

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 08/29/2014
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN 47802
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W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: August 26, 27, 28 and 29, 2014.</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.</p> <p>Quality review completed September 10, 2014 by Dotty Walton, QIDP.</p>	W000000	<p>Mosaic plan of correction in relation to Survey Event ID OIRQ11 conducted at 5743 Ernest Dr. Terre Haute, IN 47802 resulting in NONCOMPLIANCE WITH STANDARDS. All follow-up items mentioned in this Plan of Correction have been completed as of 9/22/14. Corrections are as follows:</p>	
W000325	<p>483.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (#1) to ensure client #1 received routine laboratory examinations as ordered by his physician.</p>	W000325	<p>483.460(a)(3)(iii) PHYSICIAN SERVICES – W325 Laboratory examination ordered by the physician of Client #1 was completed on 8/29/14. A copy of this Laboratory Report is attached to the survey document. Mosaic</p>	09/22/2014

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.

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W000369	<p>Findings include:</p> <p>Record review for client #1 was done on 8/28/14 at 3:22p.m. Client #1's 7/1/14 physician's orders indicated the physician ordered a Depakote lab (laboratory) test to be done. There were no Depakote lab test results for client #1 since the 7/1/14 order.</p> <p>Professional staff #2 was interviewed on 8/28/14 at 3:54p.m. Staff #2 indicated client #1's most recent Depakote lab test was completed on 3/14/14. Staff #2 indicated client #1 had not had a Depakote lab completed in regards to 7/1/14 physician's order. Staff #2 indicated they would get the lab completed as soon as possible.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed for 1 of 3 clients (client #3) observed to receive medication administered by facility staff, to ensure client #3 received his</p>	W000369	<p>Terre Haute agency RN will monitor more closely physician orders to discover lab requests in the event that the physician does not provide scripts as typical (As was the case in this instance). In the absence of laboratory scripts, agency RN will contact the physicians office to obtain the scripts for the labs.</p> <p>483.460 (k)(2) DRUG ADMINISTRATION –W369 Staff #4 was retrained on 9/15/14 by agency RN on the responsibilities, principles, performance and documentation of Medication Administration.</p>	09/28/2014			

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	<p>medication without error.</p> <p>Findings include:</p> <p>Observation was done at the group home on 8/26/14 from 3:52p.m. to 6:08p.m. Client #3 was observed to receive medication at 4:18p.m. Client #3 received the medications Seroquel 150 milligrams and Clonidine 0.1 milligrams for Attention Deficit Hyperactivity Disorder (ADHD).</p> <p>Record review of the facility's 8/14 medication administration record (MAR) on 8/26/14 at 4:26p.m. indicated client #3 was to receive Clonidine 0.1 milligram tablet at bedtime (9p.m.) and Seroquel 150 milligrams at 2p.m.</p> <p>Record review for client #3 was done on 8/28/14 at 2:46p.m. Client #3's 8/11/14 physician's orders indicated client #3 was to receive Seroquel at 2p.m. and Clonidine at bedtime.</p> <p>Staff #4 was interviewed on 8/26/14 at 4:26p.m. Staff #4 indicated client #3's Seroquel should have been passed by 3p.m. but she had forgotten to administer the medication.</p> <p>Interview of professional staff #2 on 8/28/14 at 3:54p.m. indicated client #3</p>		<p>Staff #4 received a corrective action on 9/16/14 for violating general Mosaic work rules and our Medication Administration Policy. Copies of these documents are attached to the survey document. Monitoring: Staff #4 will be observed for accuracy and compliance with our Medication Administration Policy by the Direct Support Manager of this site during their next 3 medication administrations. These observations will be documented using a Medication Pass Observation document and the assistance of a Quality Assurance Medication Administration checklist. These observations will be completed on or before 9/28/14. These observations will be reviewed by the agency RN/Health Services Coordinator after they have been completed. All Direct Support Staff at this site will be observed for accuracy and compliance with our Medication Administration Policy by the Direct Support Manager of this site during a medication administration that they perform. These observations will be documented using a Medication Pass Observation document and the assistance of a Quality Assurance Medication Administration checklist. These observations will be completed on or before 9/28/14. These observations will be reviewed by the agency RN/Health Services Coordinator</p>				

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W000382	<p>should have received his Seroquel within an hour of the time indicated on the MAR. Staff #2 indicated the Clonidine should not have been administered until client #3's bedtime, 9p.m. on the MAR.</p> <p>9-3-6(a)</p> <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 and interview, the facility failed for 5 of 5 clients (#1, #2, #3, #4, #5) 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 8/27/14 from 6:22a.m. to 7:22a.m. for clients #1, #2, #3, #4 and #5. At 6:32a.m., staff #5 got medication out of the medication cabinet and did not lock the cabinet. Staff #5 went to the kitchen and passed a medication to client #2. The unlocked medication cabinet was located</p>	W000382	<p>after they have been completed. The Direct Support Manager of this site will conduct at least two random Medication Administration observations per month for the next six months. These observations will be documented using a Medication Pass Observation document and the assistance of a Quality Assurance Medication Administration checklist. These observations will be reviewed by the agency RN/Health Services Coordinator after they have been completed.</p> <p>483.460 (k)(2) DRUG STORAGE AND RECORDKEEPING – W382 Staff #5 received a corrective action on 9/16/14 for violating Mosaic Medication Administration Policy. Medications were temporarily moved to a locked office area. A work order for repairs to the medication cabinet lock was issued and the cabinet was repaired on 8/28/14. All staff responsible for administering medications at this site have been re-trained on the security of medications. Copies of these documents are attached to the survey document.</p>	09/22/2014

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	<p>in the living room/computer room located next to the kitchen. The medication cabinet was not visible from the kitchen. There were no staff in line of sight of the unlocked medication cabinet. Client #5 was in the room with the unlocked medication cabinet. At 6:38a.m., staff #5 indicated the medication cabinet lock had broken last night and the cabinet could not be locked. Staff #5 indicated a work order had been placed.</p> <p>Interview of professional staff #2 was done on 8/28/14 at 3:54p.m. Staff #2 indicated facility staff were to never leave any medication unlocked and unattended. Staff #2 indicated the medication cabinet lock had been repaired on 8/27/14. Staff #2 indicated the medication should have been moved to a secure area after discovering the medication cabinet door lock was broken.</p> <p>9-3-6(a)</p>				