STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G373	A. BUILDING 00 B. WING	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MOSAIC	8556 S US HWY 41 TERRE HAUTE, IN 47802

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W 0000 Bldg. 00	This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00280661. Complaint #IN00280661: Substantiated. Federal and state deficiencies related to the allegations are cited at: W127 and W153. Survey Dates: January 23, 24, and 25, 2019. Facility Number: 000887 Provider Number: 15G373 AIMS Number: 100249240 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/11/19.	W 0000	Mosaic has removed the locks on the windows. Mosaic has installed window alarms on the outside of the window with a speaker box in place in the living room so the staff can hear when the window is raised due to the individuals identified behavior of Elopement risk. Responsible person: Program Coordinator	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 1 additional client (F), the governing body failed to exercise general policy, budget and operating direction over the facility by blocking a secondary emergency exit in client F's bedroom. Findings include: Observations were conducted at client F's home on 1/23/19 from 3:40 PM to 6:10 PM. At 4:49 PM, both of client F's bedroom windows would not open. The windows were screwed shut.	W 0104	Mosaic has removed the locks on the windows. Mosaic has installed window alarms on the outside of the window with a speaker box in place in the living room so the staff can hear when the window is raised due to the individuals identified behavior of Elopement risk. Responsible person: Program Coordinator	02/22/2019

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

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	Home Manager (HM) #1 was interviewed on 1/23/19 at 4:49 PM. HM #1 stated, "[Client F] used to have window alarms on her windows. They took them off because she kept disabling them. I'm not sure when they put the locks on the windows." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/23/19 at 4:50 PM. QIDP #1 stated, "Those are sash locks on [client F's] window." QIDP #1 indicated the sash locks were placed after client F removed the window alarms from her windows. QIDP #1 stated, "If we had an emergency, staff would bring the screwdriver in and remove the locks so [client F] could exit the room, or they (Staff) would break the window." QIDP #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated client F's primary exit from her bedroom during an emergency is her bedroom door. QIDP #1 indicated client F's secondary exit from her bedroom during an emergency is her bedroom windows. QIDP #1 stated, "The sash locks are not safe for an emergency. We've already had our maintenance crew remove them." 9-3-1(a)			
W 0127 Bldg. 00	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. Based on record review and interview for 1 of 3 sampled clients (A), plus 1 additional client (Former Client (FC)) the facility failed to ensure	W 0127	Mosaic opened investigations immediately after the reports of the incidents occurred.	02/22/2019

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	client A and FC were not subjected to verbal and physical abuse by staff. Findings include: Bureau of Developmental Disabilities Services (BDDS) reports and investigations were reviewed on 1/23/19 at 10:00 AM. The review indicated the following: 1. BDDS report dated 10/22/18 indicated, "On 10/22/18 around 2:30 PM, [staff #5] reported to [Home Manager (HM) #1] and [Qualified Intellectual Disabilities Professional (QIDP) #1] that... (On 10/20/18) around 6:00 PM, [Former Client (FC)] approached [staff #5 and #6]... to assist him with locating his body lotion. [Staff #5] reports that she assisted [FC] with locating his lotion and then walked him back to the men's side and informed [staff #8 and #7] that [FC] needed assistance. [Staff #5] then reported that herself (sic) (staff #5) and [staff #6] then began looking through items in the activity cabinet located in the garage situated between the men's side and women's side of the residence. [Staff #5] reported that while in the garage with [staff #6], they overhead [staff #8] say, 'Go on [FC], [expletive] off.' [Staff #5] then went home for the evening around 6:45 PM and [staff #6] resumed normal duties on the women's side until the end of her shift." "Plan to Resolve: [Staff #5 and #6] were both immediately placed off duty on 10/22/18 pending the results of a formal investigation due to failing to report the allegation of VA (Verbal Abuse) in a timely manner. [Staff #8] was immediately placed off duty due to being the perpetrator of the alleged VA pending the results of a formal investigation."		Appropriate terminations were made to ensure the health and safety of the individuals in the home. Responsible Person: Executive Director Policy and procedure in place for abuse, neglect, exploitation and mistreatment is appropriate, staff in the home have been retrained on building positive relationships and the Abuse/ Neglect Policy that includes reporting of Abuse/ Neglect. Responsible person: Program Coordinator and House Manager Additionally, the Mosaic On Call policy has been updated to include staff calling to inform the on call manager anytime they are taking someone out of Vigo County. Responsible Person: Executive Director	

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The BDDS report listed an incident date as 10/20/18. The administrative knowledge date was listed as 10/22/18. The BDDS report for the staff to client VA incident was created on 10/22/18.

Mosaic Investigation Report (MIR) dated 10/25/18 was completed by Qualified Intellectual Disabilities Professional (QIDP) #1. The MIR indicated the following:

"Allegation: [Staff #5] stated on 10/22/18, she was on the men's side of the home when she observed [staff #8] to tell [FC] to '[expletive] off'. When asked why [staff #5] did not report this incident immediately, she stated that [staff #6] told her not to report the incident because she would get fired because [staff #8] was best friends with [Executive Director (ED) #1]."

