrence of this deficiency does not recur, Mosaic has hiring practice policy and procedure that specifically identifies references must be completed prior to employment. 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. In regards to the second piece of evidence cited by the medical surveyor, Mosaic policy and procedure specifies all</p>	11/09/2011	

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	<p>Only 2 references were available for review.</p> <p>On 10-13-11 at 10:30 a.m. an interview with the Associate Director (AD) indicated staff #15 only had 2 references available for review and there should be 3.</p> <p>9-3-2(c)(3)</p> <p>2. 460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: Governing Body</p> <p>(3) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, the facility failed to report 4 BDDS (Bureau of Developmental Disabilities Services) (clients #1, #5, #6) initial reports in a timely manner.</p> <p>Findings include:</p> <p>During record review on 10-11-11 at</p>		<p>initial BDDS incident reports regarding hospitalizations must be completed within 24 hours of the admission/visit. The findings for evidence cited did exceed the 24 hour policy. All QMRP's in the facility have been retrained as of 11/2/11. To assure this deficiency does not recur, Mosaic's safety committee reviews all incident reports to assure timely submission to the state.</p>		

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	<p>11:55 a.m. a BDDS report for client #1 with an incident date of 12-29-11 and submitted to BDDS on 1-1-11. The report indicated client #1 had to be transported by police to a crisis until. He was released to his staff and then transported to a different crisis unit.</p> <p>A BDDS report for client #5 with an incident date of 2-16-10 and submitted to BDDS on 2-18-10. The report indicated client #5 went to the Emergency Room for a fever.</p> <p>A BDDS report for client #6 with an incident date of 2-27-11 and submitted to BDDS on 3-2-11. The report indicated client #6 had a seizure, he hit his head, then went to the Emergency Room for examination.</p> <p>A BDDS report for client #6 with an incident date of 6-18-11 and submitted to BDDS on 6-20-11. The report indicated client #6 had a seizure and had to go to the hospital for stitches to his head.</p> <p>On 10-13-11 at 3:00 p.m. a review of the BDDS policy dated 3-1-11 indicated BDDS reports should be filed within 24 hours of the incident.</p> <p>On 10-12-11 at 11:45 a.m. an interview with the Associate Director indicated</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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	BDDS reports should be reported to BDDS within 24 hours. 9-3-1(b)				