

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2012
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 TERRE HAUTE, IN 47802
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: February 15, 16, 17, 21, 2012</p> <p>Provider Number: 15G373 Aims Number: 100249240 Facility Number: 000887</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III Brenda Nunan, RN PHNS III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 2/28/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the clients' health care needs for 2 of 4 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 02/16/2012 at 9:55 a.m. The governing body failed to exercise operating direction over nursing services to ensure health conditions were monitored and results from a mammogram were obtained for client #1. The governing body failed to exercise operating direction over nursing services to ensure prescribed medications were administered as ordered by the physician. Please see W331 and W368.</p> <p>2. Client #2's record was reviewed on 02/16/2012 at 12:26 p.m. The governing body failed to exercise operating direction over nursing services to ensure prescribed medications were administered as ordered by the physician. Please see W368.</p> <p>9-3-1(a)</p>	W0104	<p>The facility has put a system in place to ensure that health conditions are monitored on a monthly basis. 1. The House Manager will review all Medication administration records to ensure that all medications are being administered as prescribed. The facility nurse will also check records on a weekly basis to ensure compliance. 2. When the IDT meets on a monthly basis, the facility nurse will review all previous Dr's appointments to ensure that there is follow up with all Dr's recommendations. This system will be reviewed on a quarterly basis as part of the Quality Assurance process to ensure that this deficiency does not recur.</p>	03/21/2012			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review, the facility failed for 3 of 11 allegations of client abuse/neglect reviewed (clients #1,#2, #3), to implement policy and procedures to ensure allegations of abuse/neglect were immediately reported to the administrator (#2), a thorough investigation completed (#1, #2) and to ensure all corrective action was identified and completed (#2).</p> <p>Findings include:</p> <p>1. Review of the facility's incident/investigations was done on 2/16/12 at 12:10p.m. The following investigation indicated: On 5/20/11 at 9:35a.m., staff #8 reported to the facility an allegation of abuse by staff #2 to client #2. The incident report indicated on 5/19/11 at 8a.m. client #5 had made the allegation of abuse (inappropriate touch by staff #2 to client #2) to staff #8. The incident report indicated the facility administrator was made aware of the 5/19/11 allegation of abuse to client #2 on 5/20/11. The investigation summary did not indicate the facility staff were in need</p>	W0149	<p>The facility investigates all allegations of abuse/neglect and immediately reports to the facility Administrator. A thorough investigation is completed. 1. In the incident cited by the State Surveyor, staff failed to report immediately an allegation of abuse to the Administrator. The facility failed to retrain staff to report immediately. The facility will re-train its staff to report abuse/neglect immediately to the administrator. 2. The facility failed to include management signature and findings and recommendations on a client to client aggression investigation. The Day Program Manager has been re-trained to ensure that all client to client aggression investigations have findings and recommendations. 3. The facility will ensure that all client to client aggression incidents are investigated and documented. The incident cited by the Stat surveyor took place at the Day Program. The Day Program Manager has been re-trained on the Abuse/Neglect policy. To ensure that this deficiency does not recur, all client to client aggression investigations will be reviewed by the QMRP on a monthly basis to ensure that they contain findings and</p>	03/21/2012			

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	<p>of retraining on the facility policy and procedures regarding abuse/neglect reporting. There was no documentation the facility staff were retrained on timely reporting following this incident.</p> <p>2. An Indiana Division of Disability and Rehabilitation Services incident report, dated 09/26/2011 at 10:35 a.m., was reviewed on 02/15/2012 at 2:15 p.m. The incident report indicated, [Client #3] was sitting at the table waiting for lunch when one of his peers...grabbed the collar of his shirt and ripped it...[Client #3] was examined, a red area that later disappeared was noted on his neck where the shirt was grabbed...."</p> <p>The facility's reportable incidents reports and investigations were reviewed on 02/15/2012 at 2:15 p.m. The "Client to Client Physical Aggression Inquiry/Investigation" indicated [another consumer] grabbed [client #3's] shirt over (sic) and pulled [client #3] and chair to ground....]. The record did not include documentation in the section, "Findings and recommendations," and did not include a signature to indicate the facility investigated the allegation of abuse.</p> <p>During an interview on 02/16/2012 at 2:05 p.m., the QDDP (Qualified Developmental Disabilities Professional)</p>		recommendations.				