"Investigative Question: On 10/20/18, did [staff #8] tell [FC] to '[expletive] off' in a manner that would be verbal abuse? On 10/20/18, did [staff #6] tell [staff #5] not to report this incident?"

Staff #5 was interviewed on 10/22/18 by QIDP #1 for the investigation. Staff #5's interview indicated the following, "She (staff #5) reported that on Saturday, [FC] went over to the women's side of the home to get lotion since there was no more on the men's side that he could find. [Staff #5] then assisted [FC] with the lotion and then went over the men's side to inform the staff that [FC] needed assistance with something and he went over the women's side for lotion. [Staff #5] reported that [staff #7 and #8] were in the kitchen on the men's side facetiming (video chatting) someone during this time. She (staff #5) was unaware who they were facetiming. When [staff #5] was walking back to the women's side, she (staff #5) was in the

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	garage when she (staff #5) heard [staff #8] holler, '[expletive] off' to [FC]. At this time, [staff #5] reported she was in the garage, [staff#6] was also in the garage with her and [staff #7 and #8] were on the men's side with [clients A, E, and FC]. [Staff #5] reported that she (staff #5) told [staff #8] that it was not right which was when [staff #8] went over to the women's side to apologize to [staff #5]. [Staff #5] informed [staff #8] she was not the one he should be apologizing to. [Staff #5] reported that she was upset and stressed by the situation so she then asked to go home early. [Staff #5] reported she did not report the incident right away because she was told by [staff #6] numerous times over the course of her employment that [ED #1 and staff #8] are best friends and that nothing would happen to [staff #8] ever because of him (sic) and the executive director's friendship." Staff #6 was interviewed on 10/23/18 by QIDP #1 for the investigation. Staff #6's interview indicated the following, "She (staff #6) was unaware if someone told [FC] to '[expletive] off' as she (staff #6) was on the girls side of the home working and [staff #7 and #8] were on the men's side of the home. [Staff #6] reported that [FC] only went on the women's side of the home when he needed lotion. [Staff #6] said she did not go over to the men's side to work, she stayed on the women's side. [Staff #6] reported that she was under the impression that [staff #5] left due to wanting to spend time with her grandchildren. She (staff #6) did not hear anyone curse at [FC]." Staff #7 was interviewed on 10/23/18 by QIDP #1 for the investigation. Staff #7's interview indicated the following, "He (staff #7) was on the men's side on Saturday and he did not hear anyone say '[expletive] off' or be mean to [FC] in any way... He			

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	(FC) did go over to the women's side on Saturday. [Staff #7] reported that he (staff #7) did not witness any staff member facetiming on his shift. [Staff #7] reported that for the duration of his employment, he (staff #7) has never heard a staff member curse at any individual. [Staff #7] reported that the reason [staff #5] left early from her shift was to see her grandchildren." FC was interviewed on 10/23/18 by QIDP #1 for the investigation. FC's interview indicated the following, "When asked if someone told him (FC) to '[expletive] off', [FC] reported that someone did. [FC] reported that he did not know who told him this. When asked if he (FC) knew the perpetrator's gender, [FC] reported that they were male... [FC] reported that on Saturday he did go over to the women's side of the home... [FC] reported that it was a 'black boy' whom told him to '[expletive] off' on Saturday... [FC] reported that the person did not apologize to him following saying '[expletive] off'...". Staff #8 was interviewed on 10/23/18 by QIDP #1 for the investigation. Staff #8's interview indicated the following, "He reported that [staff #5] came over to the men's side to ask why [FC] came over to the women's side to get lotion. [Staff #8] responded with probably because the men's side was out. [Staff #8] reported that nobody called [FC] a bad name nor has anyone every (sic) called an individual in service a bad name. [Staff #8] reported that nobody was on facetime at the home because that is not allowed to happen...". "Analysis and Findings: Based on the interviews conducted, there is no conclusion on weather (sic) or not either event happened. Due to [staff #5 and #6] being in the garage when [staff #8] was conversing with [FC], and [FC's] statements being			

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	inconsistent. It is not concluded weather (sic) or not [staff #6] told [staff #5] not to report this allegation of verbal abuse due to lack of evidence." "Actions Taken and Follow Up:" "Corrective Action for [staff #5] for not reporting the incident immediately." "Return [staff #5, #6, and #8] (to work)." "[Staff #5] retrained on when to report abuse and neglect." "Management will complete observations on the group home while [staff #8] is working to ensure verbal abuse is not taking place." The Investigation file included one administrative observation dated 11/4/18 from 4:20 PM to 5:15 PM completed by Home Manager (HM) #2. The file did not include additional observations in the home while staff #8 was working with clients. 2. BDDS report dated 11/29/18 indicated, "[Staff #1] called management on 11/29/18 around 4:15 PM to report an allegation of abuse. [Client A] had just arrived back home from a medical appointment with [Staff #10]. Upon his arrival, [staff #10] informed [staff #1] that [client A] reported to her that [staff #6] would throw water on him when he would have a behavior to get him to cease his negative behaviors. [Staff #6] was immediately placed off duty pending the results of a formal investigation." "Plan to Resolve: A formal investigation into the allegation of abuse is ongoing at this time."			

