STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G676	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MOSAIC	1703 WOODMONT DR SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. Survey Dates: 10/4/21, 10/5/21, 10/6/21 and 10/7/21. Facility Number: 009969 Provider Number: 15G676 AIM Number: 200129000 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/18/21.	W 0000		
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 2 incident/investigative reports reviewed, the facility failed to report the results of client #4's injury of unknown origin within 5 business days. Findings include: On 10/5/21 at 11:52 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/8/21 at 3:00 PM, "On 1/2/2021, around 4:00 AM, staff assisting [client #4] with his morning	W 0156	Although the investigation was completed, it was not completed within 5 business days as the investigator was called away for a family emergency. Should the investigator be unable to complete the investigation as assigned, the Investigation Coordinator will reassign the investigation to a trained investigator who will finish the investigation within the 5 business days as required. This timeline will be monitored by the	11/06/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	personal care noticed that [client #4] had some bruising on his right buttock and on the inner right thigh. Staff did not know where the bruising came from and contacted the Mosaic on Call Supervisor and Nurse to report the incident. Mosaic's on Call Nurse advised staff to reposition [client #4] every 2 hours and to monitor for any increase in pain when he is being re-positioned or changed. [Client #4] also had a different size of adult briefs ordered for him and he is currently using these. Mosaic staff also followed the nurses instructions to avoid putting any tight clothing or briefs on [client #4]. Plan to Resolve (Immediate and Long Term). The bruises were assessed by [client #4's] wound care doctor on 1/8/2021 around 3:00 PM and he advised for [client #4] to have an X-ray of the area completed to check for any injuries. The Mosaic nurse and Direct Support Supervisor (DSS) are working with [client #4's] PCP (Primary Care Physician) to get the X-ray completed. The Mosaic Nurse and staff will continue to reposition [client #4] every 2 hours and monitor him for any change in the condition of his skin. The Mosaic Nurse and staff will continue to provide [client #4] with the best possible health." The 1/11/21 - 1/29/21 Investigation Summary of Evidence indicated, "When talking to staff who worked with [client #4] the two days (48 hours) prior to the being reported, no incidents of falling, or any other type of injury was (sic) reported. The doctor that saw [client #4] in the hospital reported that his blood thinner medication was very high and it caused the large hematoma." The results of the investigation were not reported to the administrator within 5 working days.		Investigation Coordinator as well as the Executive Director as investigations are conducted.	

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	On 10/7/21 at 10:38 AM, QA (Quality Assurance) stated, "Investigations are to be completed within 5 business days." QA indicated investigations were assigned by the QA to a trained investigator. QA indicated the assigned investigator ended up having to leave during the investigation for a family emergency so the investigation got delayed. 9-3-2(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM 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 and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure staff had competency based training to perform her duties. Finding include: On 10/5/21 from 4:01 PM to 5:26 PM, an observation was conducted at the group home. At 4:02 PM, client #2 sat in his wheelchair looking out the front door. At 4:04 PM, staff #4 wheeled client #2 to the doorway leading to the garage and walked away to the dining room. At 4:49 PM, client #2 sat in his wheelchair at the front door. At 4:52 PM, client #2 came to the dining room table for dinner. At 5:05 PM, staff #4 wheeled client #2 to the doorway between the garage and the laundry room and returned to the dining room. Client #2 attempted to turn his wheelchair around but got stuck on the wall. Staff #4 came and assisted client #2 with turning his wheelchair around and wheeled client #2 to the front door to	W 0189	Staff were retrained on all aspects of providing proper care for each individual's needs. This training addressed the ISP's, BSP's, and other individualized protocols. Staff will be observed through scheduled and unscheduled visits carrying out individualized supports. This will be completed by the Direct Support Supervisor, QIDP, QA, and safety committee members.	11/06/2021

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	sit and look out. At 5:09 PM, staff #4 wheeled client #2 to the doorway leading to the garage and walked back to the dining room. Client #2 attempted to turn his wheelchair around. Staff #4 came and assisted. At 5:15 PM, staff #4 wheeled client #2 to the front living room door and walked away. Client #2 turned his wheelchair around and began to wheel himself toward the hallway leading to the laundry room and kitchen. At 5:22 PM, client #2 was in the laundry room shutting the door leading to the garage. At 5:25 PM, client #2 ate ice cream at the dining room table. On 10/5/21 at 4:20 PM, staff #2 indicated the clients usually do activities during the day. Staff #2 stated, "My supervisor has never told us of activities we can do with them (the clients)." At 5:12 PM, staff #2 indicated she had worked in the home for 8 months. Staff #2 stated, "[Supervisor's name] hasn't really told me anything the clients can and cannot do." On 10/6/21 at 10:25 AM, QA (Quality Assurance) indicated active treatment should have been done. QA indicated staff #4 had completed ISP (Individual Support Plan) training when she was hired. 9-3-3(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION 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.			