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	<p>indicated the facility did not investigate the incident. She stated, "Day services (facility owned) did not report the incident to the group home."</p> <p>3. A facility incident report, dated 12/20/2011 at 7:45 a.m., was reviewed on 02/15/2012 at 2:15 p.m. The incident report indicated, "...[Another consumer] hit [client #1] in the back (symbol for with) her fist 2 times..." The record did not include documentation to indicate the facility investigated the allegation of abuse</p> <p>The facility's policy and procedures were reviewed on 2/15/12 at 3:44p.m. The policy dated 5/1/05 "Abuse, Neglect, Exploitation or Mistreatment" indicated "abuse, neglect, exploitation and mistreatment of clients are strictly prohibited." The policy indicated "Neglect is the failure to provide the client with sufficient services, treatment or supports necessary for well being or the failure to act or intervene in a situation that may result in physical, psychological or emotional harm." The policy indicated "Abuse is any real or potential infliction of physical, psychological or emotional harm, injury, or pain that is</p>			

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	<p>the result of non-accidental conduct. This includes verbal, physical or sexual abuse or exploitation." The policy indicated "any employee who observes or suspects abuse, neglect, exploitation or mistreatment of a client shall intervene immediately on the client's behalf and shall immediately report the incident according to the local agency procedure. Failure to report an incident is considered abuse." The policy indicated "employees will receive training in prevention strategies, the definitions of abuse, neglect, exploitation and mistreatment, the identification of such issues, and the proper reporting process." The policy indicated "agencies must adopt written local procedures that include, at a minimum: the identification of potential actions that may be taken to protect a victim from future harm and specific training requirements."</p> <p>A facility policy, titled "INVESTIGATIONS AND INQUIRIES." dated July 1, 2008, indicated, "...[Facility] investigates in a timely manner an Incident/Allegation which places anyone associated with [facility] or the organization as a whole at risk.</p>			

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	<p>Investigations may involve but are not limited to issues related to abuse/neglect...Investigations must be completed within 5 working days...Investigation Reports should be completed within 7 working days of the completion of the Investigation...."</p> <p>Professional staff #3 was interviewed on 2/16/12 at 12:28p.m. Professional staff #3 indicated a facility staff had not followed facility policy and procedures by failing to immediately report an allegation of staff to client abuse on 5/19/11. Professional staff #3 indicated the facility's corrective action for the 5/19/11 allegation of abuse, had not identified the need to retrain staff on policy and procedures regarding immediately reporting allegations of abuse/neglect.</p> <p>During an interview on 02/16/2012 at 2:05 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the facility did not investigate the incident. She stated, "Day services did not report the incident to the group home." 9-3-2(a)</p>						

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 1 of 11 alleged abuse/neglect incidents (client #2) reviewed, to immediately report allegations to the administrator.</p> <p>Findings include:</p> <p>Review of the facility's incident/investigations was done on 2/16/12 at 12:10p.m. The following investigation indicated: On 5/20/11 at 9:35a.m., dsp staff #8 reported to the facility an allegation of abuse by dsp staff #2 to client #2. The incident report indicated on 5/19/11 at 8a.m. client #5 had made the allegation of abuse (inappropriate touch by dsp staff #2 to client #2) to staff #8. The incident report indicated the facility administrator was made aware of the 5/19/11 allegation of abuse to client #2 on 5/20/11.</p> <p>Professional staff #3 was interviewed on 2/16/12 at 12:28p.m. Professional staff #3 indicated a facility staff had not followed facility policy and procedures by failing to</p>	W0153	See W149 # 3 for POC. Facility staff have been re-trained to report allegations of client abuse/neglect to the administrator immediately.	03/21/2012			