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	Mosaic Investigation Report (MIR) dated 12/6/18 was completed by Home Manager (HM) #2. The MIR indicated the following: "Allegation: It was reported on 11/29/18 by [staff #10] that [client A] reported to her that [staff #6] threw water on him while in his room because he was bad." "Investigative Question: Did [staff #6] throw water on [client A]?" Staff #7 was interviewed on 12/3/18 and 12/4/18 by HM #2 for the investigation. Staff #7's interview indicated the following, "[Client A] had a behavior at the table while [staff #6] was passing medication. [Staff #7] went on to state that he (staff #7) turned around when he heard [client A] raising his voice. He (staff #7) did notice that [client A's] chin was wet along his shirt. [Staff #7] went on to state that he seen (sic) [client A] get up and go to his (client A's)room at that point in time is when [staff #7] went out to the garage to get the broom. He (staff #7) did state that he would not know if [staff #6] went to his (client A's) room due to him (staff #7) being in the garage." Client A was interviewed on 12/3/18 and 12/4/18 by HM #2 for the investigation. Client A's interview indicated the following, "[Staff #6] was working with him (client A). She (staff #6) threw water on him (client A) in his bedroom because, 'He (client A) was bad'...". FC was interviewed on 12/4/18 by HM #2 for the investigation. FC's interview indicated the following, "[FC] stated that he saw [staff #6] throw water on [client A] because [client A] was being bad. [FC] went on to say that [client A] tried			

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	to hit [staff #6], and [staff #6] told him to go to his room. [FC] went on to say that [staff #6] followed [client A] into his (client A's) bedroom where he (FC) heard [client A] yell. [FC] went on to say that [staff #6] took water with her to [client A's] room." Client E was interviewed on 12/4/18 by HM #2 for the investigation. Client E's interview indicated the following, "It was stated (by client E) that he has seen staff throw water on [client A] and when asked who the staff was saying all staffs name, he shook his hand (sic) 'yes' to [staff #6](sic)." Client B was interviewed on 12/5/18 by HM #2 for the investigation. Client B's interview indicated the following, "[Client B] was able to tell me that it was [staff #6] who threw water on [client A] in [client A's] room. [Client B] went on to state that he (client B) knows this because he was going to his room and saw it because it happened at [client A's] door to his room. [Client B] also stated that [client A] had hit [staff #6] as well. [Client B] was able to tell me that [staff #7] was in the garage getting ready to leave." Staff #6's was interviewed on 12/3/18 and 12/6/18 by HM #2 for the investigation. Staff #6's interview indicated the following, "She (staff #6) stated that the night in question was the night of 11/24/18 was the night that she (staff #6) was passing medication to [client A] when [client A] asked for her assistance with passing his medications due to him shaking while holding water and medication cup (sic). [Staff #6] goes on to state what while assisting with holding his water he began to shake and split (sic) on himself. [Staff #6] went on to say that [client A] began to get upset and yell that she (staff #6) had thrown water on him. [Staff #6] said that their (sic) was [staff #7] in the kitchen putting dishes in the			

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	dishwasher. [Staff #6] went on to say that this is when [client A] got up and went to his room. When asked why she (staff #6) did not document this event, [staff #6] stated it had just slipped her mind. In a follow up interview with [staff #6], she (staff #6) stated that she never went into [client A's] room. [Staff #6] went on to say that [client A] went to his bedroom and sat in his chair. When I (HM #2) asked [staff #6] if she did not go into his room, how did she (staff #6) know that [client A] sat in his chair. [Staff #6] said that she knows because she has worked in the house so long that she (staff #6) knows certain sounds and since [client A] walks so heavy, she remembers him taking six or seven steps and then sitting in his chair. I (HM #2) asked [staff #6] where [staff #7] was, and [staff #6] stated that she can not state where [staff #7] was at the time of the incident because she doesn't remember." "Analysis and Findings: Based on the statements gathered during this investigation and the preponderance of evidence it has been found that [staff #6] did in fact throw water on [client A]." "Actions Taken and Follow Up:" "In the next resident meeting, discuss reporting abuse, neglect and exploitation with individuals served." "Terminate [staff #6]." "Retrain staff on documenting behaviors." 3. BDDS report dated 12/22/18 indicated, "[Client A and staff #11] were in [city] at [mall] doing some shopping. [Client A and staff #11] were leaving and loading into the car when [client A] became upset because [staff #11] had not shut his car			

