

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 05/06/2016
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CROYDEN CT SOUTH BEND, IN 46614
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(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
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/06/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/06/16</p> <p>Facility Number: 000778 Provider Number: 15G258 AIM Number: 100243480</p> <p>At this PSR 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</p>	K 0000		
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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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K 0130 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.2.</p> <p>Quality Review completed on 05/09/16 - DA</p> <p>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 05/06/16 at 10:29 a.m., the Property Manager acknowledged the maintenance stamp on the Medication Room fire extinguisher indicated the last six year test was completed 01/2010.</p> <p>This deficiency was cited on 03/10/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</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. Once the inspection has been completed, the documentation is submitted to the Safety Committee Chairman for review prior to the end of each month. In addition, the property manager replaced the old fire extinguisher with a new fire extinguisher that was inspected January 2016. 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 inspection is reviewed by the agency Safety committee. To assure there will not be recurrence of this deficiency, Mosaic policy and procedure requires committee</p>	05/13/2016			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2016
FORM APPROVED
OMB NO. 0938-0391

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			meeting records to be reviewed on a quarterly basis to assure all inspections are current.		