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	immediately report an allegation of staff to client abuse on 5/19/11. Professional staff #3 indicated the dsp staff were aware of the allegation on 5/19/11 and reported it to the facility and the administrator on 5/20/11. 9-3-2(a)				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate allegations of abuse/neglect for 2 of 11 incident reports reviewed for allegations of abuse/neglect (clients #1 and #3).</p> <p>Findings include:</p> <p>1. An Indiana Division of Disability and Rehabilitation Services incident report, dated 09/26/2011 at 10:35 a.m., was reviewed on 02/15/2012 at 2:15 p.m. The incident report indicated, [Client #3] was sitting at the table waiting for lunch when one of his peers...grabbed the collar of his shirt and ripped it...[Client #3] was examined, a red area that later disappeared was noted on his neck where the shirt was grabbed...."</p> <p>The facility's reportable incidents reports and investigations were reviewed on 02/15/2012 at 2:15 p.m. The "Client to Client Physical Aggression Inquiry/Investigation" indicated [another consumer] grabbed [client #3's] shirt over (sic) and pulled [client #3] and chair to ground....]. The record did not include documentation in the section, "Findings and recommendations," and did not</p>	W0154	See W149 # 1 for POC 1. Facility Day Manager and staff have been re-trained to document all client to client aggression and ensure that there are findings and recommendations and a signature of the investigator.2. The facility will ensure that all client to client aggression incidents are investigated in a timely manner. To ensure that this deficiency does not recur, all client to client aggression investigations will be reviewed by the QMRP during client monthly meetings.	03/21/2012			

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	<p>include a signature to indicate the facility investigated the allegation of abuse.</p> <p>During an interview on 02/16/2012 at 2:05 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the facility did not investigate the incident. She stated, "Day services (facility owned) did not report the incident to the group home."</p> <p>2. A facility incident report, dated 12/20/2011 at 7:45 a.m., was reviewed on 02/15/2012 at 2:15 p.m. The incident report indicated, "...[Another consumer] hit [client #1] in the back (symbol for with) her fist 2 times...." The record did not include documentation to indicate the facility investigated the allegation of abuse</p> <p>During an interview on 02/16/2012 at 2:05 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the facility did not investigate the incident. She stated, "Day services (facility owned) did not report the incident to the group home."</p> <p>9-3-2(a)</p>				

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 1 of 11 investigations of alleged neglect/abuse reviewed (client #2), to ensure appropriate corrective action was identified.</p> <p>Findings include:</p> <p>Review of the facility's incident/investigations was done on 2/16/12 at 12:10p.m. The following investigation indicated: On 5/20/11 at 9:35a.m., dsp staff #8 reported to the facility an allegation of abuse by dsp staff #2 to client #2. The incident report indicated on 5/19/11 at 8a.m. client #5 had made the allegation of abuse (inappropriate touch by dsp staff #2 to client #2) to dsp staff #8. The incident report indicated the facility administrator was made aware of the 5/19/11 allegation of abuse on 5/20/11. The investigation summary did not indicate the facility staff were in need of retraining on the facility policy and procedures regarding abuse/neglect reporting. There was no documentation the facility staff were retrained on timely reporting following this incident.</p>	W0157	The facility will re-train its staff on its abuse/neglect policies. This includes ensuring that staff report immediately the administrator any suspected abuse/neglect. Facility staff investigators have been instructed to recommend re-training (in addition to other necessary measures) to ensure that clients are safe. The re-training will be documented. To ensure that this deficiency does not recur, the QMRP will review all abuse/neglect incidents on a monthly basis to ensure that there has been follow up with training and other recommendations.	03/21/2012	

