

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802		
(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 a recertification and state licensure survey.</p> <p>Dates of Survey: August 21, 23, 27, 2013</p> <p>Provider Number: 15G589 Aims Number: 100235510 Facility Number: 001103</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/9/13 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802			
(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			
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview, the facility failed for 6 of 6 clients (#1, #2, #3, #4, #5, #6) residing in the group home, to ensure facility staff (#4, #5) received identified retraining needs in regards to client medication storage and disposal procedures.</p> <p>Findings include:</p> <p>An observation was done at the facility on 8/23/13 from 6:15a.m. to 7:44a.m. At 6:22a.m., client #3 (seated in a wheelchair) received his medication at the kitchen counter. Client #3 continually refused verbal prompts to take his prepared (in a medication cup) medication which consisted of Claritin 10 milligrams, Sabril 300 milligrams and Fluoxetine 20 milligrams. At 6:35a.m., client #3's school bus arrived and staff #4 pushed client #3 in his wheel chair out to the school bus. Staff left client #3's medication out on the kitchen counter and unattended. Clients #1, #2, #4, #5 and #6 were in the house at this time. At 6:42a.m., staff #5 disposed of the medication that was in the med cup. Staff</p>	W000189	All agency staff have been retrained on the Medication Administration Protocol. Training focused on Medication storage, record keeping, what to do when a client refuses to take medication, and proper medication disposal. House Manager will do weekly observation to ensure that staff are following the protocol. QDDP and ot the agnecy nurse will provide refresher training as needed to ensure staff stay current on their training and skill level. In the future, the agency will ensure that each employee has both the initial and ongoing training to enable employees to perform their duties effectively, efficiently, and competently.	09/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802			
(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>#5 had put the medication in the kitchen trash can. Staff #5 was interviewed at 6:42a.m. Staff #5 indicated they had disposed of the refused medication by rolling it up in a plastic glove and put it in the kitchen trash can. Staff #5 indicated they weren't sure what they were supposed to with the refused medication and who they were to call.</p> <p>Record review of the facility's 8/13 "Medication Administration Record" (MAR) was done on 8/23/13 at 7:50a.m. The MAR indicated client #3 received Claritin for allergies, Fluoxetine for allergies and Sabril for seizures.</p> <p>Record review of the facility's 10/23/12 "Medication Administration" policy was done on 8/27/13 at 10:52a.m. The policy indicated staff were to "lock the medications back up in the cabinet. Never leave the the cabinet unlocked." The policy indicated the disposal of a medication was to include the following steps: "1) Place contaminated medication in a plastic Ziploc bag. 2) Include a note or write on the outside of the bag the individual's name, date, time and a brief explanation as to what happened. 3) Tape the bag to the inside of the medication cabinet door. The nurse or manager will take them to the office to be destroyed. 4) The nurse will account for the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802		
(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>medications. Staff are not permitted to destroy the medications themselves." Staff #4 and #5 had received initial medication administration training on 5/15/13. There was no documented staff retraining in regards to the administration of client medication.</p> <p>Interview of professional staff #2 (nurse) was done on 8/27/13 at 10:42a.m. Staff #2 indicated all staff should follow the facility's medication administration policy. Staff #2 indicated staff were to never leave any medication unattended. Staff #2 indicated direct care staff were to never throw any medication away, they are trained to put the medication in a baggie and lock it in the medication cabinet. Staff #2 indicated all staff have received training on Core A and B before allowed to pass client medication. Staff #2 indicated all staff were in need of retraining on the process of administering client medication (facility "Medication Policy)."</p> <p>9-3-3(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802			
(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			
W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (#2) to ensure client #2's individual habilitation plan (IHP) had a training program in place to address his identified dental hygiene need.</p> <p>Findings include:</p> <p>Record review for client #2 was done on 8/27/13 at 12:07p.m. Client #2 had a 3/21/13 dental exam that indicated client #2 had gingivitis and "needs to improve brushing." Client #2 had a 5/29/13 IHP. Client #2's IHP did not address his identified dental hygiene need.</p> <p>Staff #1 was interviewed on 8/27/13 at 2:15p.m. Staff #1 indicated client #2's 3/21/13 dental recommendation had not been addressed. Staff #1 indicated client #2 did not have any training programs in place to address his identified dental hygiene needs.</p>	W000242	The individual program plan that follows the recommendations by the dentist to ensure client brushes teeth regularly (twice a day) has been put in place. All staff that work with this individual have been trained on this program plan. To ensure that this deficiency does not recur, the QDDP, House Manager and Agency nurse will review all recommendations from other providers during the monthly and quarterly meetings.	09/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802			
(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			
	9-3-4(a)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802			
(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			
W000382	<p>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, record review and interview, the facility failed for 6 of 6 clients (#1, #2, #3, #4, #5, #6) residing in the facility, to keep all drugs locked except during administration.</p> <p>Findings include;</p> <p>An observation was done at the facility on 8/23/13 from 6:15a.m. to 7:44a.m. At 6:22a.m., client #3 (seated in a wheelchair) received his medication at the kitchen counter. Client #3 continually refused verbal prompts to take his prepared (in a medication cup) medication which consisted of Claritin 10 milligrams, Sabril 300 milligrams and Fluoxetine 20 milligrams. At 6:35a.m., client #3's school bus arrived and staff #4 pushed client #3 in his wheel chair out to the school bus. Staff left client #3's medication out on the kitchen counter and unattended. Clients #1, #2, #4, #5 and #6 were in the house at this time. At 6:42a.m., staff #5 disposed of the medication that was in the med cup. Staff #5 had put the medication in the kitchen trash can. Staff #5 was interviewed at 6:42a.m. Staff #5 indicated they had disposed of the refused medication by</p>	W000382	<p>Staff have been re-trained to ensure that all medications and biologicals are locked except when being prepared for administration. All agency staff have been retrained on the Medication Administration Protocol. Training focused on Medication storage, record keeping, what to do when a client refuses to take medication, and proper medication disposal. House Manager will do weekly observation to ensure that staff are following the protocol. QDDP and of the agency nurse will provide refresher training as needed to ensure staff stay current on their training and skill level.</p>	09/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802			
(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>rolling it up in a plastic glove and put it in the kitchen trash can.</p> <p>Record review of the facility's 8/13 "Medication Administration Record" (MAR) was done on 8/23/13 at 7:50a.m. The MAR indicated client #3 received Claritin for allergies, Fluoxetine for allergies and Sabril for seizures.</p> <p>Record review of the facility's 10/23/12 "Medication Administration" policy was done on 8/27/13 at 10:52a.m. The policy indicated staff were to "lock the medications back up in the cabinet. Never leave the the cabinet unlocked." The policy indicated the disposal of a medication was to include the following steps: "1) place contaminated medication in a plastic Ziploc bag. 2) Include a note or write on the outside of the bag the individual's name, date, time and a brief explanation as to what happened.. 3) tape the bag to the inside of the medication cabinet door. The nurse or manager will take them to the office to be destroyed.</p> <p>Interview of professional staff #2 (nurse) was done on 8/27/13 at 10:42a.m. Staff #2 indicated all staff should follow the facility's medication administration policy. Staff #2 indicated staff were to never leave any medication unattended. Staff #2 indicated direct care staff were to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802
--	--

(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>never throw any medication away, they are trained to put the medication in a baggie and lock it in the medication cabinet. Staff #2 indicated client medications should be kept locked unless they were being administered.</p> <p>9-3-6(a)</p>			