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	Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #2), the facility failed to ensure 1) client #1's program plan for door alarms was implemented and 2) client #2 was engaged in meaningful activities including implementation of his program plan. Findings include: On 10/5/21 from 7:06 AM to 9:14 AM, an observation was conducted at the group home. At 8:05 AM, the sliding glass door which led to the back deck did not have an alarm present. At 8:33 AM, the side garage door which led to the side of the house did not have an alarm present. The door which led from the laundry room to garage had an alarm present but did not sound when the door was opened. The alarm was turned off. At 8:39 AM, the bedroom next to the bathroom had a door which led to the backyard with an alarm present but did not sound when the door was opened. The alarm was turned off. At 8:41 AM, the bedroom off of the living room had a door which led to the back deck with no alarm present. On 10/5/21 from 4:01 PM to 5:26 PM, an observation was conducted at the group home. At 4:02 PM, client #2 sat in his wheelchair looking out the front door. At 4:04 PM, staff #4 wheeled client #2 to the doorway leading to the garage and walked away to the dining room. At 4:49 PM, client #2 sat in his wheelchair at the front door. At 4:52 PM, client #2 came to the dining room table for dinner. At 5:05 PM, staff #4 wheeled client #2 to the doorway between the garage and the laundry room and returned to the dining room. Client #2 attempted to turn his wheelchair around but got stuck on the wall. Staff #4 came and assisted client #2 with turning his wheelchair	W 0249	The agency's Property Manager reviewed the placement of the door alarms and ensured they were placed appropriately and were all in working order on 10/18/2021. Staff were retrained on all individual's active treatment on 10/06/2021. The training consisted of client specific activities; times when the activities were appropriate to be carried out; and identifying opportunities for active treatment. Staff will be observed through scheduled and unscheduled visits carrying out active treatment. This will be completed by the Direct Support Supervisor, QIDP, QAM, and Safety Committee members.	11/06/2021

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	around and wheeled client #2 to the front door to sit and look out. At 5:09 PM, staff #4 wheeled client #2 to the doorway leading to the garage and walked back to the dining room. Client #2 attempted to turn his wheelchair around. Staff #4 came and assisted. At 5:15 PM, staff #4 wheeled client #2 to the front living room door and walked away. Client #2 turned his wheelchair around and began to wheel himself toward the hallway leading to the laundry room and kitchen. At 5:22 PM, client #2 was in the laundry room shutting the door leading to the garage. At 5:25 PM, client #2 ate ice cream at the dining room table. 1) On 10/5/21 at 2:22 PM, a review of client #1's May 2021 BSP (Behavior Support Plan) indicated the following: -"Behaviors Targeted for Reduction: Wandering from current setting without informing staff." A review of client #1's May 2021 Rights Restrictions indicated the following: -"Rights Restriction: Alarm on exit doors at Woodmont home. Reason for Restriction: Safety Plan for Restriction: Risk Plan for wandering, working on awareness." On 10/6/21 at 10:54 AM, QA (Quality Assurance) stated, "Yes, all of the doors leading outside should have had them (alarms) and they (alarms) should have been turned on." 2) On 10/5/21 at 2:45 PM, a review of client #2's 1/1/21 ISP (Individual Support Plan) staff supports indicated the following meaningful activities: -"assisted with taking his shower/ bath. -assisted with dressing in clean, properly fitting			

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	and weather appropriate clothing. -assisted with his personal hygiene. -assisted with meal preparation. -assist with taking his plate to the kitchen, wiping the dining table after meals and taking his clean laundry to his room. -assisted with nail care. -assisted with staying in contact with his natural supports. -participate with verbal prompting and hand over hand support from staff with his Range of Motion." On 10/5/21 at 4:20 PM, staff #2 indicated the clients usually do activities during the day. Staff #2 stated, "My supervisor has never told us of activities we can do with them (the clients)." At 5:09 PM, staff #2 was asked what kinds of things she enjoyed doing. Staff #2 indicated she enjoyed doing adult coloring. Staff #2 was asked if client #2 could do adult coloring. Staff #2 stated, "My supervisor used to print off sheets for the clients to color but I'm not sure why she doesn't anymore." At 5:12 PM, staff #2 indicated she had worked in the home for 8 months. Staff #2 stated, "[Supervisor's name] hasn't really told me anything the clients can and cannot do." On 10/6/21 at 10:25 AM, QA indicated active treatment should have been done. QA indicated active treatment included providing supports for the person not to the person. QA stated, "Staff should assist with activities but not doing for the client and offering choices to the client." 9-3-4(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual			

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	physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure clients #2 and #3 had their vision assessed. Findings include: On 10/5/21 at 2:45 PM, a review of client #2's record was conducted. Client #2's record did not include documentation of a vision screening since 12/17/18 with a follow up screening in 2 years. On 10/5/21 at 3:15 PM, a review of client #3's record was conducted. Client #3's record did not include documentation of a vision screening since 12/17/18 with a follow up screening in 2 years. On 10/6/21 at 12:11 PM, QA (Quality Assurance) stated, "No an appointment had not been scheduled or completed." QA indicated an appointment should be completed as requested by the physician. On 10/6/21 at 12:13 PM, the nurse stated, "Yes, they (the vision appointments) should have been scheduled." The nurse indicated the health services assistant should have scheduled the appointments. 9-3-6(a)	W 0323	Mosiac will use our monthly tracking reports completed by each Program Manager, who shares the reports with the Mosaic nursing staff. The Health Services assistant will check the reports weekly and schedule appointments within the required time frame. The QIDP will continue to audit their caseload monthly to ensure that the appointments are in compliance.	11/06/2021
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.			