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	Professional staff #3 was interviewed on 2/16/12 at 12:28p.m. Professional staff #3 indicated the facility's corrective action for the 5/19/11 allegation of abuse incident, had not identified the need to retrain facility staff on policy and procedures regarding immediately reporting allegations of abuse/neglect. 9-3-2(a)				

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review, and interview, the facility failed to implement training objectives for appropriate social skills and use of adaptive equipment for 1 of 4 sampled clients (client #2).</p> <p>Findings include:</p> <p>During observations on 02/15/2012 at 4:30 p.m., client #2 hugged PHNS (Public Health Nurse Surveyor) #1 after being introduced. DSP #1 did not redirect client #2 from hugging someone she just met. Client #2 was not wearing bilateral hearing aids.</p> <p>During observations on 02/16/2012 at 6:30 a.m. and 12:45 p.m., client #2 was not wearing bilateral hearing aids.</p> <p>Client #2's record was reviewed on 02/16/2012 at 12:26 p.m.</p> <p>A medical appointment form, dated, 02/09/2011, indicated client #2 received a replacement right hearing aid. The record indicated client #2 had a left hearing aid.</p>	W0227	<p>The facility has put a goal in place to train client #2 on appropriate social skills (avoiding hugging strangers). Client #2's program plan has been revised to reflect this goal. Facility staff (Day program and House staff) will be trained to implement this goal. Another goal has been put in place for client #2 to utilize her hearing aids. Client #2's program plan has been revised to reflect this goal. Facility staff (day Program and House staff) have also been trained on this goal. These two goals will be reviewed on a monthly basis by the QMRP and necessary revisions will be made.</p>	03/21/2012			

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	<p>A "Nursing Health Care Plan," dated 08/26/2011, indicated, "...ADAPTIVE EQUIPMENT: Glasses, bilateral hearing aids...wears hearing aids...staff to assist putting on daily...."</p> <p>An IHP (Individual Habilitation Plan), dated 11/15/2011, indicated client #2 had the following program objectives: 1) medication awareness, 2) discuss where to locate the proper emergency equipment in case of power outage, 3) contact family/friend by telephone or sending mail, 4) walk 30 minutes or weight bearing exercises daily with staff assistance, 5) clean bathroom floor, 6) increase bathing skills, 7) communicate want or need without swearing, 8) complete tooth brushing, and 9) eat slowly and take appropriate bite sizes. The record did not include documentation to indicate a goal for encouraging client #2 to wear her bilateral hearing aids.</p> <p>During an interview on 02/16/2012 at 12:45 p.m., DSS (Day Service Staff) #1 indicated client #2 had bilateral hearing aids. She stated, "[Client #2] doesn't usually wear her hearing aids."</p> <p>During an interview on 02/16/2012 at 2:05 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the House Manager informed</p>				

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	her client #2 refused to wear the hearing aids. The QDDP indicated there was not a goal to encourage client #2 to wear her hearing aids. The QDDP indicated the House Manager stated, "[Client #2] is an adult and can hug anyone she wants." The QDDP indicated there was not a program goal to encourage appropriate social interactions. 9-3-4(a)				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <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, interview, and record review, the facility failed to implement training objectives/Individual Program Plan (IPP) when training opportunities existed for 1 of 4 sampled clients (clients #2).</p> <p>Findings include:</p> <p>1. During observations on 02/15/2012 at 4:55 p.m., DSP (Direct Support Professional) #1 cut client #2's ham into 1 inch by 1 inch pieces. Client #2 placed 3 pieces of the ham on her fork and put all pieces in her mouth at once. DSP #1 was cleaning the floor near the dining table and did not redirect client #2 from stuffing her mouth. DSP #1 went into the kitchen and turned her back to client #2 for 2 minutes. Client #2 placed 2 pieces of ham on her fork, then placed both pieces in her mouth. Client #2 was not monitored or redirected to safe eating habits.</p> <p>During an observation on 02/16/2012 at</p>	W0249	<p>1. Facility staff will be trained to always monitor clients during meal time to ensure that clients' aspiration/choking protocols are being followed. This training will include cutting client #'s food to the recommended size. Staff will be trained to sit at the table with clients in a family style setting during all meals. This training will include both Day Program staff and House staff. Laundry will be assigned to other times other than meal times.2. Staff will be re-trained on client #2's ambulation protocol which requires providing walking assistance on uneven surfaces. This training will include Day Program staff and house staff.</p>	03/21/2012			