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	door. [Client A] began having a behavior and hit [staff #11]. [Client A] reports after he hit [staff #11], [staff #11] hit him back, and [client A] then hit [staff #11] again before a witness contacted police. [Client A] reported to police he was hit in the back of the head. [Client A] was transported to [hospital]. [Staff #11] was taken to [county jail] with charges of battery... Upon arrival at the hospital, a CT (Computed Tomography) was performed on [client A] that showed no signs of injury or trauma. The hospital was comfortable with releasing [client A] to [ED #1 and HM #2]. [Client A] returned home and head tracking began to observe for any signs of a concussion... Mosaic will open a formal investigation to look into the incident further." "Plan to Resolve: [Staff #11] has been suspended from working at Mosaic and an investigation has been opened. Emergency safeguards have been put into place to ensure [client A's] safety to ensure [staff #11] does not come near the home or [client A]. Mosaic will continue to monitor [client A] for signs of a concussion and have him seen for a follow up appointment. Mosaic will follow the case with [client A's] team and ensure all legal obligations [client A] has in this case are met." Mosaic Investigation Report (MIR) dated 12/31/18 was completed by Home Manager (HM) #3. The MIR indicated the following: "Allegation: On 12/22/18, [County] police contacted Mosaic saying [client A] was being taken to [hospital]. [ED #1 and HM #2] picked up [client A] from the hospital." "Investigative Question: On 12/22/18, did [staff #11] intentionally hit [client A]?"			

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	Staff #7 was interviewed on 12/28/18 by HM #3 for the investigation. Staff #7's interview indicated the following, "[Staff #7] stated that at some point, he (staff #7) does not know what time it was, but that he received a phone call from whom he thought was [staff #11], but it was an officer saying that if someone was close [client A] could be picked up. [Staff #7] stated that the officer said [staff #11] had hit [client A] and someone needed to come get [client A] that he (client A) was going to [hospital]... [Staff #7] stated that he (staff #7) called on call (manager) and spoke with [HM #2]. He (staff #7) also called HM #1 and explained to them what the officer had said happened...". Client A was interviewed on 12/26/18 by HM #3 for the investigation. Client A's interview indicated the following, "[Client A] then stated that he (client A) and [staff #11] got into [staff #11's] car and drove to a big store. While at the store, [client A] stated that [staff #11] was looking for something, but didn't buy anything. [Client A] then stated they went back to [staff #11's] car and that [client A] could not get the car door closed and asked for help. [Client A] stated that [staff #11] was in the car and he (staff #11) asked [client A] to calm down. [Client A] then stated that he (client A) got mad and hit [staff #11]. [Client A] stated he (client A) forgot where he hit [staff #11]. [Client A] then stated [staff #11] hit him (client A) in the back of the head. [Client A] stated that [staff #11] has never hit him before. [Client A] also stated that after [staff #11] hit him,that the police came and told [staff #11] to get out of the car and that they (the police) arrested [staff #11], but they did not put handcuffs on him (staff #11). [Client A] then states that the ambulance came and took him (client A) to the hospital where [ED #1 and HM #2] picked him up and drove him home."			

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	Staff #11 was interviewed on 12/28/18 by HM #3 for the investigation. Staff #11's interview indicated the following, "While at the [city] mall, they (client A and staff #11) went to the food court then to a number of different stores. Once at the mall, [staff #11] states that he got [client A] a wheelchair so that he did not have to walk. [Staff #11] stated that [client A] was in a good mood until it was time to leave and there were a lot of people causing [client A] to get aggravated so he (staff #11) decided it was time to go. [Staff #11] stated he (staff #11) went to get an escort (a mall police officer) to the car because they (the mall) had his ID (Identification Card) to be sure he (staff #11) would bring the chair (wheelchair) back. He (staff #11) states that a mall cop walked he and [client A] to [staff #11's] car so he (the mall police officer) could take the chair back inside and [staff #11] could get his ID back. Once at the car, [staff #11] stated that he (staff #11) opened the door for [client A] and assisted him inside of the car. [Client A's] shoe came off and he (staff #11) put it back on. He (staff #11) went to close the door, and [client A] stated that he could do it. [Staff #11] states he went around to get in on the drivers side and before he could get there, he heard [client A] cussing and beating the dash board. He (staff #11) stated he then tried to put [client A] in a hold as to prevent him from harming himself... while doing so, [client A] punched [staff #11] in the mouth. The cops came over and it was dark, as [staff #11] states his windows are very dark and it was dark outside so they had to shine their flashlights inside of the car to see. By this time, [staff #11] states he had attempted to put [client A] into a hold twice. [Staff #11] stated he was talking to [client A] trying to get him to calm down and letting him know everything was okay. [Staff #11] states he tried to explain to the police who he was and who [client A] was, as well as where he			

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	worked, but they were not listening... [Staff #11] states that he never got a chance to explain or get someone to listen until after [client A] was already gone in the ambulance. [Staff #11] states he explained to the officer and the officer said he wished [staff #11] had said all of that before because he would have just wrote (sic) it up and sent them on their way, but now he has already called his boss who said to take him to jail and let the prosecutor figure it out and that [staff #11] has to go to jail...". "Analysis and Findings: Based on the statements and evidence gathered during the course of this investigation... while attempting to put [client A] in a hold while in the car, [staff #11] inadvertently hit [client A] in the back of the head...". "Actions Taken and Follow Up:" "Terminate [staff #11]." "Retrain staff on [client A's] Behavior Support Plan (BSP)." QIDP #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated staff should not use profanity towards any individual in the home. QIDP #1 stated, "Profanity towards a client is verbally abusive." QIDP #1 indicated clients' BSPs should be followed as written. QIDP #1 stated, "Staff should not deviate from the BSP." QIDP #1 indicated the use of water as a form of discipline is not acceptable. QIDP #1 stated, "Any physical abuse of clients, including hitting is not tolerated." QIDP #1 indicated staff #6 and #11 were terminated from employment. QIDP #1 indicated staff #7 continues to work at the home, but has had administrative observations to ensure he is not being verbally abusive to clients. QIDP			

