

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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
K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/23/12</p> <p>Facility Number: 000887 Provider Number: 15G373 AIM Number: 100249240</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Mosaic was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors,</p>	K0000		

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:  15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/23/2012
NAME OF PROVIDER OR SUPPLIER  MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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>sleeping rooms, and common living areas. The facility has a capacity of eight and had a census of eight at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.2.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G373		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/23/2012	
NAME OF PROVIDER OR SUPPLIER  MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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			
KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients. Such instruction is reviewed by the staff not less than every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p>	KS147	<p>Based on the State Surveyor's citations, the facility will review safety plans and fire evacuation plans on a monthly basis with staff during house meetings. The training will cover the following staff objectives;1. Learn and understand what types of assistance each individual who resides in our facility needs in case of a fire.2. Learn what to do and who to contact in case of a fire alarm/sprinkler system failure.3. Learn what steps to be taken during the time the fire alarm/sprinkler is down.4. learn how to fill the "fire watch" sheet as specified in the facility policy.To ensure that this deficiency does not recur, the staff monthly trainings will be</p>	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/23/2012
NAME OF PROVIDER OR SUPPLIER  MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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	
	Based on interview during review of the facility's Evacuation and Fire Plan on 02/23/12 at 9:55 a.m., the Maintenance Supervisor indicated employees are instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of any resident, however, the Maintenance Supervisor indicated such instructions are not reviewed by the staff every two months. The two most recent reviews of the Evacuation and Fire Plan by staff were on 02/01/11. The facility was lacking written documentation of a fire drill for the third shift (night) during the first quarter of 2011.		reviewed on a monthly basis during client house meetings and also during the monthly safety inspections by the safety committee chair.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/23/2012
NAME OF PROVIDER OR SUPPLIER  MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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	
KS152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill:</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the facility's</p>	KS152	The facility has put in place a new Safety committee chair to ensure that once fire drills are done, they are analyzed for accuracy, establish some trends and filed. He will also ensure that fire evacuation drills are done during varied times, shifts, and conditions. This will help ensure that the facility has run fire evacuation drills quarterly for each shift of personnel and varied conditions. The facility will ensure	03/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G373		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/23/2012	
NAME OF PROVIDER OR SUPPLIER  MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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>Fire Drill folder on 02/23/12 at 9:45 a.m. with the Maintenance Supervisor present, the facility lacked documentation a fire drill was conducted during the third shift (night) of the first quarter (January, February, and March) of 2011. Based on interview at the time of record review, the Maintenance Supervisor said there was no fire drill performed during the third shift of the first quarter of 2011.</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drills folder on 02/23/12 at 9:45 a.m. with the Maintenance Supervisor present, three of four first shift (day) fire drills performed since February of 2011 were held between 1:00 p.m. and 1:30 p.m., and four of four second shift (evening) fire drills</p>		<p>that clients are actually at least during one drill each shift and make special provisions for clients with physical disabilities. Reports will be made for each separate fire drill. To ensure that this deficiency does not recur, the Safety Committee will review all fire drills on a monthly basis to ensure that they meet all requirements.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/23/2012
NAME OF PROVIDER OR SUPPLIER  MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 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	
	performed since February of 2011 were held between 4:10 p.m. and 4:28 p.m. Based on interview at the time of record review the Maintenance Supervisor acknowledged the times of the first and second shift fire drills were not varied.				