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	<p>6:55 a.m., client #2 placed two 1 inch by 1 inch pieces of toast with cheese in her mouth at once. She stuffed a large bite of oatmeal in her mouth. DSP #4 was standing in the kitchen and DSP #3 was removing a load of towels from the dryer in the laundry room. Client #2 was not monitored or redirected to safe eating habits.</p> <p>During observations on 02/15/2012 between 4:30 p.m. and 6:05 p.m., client #2 ambulated in her home without assistance. She walked down a ramp from the living room to garage/laundry area and ambulated between the living room, her bedroom, kitchen, and dining area without staff assistance. Client #2 walked without staff assistance on the ramp from the group home to the van. The side walk had broken concrete and was an uneven surface.</p> <p>Client #2's record was reviewed on 02/16/2012 at 12:26 p.m.</p> <p>An IHP (Individual Habilitation Plan), dated 11/15/2011, indicated client #2 had an objective for walking 30 minutes or weight bearing exercises daily with staff assistance.</p> <p>An "Aspiration/choking protocol," dated 01/18/201, indicated, "...Staff is to cut</p>			

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	<p>food into bite-sized 1/2" size pieces for [client #2]...Monitor and encourage [client #2] no to over-fill mouth...."</p> <p>An "Ambulation/fall protocol," dated 08/25/2011, indicated, "[Client #2 has increased susceptibility to falling that may cause physical harm. [Client #2] has an unsteady gait with a history of falls... [Client#2] has a history of falls with fractures...Provide physical assistance by placing one hand in the lower back/waist and one hand on her arm while she is attempting to ambulate on uneven surfaces...Assist [client #2] to transfer and ambulate short distance, i.e. to the rest room, to be, and to meals...."</p> <p>During an interview on 02/16/2012 at 7:00 a.m., DSP #4 indicated client #2 should have been monitored when eating and food should have been cut into bite size pieces.</p> <p>During an interview on 02/16/2012 at 7:15 a.m., DSP #3 stated, "[Client #2] is prescribed for bite size pieces because she choked at day services." DSP #3 indicated she didn't observe client #2 stuffing her mouth during breakfast. She stated, "Staff do not have to be at the table at all times. They just have to monitor the meal." She indicated she was unable to monitor the meal from the laundry room.</p>						

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	<p>During an interview on 02/16/2012 at 2:20 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated staff should have followed the guidelines in the aspiration/choking protocol. She stated, "If the protocol says to monitor, that's what staff should have been doing." The QDDP indicated staff should have followed guidelines in the ambulation/fall protocol for assisting client #2 when walking.</p> <p>9-3-4(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed to ensure nursing services monitored health conditions, obtained results of diagnostic tests, and failed to ensure prescribed medications were available in the home and administered per physician's orders for 3 of 4 sampled clients (clients #1, #2, and additional client #6).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 02/16/2012 at 9:55 a.m.</p> <p>A medical appointment form, dated 08/29/2011, indicated client #1 had a screening mammogram on 08/29/2011. The record did not include documentation to indicated results of the screening.</p> <p>A medical appointment form, dated 01/11/2012, indicated client #1 was assessed for vaginal bleeding. The report indicated, "...If persists or worsens, return for Dilatation and Curettage (D&C) and hysteroscopy (gynecological surgical procedures)." The record did not include documentation to indicate staff were monitoring vaginal bleeding.</p>	W0331	<p>See W104 for POC. 1. The facility nurse will follow up all Dr's recommendations. This process will be reviewed by the QMRP and the facility nurse monthly during the client's monthly meeting. Results from labs and other Dr's visits will be reviewed and followed up on accordingly. The facility nurse will meet with clients that may have ongoing health issues to ensure that their health condition is improving. 2. The House Manager will check Medication Administration records to ensure that all medications are being administered as prescribed by the physician. If there are medications that are not available, the House Manager will contact the staff nurse and ensure that those medications are ordered from the pharmacy. The facility nurse will also review medication administration records regularly when she does her weekly client home visits to ensure that medications are being administered as prescribed by the physician. 3. The facility has changed client #6's diet to ensure he is on a mechanical soft diet. A diet protocol has been put in place and staff have been trained on his diet. This protocol will be reviewed and revised as client's needs change.</p>	03/21/2012			