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	#1 stated, "The culture of the house has really improved in the past month or so. I think we have the right staff there now to care for the clients." This federal tag relates to complaint #IN00280661. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 5 of 8 allegations of abuse, neglect and mistreatment reviewed, the facility failed to report allegations of abuse and verbal and physical aggression of clients A, C, D, F, and Former Client (FC) to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours of the alleged incidents. Findings include: BDDS reports were reviewed on 1/23/19 at 10:00 AM. The review indicated the following: 1. BDDS report dated 10/22/18 indicated, "On 10/22/18 around 2:30 PM, [staff #5] reported to [Home Manager (HM) #1] and [Qualified Intellectual Disabilities Professional (QIDP) #1] that... (On 10/20/18) around 6:00 PM, [Former Client (FC)] approached [staff #5 and #6]... to assist him with locating his body lotion. [Staff #5] reports that she assisted [FC] with locating his lotion and then walked him back to the men's side and informed [staff #8 and #7] that [FC] needed assistance. [Staff #5] then reported that herself	W 0153	Policy and procedure are appropriate. Mosaic staff have been retrained on the Abuse and Neglect policy as well as the Incident Reporting policy to ensure competency in reporting events within 24 hours of occurrence. Responsible Person: House Manger and Program Coordinator	02/22/2019

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	(staff #5) and [staff #6] then began looking through items in the activity cabinet located in the garage situated between the men's side and women's side of the residence. [Staff #5] reported that while in the garage with [staff #6], they overhead [staff #8] say, 'Go on [FC], [expletive] off.' [Staff #5] then went home for the evening around 6:45 PM and [staff #6] resumed normal duties on the women's side until the end of her shift." "Plan to Resolve: [Staff #5 and #6] were both immediately placed off duty on 10/22/18 pending the results of a formal investigation due to failing to report the allegation of VA in a timely manner. [Staff #8] was immediately placed off duty due to being the perpetrator of the alleged VA pending the results of a formal investigation." The BDDS report listed an incident date as 10/20/18. The administrative knowledge date was listed as 10/22/18. The BDDS report for the staff to client VA incident was created on 10/22/18. QIDP #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated all allegations of abuse, neglect, or mistreatment should be reported to administration immediately. QIDP #1 indicated she was unsure why staff #5 did not report the allegation of staff to client VA immediately. QIDP #1 indicated all incidents should be reported to BDDS in 24 hours of administrative knowledge. 2. Client A's record was reviewed on 1/24/19 at 12:30 PM. The review indicated the following: - Client A's Behavior Tracking (BT) dated 1/3/19 indicated, "[Client A] came home from day program upset. He began yelling at [client E] and calling him a '[expletive] r... [expletive]'... [client A]			

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	immediately charged at [client E] and tried hitting him...". BDDS reports were reviewed on 1/23/19 at 10:00 AM. The review did not indicate a report was filed for the client to client VA and PA between clients A and E detailed in client A's 1/3/19 BT. 3. Client A's record was reviewed on 1/24/19 at 12:30 PM. The review indicated the following: - Client A's BT dated 1/18/19 indicated, "(Client A) kept telling a peer (unnamed client) to shut up and threatened to hit that peer. A little later, he (client A) tried to swing back and hit a different peer (unnamed client), but that peer moved...". BDDS reports were reviewed on 1/23/19 at 10:00 AM. The review did not indicate a report was filed for the client to client VA and PA between client A and the unnamed clients detailed in client A's 1/18/19 BT. 4. Client C's record was reviewed on 1/24/19 at 11:20 AM. The review indicated the following: - Client C's BT dated 1/8/19 indicated, "[Client C] started to tell [client F] to get out of the house and cussing her out... [Client C] end (sic) up walking outside yelling she was going to call [HM #1] and get [client F] in trouble...". BDDS reports were reviewed on 1/23/19 at 10:00 AM. The review did not indicate a report was filed for the client to client VA and PA between clients C and F detailed in client C's 1/8/19 BT. 5. Client C's record was reviewed on 1/24/19 at 11:20 AM. The review indicated the following:			

