

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 11/15/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN47802
--	---

(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
W0000	<p>This visit was for an investigation of complaint #IN00099469.</p> <p>Complaint #IN00099469: Substantiated, a federal and state deficiency related to the allegation(s) is cited at W189.</p> <p>Dates of Survey: 10/14 and 10/15/11</p> <p>Facility Number: 001103 Provider Number: 15G589 Aim Number: 100235510</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>This deficiency also reflects a state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 11/22/11 by Tim Shebel, Medical Surveyor III.</p>	W0000		
W0189	<p>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. Based on observation, interview and record review for 1 of 3 sampled clients (C), the facility failed to ensure all staff were trained in regard to the use of Hoyer</p>	W0189	In response to the deficiency cited by the State Surveyor, Mosaic revised the Hoyer Lift protocol. The new protocol stipulates that one staff can	11/23/2011

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.

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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN47802			
(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>lifts to ensure a safe tranfer.</p> <p>Findings include:</p> <p>During the 11/15/11 observation period between 5:56 AM and 7:30 AM, at the facility, staff #4 was assisting client C to get dressed for the morning. At 6:14 AM, staff #4 came out of client C's bedroom and asked staff #2 to assist her to get client C into her wheelchair. Staff #2 and #4 went into the bedroom to transfer client C from her bed to her wheelchair. Client C was placed in a custom made wheelchair. During the 11/16/11 observation period, staff did not utilize a mechanical/Hoyer Lift with C.</p> <p>Client C's record was reviewed on 11/15/11 at 10:28 AM. Client C's 3/10/11 Individual Habilitation Plan (IHP) indicated client C's diagnoses included, but were not limited to, Cerebral Palsy, Bilateral Hip Dislocation, Scoliosis and Spinal Fusion with Rod Placement. Client C's undated Hoyer Lift Protocol indicated the following:</p> <p>"-Staff should use the hoyer lift every time [client C] is to be transferred (to and from wheelchair, furniture, shower chair, bed, etc.)</p> <p>-If any part of the sling or the lift becomes inoperable or in disrepair, call the DSM</p>		<p>operate the Hoyer lift.All staff were trained on the usage of the Hoyer lift. The training took place on 11/23/11.The house Manager and QMRP will do random visits to the house during different and odd times when the Hoyer lift is likely to be used to ensure that staff are following this protocol.To ensure that this deficiency does not recur, the House Manager and QMRP will also discuss the usage of the Hoyer lift during house meetings to ensure that staff continue to remember.</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 11/15/2011
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN47802		
(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>(Direct Support Manager) immediately. [Client C] must be lifted by no more than 2 people. There are no exceptions. -When using the hoyer lift, one person must operate the lift while the second person supports [client C] in the sling."</p> <p>Confidential interview A indicated client C required a 2 person lift due to the client's physical disabilities and size. Confidential interview A indicated a Hoyer Lift was not used with client C. When asked where a Hoyer Lift was located in the group home, confidential interview A stated "in [client C and D's] closet in their bedroom." Confidential interview A indicated they had not been trained on the use of the Hoyer Lift.</p> <p>Interview with Habilitation Coordinator (HC) #1 on 11/15/11 at 12:45 PM indicated client C was not able to independently transfer herself. HC #1 indicated a Hoyer Lift should be used with client C and/or a 2 person lift should be used when transferring the client. HC #1 stated the facility's nurse "recently" changed client C's protocol. HC #1 indicated the above mentioned undated protocol indicated a Hoyer Lift should be utilized with client C for all transfers. HC #1 indicated she was under the impression the Hoyer Lift and/or a 2 person transfer could be utilized with client C. HC #1</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 11/15/2011
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 5743 ERNEST DR TERRE HAUTE, IN47802		
(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>indicated the Hoyer Lift was in the closet in a bathroom in client C's bedroom. When asked if staff had been trained on using the Hoyer Lift, HC #1 stated "Not most recent staff. They are using a 2 person lift." HC #1 did not provide any documentation which indicated any staff (staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13), who worked with client C, had been trained in regard to the Hoyer Lift.</p> <p>This federal tag relates to complaint #IN00099469.</p> <p>9-3-3(a)</p>				