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	<p>The physician's orders, dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated, "...THERA-M TABLET (MULTIVITAMIN W/MINERALS AND IRON) GIVE 1 TABLET ORALLY ONCE A DAY FOR VITAMIN SUPPLEMENT...."</p> <p>The MARs (Medication Administration Records), dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated client #1 did not receive any doses of Thera-M from 01/01/2012-02/16/2012. The record indicated the medication was not available in the home for administration.</p> <p>During an interview on 02/16/2012 at 4:00 p.m., RN #1 stated she did not have results of the mammogram. She indicated a system for ensuring receipt of diagnostic test results was implemented in October 2011. She stated, "It is the med (medical) float staff's responsibility to inform staff," when asked how staff monitored client #1 for persistent or worsening vaginal bleeding. She stated, "All staff know to document anything unusual," when asked if there were specific instructions for what to monitor and when to report findings to the nurse. RN #1 indicated she was "unaware until recently the medication</p>						

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	<p>had not been given, " when asked about the Thera M not being administered for more than a month. She stated the medicine not covered by Medicaid and was not shipped by pharmacy to the facility in January or February 2012. RN #1 indicated she did not inform client #1's physician of the medication errors occurring daily since 01/01/2012. She indicated the medication had not been obtained and was unavailable in the home for medication administration.</p> <p>2. Client #2's record was reviewed on 02/16/2012 at 12:26 p.m.</p> <p>The physician's orders, dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated, "...THERA-M TABLET (CEROVITE ADVANCED FORM TABLET) FIVE 1 TABLET ORALLY ONCE A DAY FOR VITAMIN SUPPLEMENT...."</p> <p>The MARs (Medication Administration Records), dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated client #1 did not receive any doses of Thera-M from 01/01/2012-02/16/2012. The record indicated the medication was not available in the home for administration.</p> <p>During an interview on 02/16/2012 at</p>						

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	<p>4:00 p.m., RN #1 indicated she was "unaware until recently the medication had not been given," when asked about the Thera M not being administered for more than a month. She stated the medicine not covered by Medicaid and was not shipped by pharmacy to the facility in January or February 2012. RN #1 indicated she did not inform client #1's physician of the medication errors occurring daily since 01/01/2012. She indicated the medication had not been obtained and was unavailable in the home for medication administration.</p> <p>3. An observation at the group home was done on 2/15/12 from 4:20p.m. to 6:09p.m. At 5:09p.m., client #6 received baked ham cut into pieces (chunks). Client #6 coughed on a piece of ham and spit it out onto his plate. Client #6 ate 50% of his ham pieces.</p> <p>The record for client #6 was reviewed on 2/16/12 at 10:02a.m. Client #6 had physician's orders on 1/24/12 to receive a mechanical soft diet. A 2/3/10 Barium Swallow Study (most recent in record) indicated client #6 was to receive mechanical soft diet with ground meat. A 3/4/10 nurse note indicated "received recommendations from swallow study with dietician, agree with mechanical soft with ground meat moistened with gravy."</p>						