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	Based on observation, record review and interview for 1 of 2 clients (#2) receiving medications at the morning medication pass, the facility failed to ensure client #2 received his medications per his physician's orders. Findings include: On 10/5/21 from 7:06 AM to 9:14 AM, an observation was conducted at the group home. At 7:11 AM, staff #2 administered Fluticasone 50 mcg (micrograms) 3 sprays into each nostril for seasonal allergies to client #2. Staff #2 administered client #2 the following medications whole in applesauce: Calcium 500 mg (milligram) for osteoporosis 1 tablet; Docusate 100 mg for constipation 1 capsule; Levetiracetam 500 mg for seizure disorder 1 capsule. On 10/5/21 at 2:45 PM, a review of client #2's MAR (Medication Administration Record) indicated the following: -"FLUTICASONE PROP 50 MCG SPRAY - Inhalant, Nasal (nose) Indication / Purpose: Seasonal allergies Instruction/Comments Give 1 spray in each nostril 2 times a day Schedule Repeat: Everyday Schedule Time Slot(s): 7:00 AM, 8:00 PM." A review of client #2's 1/2021 Choking risk plan indicated the following: -"Crush medications and give with at least ½ (half) cup additional applesauce." On 10/6/21 at 12:25 PM, the nurse stated, "Yes, it is a medication error, she gave him too many doses. It could cause an overdose and cause reactions." The nurse stated, "Yes, the	W 0369	All staff will be retrained by the nurse on the proper method of administering prescription medications, especially when directed to crush and administer with applesauce/pudding. In addition, the nurse will retrain staff on the proper way to dose and administer nasal sprays. Through scheduled and unscheduled visitis by the Direct Support Supervisor, QIDP, and administrative staff, medications passes will be observed to ensure they are being properly administered.	11/06/2021

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	medications were to be crushed except for the soft gel capsule since he is on a pureed diet due to being a choking risk." 9-3-6(a)			
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 of 3 clients in the sample (#2) and 1 additional client (#4), the facility failed to ensure 1) client #2 received his nectar thick liquids as ordered by the physician and 2) clients #2 and #4's pureed foods were not mixed and served in one dish to each client. Findings include: On 10/5/21 from 4:01 PM to 5:26 PM, an observation was conducted at the group home. At 4:15 PM, staff #3 gave client #2 a cup with water to drink. Client #2 drank the water. The water did not contain thick-it powder. The water was not nectar thick. At 4:52 PM, staff #3 gave staff #4 a bowl containing a brown pureed substance for client #2. When staff #4 was asked what was in the bowl, staff #4 stated, "I'm not sure what she fixed him (client #2)." At 4:55 PM, Staff #3 fed client #4 a brown pureed substance from a bowl. When staff #3 was asked what was in the bowl, staff #3 stated, "I pureed the pork chop, broccoli and 1 slice of bread all together for them (clients #2 and #4). We always mix it all together." On 10/5/21 at 2:45 PM, a review of client #2's record was conducted. Client #2's choking risk plan dated 1/2021 indicated the following:	W 0474	All staff have been retrained on meal preparation as ordered by the dr. The training addressed proper preparation of beverages/liquids as well as solid foods to support the needs of each individual. This training further addressed the way food items are to be plated in order for the meal to be more appetizing and appropriate. Staff will be observed through scheduled and unscheduled visits which will be completed by the Direct Support Supervisor, QIDP, QA, and Safety Committee Members.	11/06/2021

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	-" Diet Orders: Nectar thick liquids with dysphagia level 1 (PUREE - a smooth, creamy substance) . No straws. [Client #2] needs to have all food pureed to (sic) [client #2] will be supervised always at meals. Provide quiet and give [client #2] plenty of time to chew and swallow his food. Avoid distractions." On 10/5/21 at 3:35 PM, a focused review of client #4's record was conducted. Client #4's choking risk plan dated 5/21/21 indicated the following: -"Diet Orders: Nectar thick liquids with dysphagia level 1 (PUREE). No straws [Client #4] needs to have all food pureed to avoid choking." On 10/6/21 at 10:29 AM, QA (Quality Assurance) indicated a client who had a pureed meal should not have all the food items pureed and served together. QA indicated a person without a disability would not want to eat something that did not look good, the clients shouldn't have to either. On 10/6/21 at 12:16 PM, the nurse stated, "Yes, he (client #2) should have nectar thick liquids." The nurse stated, "Yes, if the order is for nectar thick liquids, that would include milk because he is a choking risk." On 10/6/21 at 12:32 PM, the nurse indicated the foods should have been pureed and served separately. The nurse stated, "They (the staff) try to take the easy way out and do not think about the client's way of life." 9-3-8(a)			