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	- Client C's BT dated 1/15/19 indicated, "(Client C) was cussing... she (client C) was walking out the door went (sic) over to [client D] and said, 'I ain't fat like her (client D)'...". BDDS reports were reviewed on 1/23/19 at 10:00 AM. The review did not indicate a report was filed for the client to client VA between clients C and D detailed in client C's 1/15/19 BT. QIDP #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated all allegations of abuse, neglect, or mistreatment should be reported to administration immediately. QIDP #1 indicated all incidents should be reported to BDDS in 24 hours of administrative knowledge. This federal tag relates to complaint #IN00280661. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 4 of 8 allegations of abuse, neglect, and mistreatment reviewed, the facility failed to thoroughly investigate multiple allegations of abuse and client to client VA (Verbal Aggression) and Physical Aggression (PA) between clients A, C, D, E, F, and unnamed clients. Findings include: 1. Client A's record was reviewed on 1/24/19 at 12:30 PM. The review indicated the following: - Client A's Behavior Tracking (BT) dated 1/3/19	W 0154	Policy and procedure are appropriate. Mosaic staff have been retrained on the Abuse and Neglect policy as well as the Incident Reporting policy to ensure competency in reporting peer to peer events within 24 hours of occurrence to the on call manager. Responsible Person: House Manger and Program Coordinator	02/22/2019

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	indicated, "[Client A] came home from day program upset. He began yelling at [client E] and calling him a '[expletive] r... [expletive]'... [client A] immediately charged at [client E] and tried hitting him...". The review did not indicate an investigation was completed regarding the client to client VA between clients A and E detailed in client A's 1/3/19 BT. 2. Client A's record was reviewed on 1/24/19 at 12:30 PM. The review indicated the following: - Client A's BT dated 1/18/19 indicated, "(Client A) kept telling a peer (unnamed client) to shut up and threatened to hit that peer. A little later, he (client A) tried to swing back and hit a different peer (unnamed client), but that peer moved...". The review did not indicate an investigation was completed regarding the client to client VA and PA between client A and the unnamed clients detailed in client A's 1/18/19 BT. 3. Client C's record was reviewed on 1/24/19 at 11:20 AM. The review indicated the following: - Client C's BT dated 1/8/19 indicated, "[Client C] started to tell [client F] to get out of the house and cussing her out... [Client C] end (sic) up walking outside yelling she was going to call [HM #1] and get [client F] in trouble...". The review did not indicate an investigation was completed regarding the client to client VA and PA between client to client VA and PA between clients C and F detailed in client C's 1/8/19 BT. 4. Client C's record was reviewed on 1/24/19 at			

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	11:20 AM. The review indicated the following: - Client C's BT dated 1/15/19 indicated, "(Client C) was cussing... she (client C) was walking out the door went (sic) over to [client D] and said, 'I ain't fat like her (client D)'...". The review did not indicate an investigation was completed regarding the client to client VA and PA between client to client VA between clients C and D detailed in client C's 1/15/19 BT. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated all incidents of PA and VA between clients require an investigation. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. Based on observation, record review and interview for 2 of 3 sample clients (A and C), plus 3 additional clients (E, F, and G), the QIDP (Qualified Intellectual Disabilities Professional) failed to implement client F's Behavior Support Plan (BSP) in regards to her Forty Five Minute Protocol (FFMP), failed to ensure client A utilized his hearing aids, client C utilized her dentures and glasses, client E utilized his divided plate during dining, client F utilized her glasses, client G utilized her hearing aids, clients A, C, E, F, and G made appropriate choices regarding their adaptive equipment, and failed to ensure staff implemented the prescribed food consistency for clients E and G during mealtimes.	W 0159	Mosaic's QIDP must do at least 1 observation bi-weekly in the Dixie Bee home. Mosaic's QIDP is to observe the staff and ensure they are running the programs correctly and retrain as need to ensure competency. Mosaic's QIDP meets with the ED regularly for needed supports and coaching to ensure any additional supports or needs are met. Responsible Person: Executive Director	02/22/2019

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	Findings include: 1. The QIDP failed to implement client F's BSP in regards to her FFMP. Please see W249. 2. The QIDP failed to ensure client A utilized his hearing aids, client C utilized her dentures and glasses, client E utilized his divided plate during dining, client F utilized her glasses, client G utilized her hearing aids, and clients A, C, E, F, and G made appropriate choices regarding their adaptive equipment. Please see W436. 3. The QIDP failed to ensure staff implemented the prescribed food consistency for clients E and G during mealtimes. Please see W474. 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. Based on observation, interview, and record review for 1 additional client (F), the facility failed to implement client F's Behavior Support Plan (BSP) in regards to her Forty Five Minute Protocol (FFMP). Findings include: Observations were conducted on 1/28/19 from 3:40 PM to 6:10 PM at client F's home. Staff #1, #2,	W 0249	The current BSP in place for client F is appropriate. Staff have been retrained on client F's BSP and her 45 minute protocol that is in place. Responsible Person: House Manger and Program Coordinator	02/22/2019