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	<p>Client #6 had an 8/4/11 Aspiration Protocol signed by RN #1. The 8/4/11 Aspiration Protocol indicated client #6 was to have all meats cut in small pieces and tender to chew.</p> <p>Interview of RN #1 on 2/16/12 at 10:31a.m. indicated client #6 should have received his ham ground up. Interview of nurse #2 On 2/16/12 at 11:02a.m. indicated client #6's current Aspiration Protocol and his ordered diet for ground meat did not indicate the same diet. 9-3-6(a)</p>						

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to ensure medications were administered per physician's orders without error for 2 of 4 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 02/16/2012 at 9:55 a.m.</p> <p>The physician's orders, dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated, "...THERA-M TABLET (MULTIVITAMIN W/MINERALS AND IRON) GIVE 1 TABLET ORALLY ONCE A DAY FOR VITAMIN SUPPLEMENT...."</p> <p>The MARs (Medication Administration Records), dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated client #1 did not receive any doses of Thera-M from 01/01/2012-02/16/2012. The record indicated the medication was not available in the home for administration.</p> <p>During an interview on 02/16/2012 at</p>	W0368	See W331 for POCThe House Manager will review Medication Administration records several times a week to ensure clients are receiving their medications as prescribed by the physician. If there are some missing medications, the House Manager will contact the facility nurse and get those medications ordered right away. The facility nurse will also review medication administration records as she does her weekly house visits and also monthly.	03/21/2012			

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	<p>4:00 p.m., RN #1 indicated she was "unaware until recently the medication had not been given," when asked about the Thera M not being administered for more than a month. She stated the medicine not covered by Medicaid and was not shipped by pharmacy to the facility in January or February 2012. RN #1 indicated she did not inform client #1's physician of the medication errors occurring daily since 01/01/2012. She indicated the medication had not been obtained and was unavailable in the home for medication administration.</p> <p>2. Client #2's record was reviewed on 02/16/2012 at 12:26 p.m.</p> <p>The physician's orders, dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated, "...THERA-M TABLET (CEROVITE ADVANCED FORM TABLET) FIVE 1 TABLET ORALLY ONCE A DAY FOR VITAMIN SUPPLEMENT...."</p> <p>The MARs (Medication Administration Records), dated 01/01/2012-01/31/2012 and 02/01/2012-02/29/2012, indicated client #1 did not receive any doses of Thera-M from 01/01/2012-02/16/2012. The record indicated the medication was not available in the home for</p>			

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	<p>administration.</p> <p>During an interview on 02/16/2012 at 4:00 p.m., RN #1 indicated she was "unaware until recently the medication had not been given, " when asked about the Thera M not being administered for more than a month. She stated the medicine not covered by Medicaid and was not shipped by pharmacy to the facility in January or February 2012. RN #1 indicated she did not inform client #1's physician of the medication errors occurring daily since 01/01/2012. She indicated the medication had not been obtained and was unavailable in the home for medication administration.</p> <p>9-3-6(a)</p>			

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W0440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed to ensure an evacuation drill was conducted quarterly for each shift for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 02/15/20912 at 3:20 p.m. Records indicated a drill was completed during the evening shift on 05/04/2011 at 4:20 p.m. The record did not include documentation to indicate fire drills were completed during the day or night shift during the quarter covering March, April, and May, 2011.</p> <p>During an interview on 02/16/2021 at 7:30 a.m., the House Manager stated, "All drills should be at the office."</p> <p>During an interview on 02/16/2012 at 2:20 p.m., the QDDP (Qualified Developmental Disabilities Professional) stated, "There are no more drills," when asked if there were fire drills that had not been presented for review on 02/15/2012 at 3:20 p.m. She indicated the drills</p>	W0440	<p>The facility has put in place a new Safety Committee Chair to ensue that all fire drills are completed during all shifts under varied conditions (day and night shift). All the required fire drills were run but record keeping was not done well. The facility has a fire drill binder which contains all fire drills for the whole facility. The safety Committee meets monthly and reviews all fire drills to ensure compliance.</p>	03/21/2012

