

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614
--	--

(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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<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: 03/10/16</p> <p>Facility Number: 000778 Provider Number: 15G258 AIM Number: 100243480</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 fire alarm system with smoke detection in the corridors, common living areas and no smoke detectors in sleeping rooms. The facility has a capacity of six and had a census of six at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		
------------------------	---	--------	--	--

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: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614
--	--

(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
K 0130 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.2.</p> <p>Quality Review completed on 03/14/16 - DA</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 Entrance fire extinguisher requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all staff and residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 03/10/16 at 1:16 p.m., the Human Resources Manager acknowledged the maintenance stamp on the Medication Room fire extinguisher indicated the last six year test was completed 01/2010.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Hallway and 1 of 1 Office fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the</p>	K 0130	<p>In response to evidence cited by the Life Safety Code surveyor, Mosaic initiated procedures to schedule fire extinguisher inspections on a monthly basis. The schedule was established by the agency Safety Committee Chairman both in the month of March and ongoing. Once the inspection has been completed, the documentation is submitted to the SafetyCommittee Chairman for review prior to the end of each month. If an inspection is not submitted, corrective actions to agency employees are completed. In addition, Mosaic contracts with an outside agency who is scheduled to come in and provide new fire extinguishers and check them on routine basis. All 3 fire extinguishers in question were replaced with brand new ones Mosaic has implemented systematic changes to ensure the findings of this survey do not recur. Per policy and procedure, each safety inspection completed is reviewed by the agency Safety Committee Chairman for accuracy. The findings of each</p>	04/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614
--	--

(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
K S017 Bldg. 01	<p>Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on observation with the Human Resources Manager on 03/11/16 at 1:19 p.m. then again at 1:20 p.m., the gauge on the Hallway fire extinguisher indicated the extinguisher was undercharged. Then again the gauge on the Office fire extinguisher indicated the extinguisher was undercharged. Based on interview at the time each observation, the Human Resources Manager acknowledged each aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those</p>		inspection is reviewed by the agency Safety committee. To assure there will not be recurrence of this deficiency, Mosaic policy and procedure requires committee meeting records to be reviewed on a quarterly basis to assure all inspections are current.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2016
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614		
(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>of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2016	
NAME OF PROVIDER OR SUPPLIER MOSAIC				STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614			
(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			
K S051 Bldg. 01	<p>passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 clients slept in a room provided with a door which would close and latch securely in the door frame. This deficient practice could affect one client.</p> <p>Findings include:</p> <p>Based on observation with the Human Resources Manager on 03/10/16 at 1:18 p.m., Bedroom #1 failed to latch into the frame when tested. Based on interview at the time of observation, the Human Resources Manager acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire</p>	K S017	<p>In response to the findings made by the Life Safety Code Surveyor, a new bedroom door was installed to ensure the door both closes and latches securely. Mosaic has implemented systematic changes to ensure the findings of this survey do not recur. Per policy and procedure, Mosaic conducts safety inspections at each facility operated by the agency on a quarterly basis. The findings of each inspection are reviewed by the agency Safety Committee Chairperson and the committee itself.</p>	04/15/2016			
		K S051	An inspection was scheduled with VPF fire systems to check on	04/15/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2016
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614		
(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	
K S152 Bldg. 01	<p>alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could all staff and clients.</p> <p>Findings include:</p> <p>Based on record review with the Human Resources Manager on 03/11/16 at 1:08 p.m., no smoke detector testing or sensitivity testing documentation was available for review. Based on interview at the time of record review, the Human Resources Manager acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's</p>		<p>the wired smoke detection system at the facility to assure the fire alarm panel is provided with automatic smoke detection to ensure notification of a fire at that location before it was incapacitated by fire. As a result of this survey, Mosaic contracted with third party inspectors to review each facility operated by Mosaic to assure each facility is in compliance with this standard. Mosaic has implemented systematic changes to ensure the findings of this survey do not recur. Per policy and procedure, Mosaic conducts safety inspections at each facility operated by the agency on a quarterly basis. Assuring each room is provided with an approved smoke alarm is reviewed as a part of that inspection. The findings of each inspection are reviewed by the agency Safety Committee Chairperson and the committee itself. Mosaic is also inspected by a National employee and our insurance agency to help ensure that all safety components are completed as required</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2016
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614		
(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>emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (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. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include: Based on record review of the fire drill reports titled "Fire Drill Report" with the Human Resources Manager on 03/10/16 at 12:59 p.m., there was no documentation for a first shift fire drill for the fourth quarter of 2015. Based on interview at the time of record review, the Human Resources Manager acknowledged the lack of documentation.</p>	K S152	In response to evidence cited by the medical surveyor, Mosaic initiated procedures to schedule safety drills at varying times and under varying conditions. The schedule was established by the agency Safety Committee Chairman both in the month of MArch and ongoing. Once the drill has been completed, the drill is submitted to the Safety Committee Chairman for review prior to the end of each month. If a drill is not submitted, corrective actions to agency employees are completed. In addition, facility staff were trained on safety drill procedures to assure each understood their responsibility for protecting clients during a fire in the facility. Mosaic has	04/01/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G258	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2016
NAME OF PROVIDER OR SUPPLIER MOSAIC			STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614		
(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>implemented systematic changes to ensure the findings of this survey do not recur. Per policy and procedure, each safety drill completed is reviewed by the agency Safety Committee Chairman for accuracy, to assure varying conditions and times were submitted, ensuring all personnel are trained to perform each disaster plan and procedure, to assure the facility evacuates clients and provides supports as designed by the safety plan for the facility, and problems are thoroughly investigated. The findings of each drill are reviewed by the agency Safety the committee itself. To assure there will not be recurrence of this deficiency, Mosaic policy and procedure requires committee meeting</p> <p>K0152Continued records to be reviewed on a quarterly basis to assure all evaluations are current.</p>		