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	Home Manager (HM) #1, and Qualified Intellectual Disabilities Professional (QIDP) #1 were staff supervising in the home during the observation. At 4:10 PM, staff #1 administered client F's afternoon medication. At 4:30 PM, client F entered the bathroom to take a shower. Staff #1, #2, HM #1, and QIDP #1 did not prompt client F to wait for a shower, or accompany client F into the bathroom. At 4:55 PM, client F walked out of the shower and sat on the living room couch. During the shower, staff #1, #2, HM #1, and QIDP #1 did not check on client F while she was in the bathroom. Staff #2 was interviewed on 1/23/19 at 4:47 PM. Staff #2 indicated client F was in the shower. Staff #2 stated, "She (client F) wanted to take a shower before dinner." Staff #2 indicated she helped client F prepare for the shower. Staff #2 stated, "[Client F] is independent in the bathroom and doesn't need assistance during a shower." Client F's record was reviewed on 1/23/19 at 1:12 PM. The review indicated the following: Client F's BSP dated 12/14/18 indicated the following: "Proactive Strategies:" "FFMP: [Client F] will have limited access to the restroom for 45 minutes following medication administration and meals to deter her from forcing herself to vomit. If [Client F] seeks access to the bathroom during this time frame, she must be accompanied by staff...". Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated client F's BSP should be			

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	followed as written. QIDP #1 stated, "[Client F] should be in line of sight for 45 minutes after medication administration due to her attempting to vomit to get rid of her medications." QIDP #1 indicated staff was trained on client F's FFMP and should be implementing it after each medication pass. 9-3-4(a)			
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sample clients (B), the facility failed to ensure a recommendation from client B's specialist was implemented for preventative care. Findings include: Client B's record was reviewed on 1/24/19 at 10:05 AM. Client B's Annual Physical with his PCP (Primary Care Physician) dated 4/2/18 indicated, "Recommend five year colonoscopy due to (client B's) mom's history of colon cancer. Due February 2018." Client B's record did not indicate a colonoscopy for client B following his PCP's recommendation on 4/2/18. Registered Nurse (RN) #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated recommendations from specialists should be implemented. RN #1 was unable to provide documentation of a colonoscopy for client B as	W 0322	Mosaic has scheduled a colonoscopy for client B for 4/11/2019 . Responsible Person: Health Services Coordinator	02/22/2019

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	recommended by his PCP on 4/2/18. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview for 5 of 7 clients with adaptive equipment (A, C, E, F, and G), the facility failed to ensure client A utilized his hearing aids, client C utilized her dentures and glasses, client E utilized his divided plate during dining, client F utilized her glasses, client G utilized her hearing aids, and clients A, C, E, F, and G made appropriate choices regarding their adaptive equipment. Findings include: 1. Observations were conducted at the group home on 1/23/19 from 6:04 AM to 7:45 AM, and from 3:40 PM to 6:10 PM. Observations were conducted at client A's day service provider on 1/24/19 from 12:16 PM to 12:30 PM. During observations, client A did not utilize his hearing aid. Staff did not encourage client A to utilize his hearing aid. Client A's record was reviewed on 1/23/19 at 12:05 PM. The review indicated the following: Client A's Health Risk Plan (HRP) dated 1/9/19 indicated, "Hearing aid left ear daily."	W 0436	Mosaic's staff have been retrained on Adaptive Equipment needs and each individuals programs. Each staff were given a test at the end of the training to ensure competency on Adaptive Equipment and helping individuals to make appropriate decisions with their adaptive equipment needs. . Responsible Person: Program Coordinator	02/22/2019

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	Client A's Auditory Visit dated 5/4/17 indicated, "Picked up hearing aid." RN (Registered Nurse) #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client A has a hearing aid and should be wearing it daily. RN #1 indicated client A has the left hearing aid in the home. RN #1 stated, "Sometimes he wears it, sometimes he doesn't. Staff should be prompting him to wear it each day." 2. Observations were conducted at the group home on 1/23/19 from 6:04 AM to 7:45 AM, and from 3:40 PM to 6:10 PM. During observations, client C did not utilize her glasses or dentures. Staff did not encourage client C to utilize her glasses or dentures. Client C's record was reviewed on 1/23/19 at 12:35 PM. The review indicated the following: Client C's HRP dated 1/9/19 indicated, "Adaptive Equipment: Upper dentures, doesn't wear them. Glasses." Client C's Dental Visit dated 5/25/15 indicated, "Dentures fixed." Client C's Vision Visit dated 8/29/18 indicated, "Glasses. Constant wear." Client C's Quarterly Physical Exam (QPE) dated 10/19/18 indicated, "Adaptive Equipment: She (client C) has dentures, but won't wear them and glasses that she has in her bag that should be on. They are fairly new and she is not used to them." Client C's Vision Impairment Protocol dated 1/9/19 indicated, "[Client C] has a history of refusing to wear her glasses when needed...".			

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Client C's HRP dated 1/9/19 indicated, "Adaptive Equipment: Upper dentures, doesn't wear them. Glasses."

Client C's Monthly Review of Goals (MRG) dated November 2018 did not indicate a goal for client C's adaptive equipment use in regards to her dentures and glasses.

RN #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client C has glasses and an upper denture and should be wearing them daily. RN #1 indicated client C has the dentures and glasses in the home. RN #1 stated, "She will wear the glasses sometimes. Most of the time, she'll argue with staff about the dentures. Either way, staff should be prompting her to wear her adaptive equipment each day."

Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated client C needs assistance with utilizing her adaptive equipment. QIDP #1 indicated she was responsible for revising goals for client C. QIDP #1 indicated she was unsure why she did not create an adaptive equipment goal for client C.

3. Observations were conducted at the group home on 1/23/19 from 6:04 AM to 7:45 AM, and from 3:40 PM to 6:10 PM. During observations, client E did not utilize his divided plate during mealtimes. Staff did not encourage client E to utilize his divided plate.

Client E's record was reviewed on 1/23/19 at 12:44 PM. The review indicated the following:

Client E's HRP dated 1/9/19 indicated, "Adaptive

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	Equipment: Divided plate." RN #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client E has a divided plate to be utilized during meals. RN #1 indicated client E has the divided plate in the home. RN #1 indicated staff should be prompting him to utilize his divided plate during mealtimes. 4. Observations were conducted at the group home on 1/23/19 from 6:04 AM to 7:45 AM, and from 3:40 PM to 6:10 PM. During observations, client F did not utilize her glasses. Staff did not encourage client F to utilize her eyeglasses until 4:00 PM. Client F indicated she did not know where her eyeglasses were located. Staff attempted to assist client F in locating her eyeglasses, but were unsuccessful. Client F's record was reviewed on 1/23/19 at 1:12 PM. The review indicated the following: Client F's HRP dated 1/9/19 indicated, "Adaptive Equipment: Glasses." RN #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client F has glasses. RN #1 indicated client F has glasses in the home. RN #1 stated, "She'll have them one minute, then she'll lose them." RN #1 indicated staff should be prompting her to utilize her eyeglasses daily. 5. Observations were conducted at the group home on 1/23/19 from 6:04 AM to 7:45 AM, and from 3:40 PM to 6:10 PM. During observations, client G did not utilize her hearing aids. Staff did not encourage client G to utilize her hearing aids. Client G's record was reviewed on 1/23/19 at 1:30 PM. The review indicated the following:			

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	Client G's HRP dated 1/9/19 indicated, "Adaptive Equipment: Bilateral hearing aids...". Client G's Monthly Review of Goals (MRG) dated November 2018 did not indicate a goal for client C's adaptive equipment use in regards to her hearing aids. Registered Nurse (RN) #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client G has hearing aids. RN #1 stated, "I don't know if she has them in the house. She likes to hide them." RN #1 indicated staff should be prompting her to utilize her hearing aids daily. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/24/19 at 2:00 PM. QIDP #1 indicated client G needs assistance with utilizing her adaptive equipment. QIDP #1 indicated she was responsible for revising goals for client G. QIDP #1 indicated she was unsure why she did not create an adaptive equipment goal for client G. 9-3-7(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 2 additional clients (E and G), the facility failed to ensure staff implemented the prescribed food consistency for clients E and G during mealtimes. Findings include: 1. Observations were done at the home on 1/23/19	W 0474	Mosaic's staff have been retrained on each client's dietary needs. Responsible Person: Program Coordinator	02/22/2019

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	from 6:04 AM to 7:45 AM. At 6:45 AM, client E sat at the dining room table with his food in front of him. Client E's breakfast was waffles and a sausage patty. Staff #4 immediately cut client E's waffles into bite size pieces. Staff #4 did not cut client E's sausage patty into bite size pieces or provide any condiments to the sausage patty. At 6:50 AM, client E ate his sausage patty. Staff #4 was interviewed on 1/23/19 at 6:52 AM. Staff #4 indicated she prepared client E's breakfast. Staff #4 stated, "I cut up [client E's] waffle so he could eat it easier." Staff #4 indicated she didn't think client E's sausage patty needed to be cut up. Client E's record was reviewed on 1/23/19 at 12:44 PM. Client E's Health Risk Plan (HRP) dated 1/9/19 indicated, "Diet: Mechanical soft with ground meat moistened with condiments. Food cut into half inch pieces...". Registered Nurse (RN) #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client E's dietary orders should be followed. RN #1 indicated client E's food should be cut into half inch pieces and meats should be mechanical soft with a condiment to moisten it. RN #1 stated, "[Client E] has this diet plan because he is at risk for aspiration." 2. Observations were done at the home on 1/23/19 from 3:40 PM to 6:10 PM. At 5:51 PM, staff #2 assisted client G to the dining room table. At 5:57 PM, clients began serving food for dinner in a family style manner. Client G's dinner was salad, lasagna, and garlic bread. Staff #1, staff #2, HM #1, and QIDP #1 were present for dinner. Staff did not cut client G's garlic bread or lasagna into bite size pieces. At 6:03 PM, client G ate her garlic			

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	bread and lasagna. Client G's record was reviewed on 1/23/19 at 1:30 PM. Client G's HRP dated 1/9/19 indicated, "Diet: Food cut into half inch pieces...". RN #1 was interviewed on 1/24/19 at 2:00 PM. RN #1 indicated client G's dietary orders should be followed. RN #1 indicated client G's food should be cut into half inch pieces. RN #1 stated, "[Client G] has this diet plan because she is at risk for aspiration and choking." 9-3-8(a)			