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NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 TERRE HAUTE, IN 47802		
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	should have been completed quarterly. 9-3-7(a)				

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W0441	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.</p> <p>Based on record review and interview, the facility failed to ensure an evacuation drill was conducted under varied conditions for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 02/15/20912 at 3:20 p.m. Records indicated fire drills were completed on 05/04/2011 at 4:20 p.m., 6/20/11 at 7:40 a.m., 7/16/11 at 11:20 a.m., 8/16/11 at 4:10 p.m., 9/24/11 at 12:05 a.m., 10/15/11 at 1:30 p.m., 11/26/11 at 4:28 p.m., 12/20/11 at 6:45 a.m., 1/28/12 at 1:30 p.m., and 2/14/12 at 4:14 p.m. The record did not include documentation to indicate evacuations were conducted at varied times during the evening and indicated only one drill occurred during hours when clients were sleeping.</p> <p>During an interview on 02/16/2012 at 2:20 p.m., the QDDP (Qualified Developmental Disabilities Professional) stated, "There are no more drills," when asked if there were fire drills that had not been presented for review on 02/15/2012</p>			W0441	See W440 for POCThe Safety Committee chair will ensure that all fire drills are conducted monthly at varying times and under varied conditions and documented. This includes during awake and sleep hours.		03/21/2012

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	<p>at 3:20 p.m. She indicated the drills should have been completed over varied conditions and should have included more drills during hours when clients slept. She stated, "Clients would have been awake and preparing for work around 6 a.m." on Monday, 6/20/2011 and Tuesday, 12/20/2011.</p> <p>9-3-7(a)</p>				

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W0473	<p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients (#4) and 2 non-sample clients (#6, #8) to ensure the clients received milk at breakfast at an appropriate temperature, within 15 minutes upon removal from the temperature control device.</p> <p>Findings include:</p> <p>An observation was done at the group home on 2/16/12 from 6:42a.m. to 7:39a.m. From 6:42a.m. (milk on table when observation began) until 7:24a.m (at least 42 minutes), a plastic gallon of milk was on the dining room table. At 7:15a.m. clients #4, #6 and #8 put the milk on their cereal and drank a glass of milk.</p> <p>Interview of professional staff #2 on 2/16/12 at 1:03p.m. indicated the milk should not have been left out at room when not in use.</p> <p>9-3-8(a)</p>	W0473	<p>Facility staff have been re-trained to ensure that food must not be away from temperature control device for more than 15 minutes. House Manager will monitor this requirement randomly during meal times and train and remind staff as needed.</p>	03/21/2012
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W0474	<p>483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client.</p> <p>Based on observation, record review, and interview, the facility failed for 1 non-sampled client (#6) to ensure client #6 received a mechanical soft diet with ground meat diet as prescribed by his physician's orders.</p> <p>Findings include:</p> <p>An observation at the group home was done on 2/15/12 from 4:20p.m. to 6:09p.m. At 5:09p.m., client #6 received baked ham cut into pieces (chunks). Client #6 coughed on a piece of ham and spit it out onto his plate. Client #6 ate 50% of his ham pieces.</p> <p>The record for client #6 was reviewed on 2/16/12 at 10:02a.m. Client #6 had physician's orders on 1/24/12 to receive a mechanical soft diet. A 2/3/10 Barium Swallow Study (most recent in record) indicated client #6 was to receive mechanical soft diet with ground meat. A 3/4/10 nurse note indicated "received recommendations from swallow study with dietician, agree with mechanical soft with ground meat moistened with gravy."</p> <p>Interview of RN #1 on 2/16/12 at</p>	W0474	See Tag W331 for POC Client # 6 has been put on a mechanical diet. Both Day Program and House staff have been trained. An aspiration/choking protocol has been put in place.	03/21/2012			

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	10:31a.m. indicated client #6 should have received his ham ground up. 9-3-8(a)			