

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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	<p>This visit was for the investigation of complaint #IN00455941.</p> <p>Complaint #IN00455941: Federal/state deficiencies related to the allegation(s) are cited at W149 and W154.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 3/24, 3/25, 3/26, 3/27, 3/28 and 4/1/25.</p> <p>Facility Number: 009969 Provider Number: 15G676 Aims Number: 200129000</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 4/8/25.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>Based on observation, record review and interview for 2 of 2 sample clients (A and B), plus 1 additional client (C), the governing body failed to exercise general policy, budget, and operating direction to ensure the home was in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/24/25 from 2:29 pm to 3:48 pm. Clients A, B and C were present for the duration of the</p>	W 0104	<p>1. Wood was removed from the deck. Closet knobs were added. Light switch was cleaned. Kitchen cupboard door was replaced.</p> <p>2. Quality Coordinator will do monthly residential walk throughs of ICF homes, identifying potential maintenance concerns and submit maintenance tickets as needed.</p>	04/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Rachel Pemberton

Executive Director

04/15/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>observation period. The following environmental issues were noted affecting clients A, B and C:</p> <ol style="list-style-type: none"> <li>1. On the deck in the backyard were black pieces of wood leaning up against the house.</li> <li>2) The closet in client B's bedroom did not have knobs.</li> <li>3) The wall and light switch in client B's bedroom had a dark colored substance on it.</li> <li>5) The cabinet door in the kitchen had broken off and was sitting on the floor.</li> </ol> <p>An interview with Staff #2 was conducted on 3/24/25 at 2:35 pm. Staff #2 stated, "Maintenance needs to set up the drawers. They have been sitting here for a couple of weeks. There is nothing in the closet. We don't have a way to open it without knobs. I wish maintenance would take care of it."</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "The home should be clean. The light switches should be cleaned. The closet should have doorknobs. There should not be boxes sitting in a bedroom."</p> <p>An interview with the Assistant Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "The home should be clean and in good repair. All closets should have doorknobs. A maintenance ticket needs to be put in so that old bed frame is taken off the back porch."</p> <p>9-3-1(a)</p>		<p>3. Staff will be retrained on submitting maintenance tickets for household needs regarding repairs.</p> <p>4. Staff training will be audited by Staff Development Specialist and Maintenance tickets will be reviewed and prioritized twice a month with Maintenance Specialist.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 1703 WOODMONT DR 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
W 0149  Bldg. 00	<p><b>483.420(d)(1)</b> <b>STAFF TREATMENT OF CLIENTS</b></p> <p>Based on record review and interview for 2 of 2 sample clients (A and B), plus 2 additional clients (C and D), the facility failed to implement its written policies and procedures to prevent abuse of clients A, B, C and D.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 3/24/25 at 12:24 pm.</p> <p>1. A BDS report dated 1/26/25 indicated the following: "... On 1/26/25, [client D] was sitting by the front door. He was hit on his head several times by [client B]. Staff redirected [client B] and checked [client D] for injuries. None were noted at the time. Staff ensured [client D's] safety by moving him next to staff so staff could intervene if needed. Plan to Resolve: [Client D] will be given emotional support and staff will continue to observe [client D] for injuries. He will be administered PRN (as needed) medications for pain. ..."</p> <p>An investigation dated 1/28/25 indicated the following: "...Conclusion and Recommendations: [Client B] hit [client D] multiple times unprovoked. Redirection only for a little amount of time since [client B] is not a client at this time. QIDP (Qualified Intellectual Disability Professional) will follow up with superiors to see how Mosaic handles the situation. Corrective Actions to Take Place: QIDP will follow up with supervisor to find out the best options to handle the situation. Keep [client D] and [client B] separated. ...."</p>	W 0149	<p>1. Peer to Peer Abuse Investigation forms were updated to include all mandatory parts of an investigation.</p> <p>2. The new peer to peer investigation form will be used for all investigations moving forward to ensure all parts of the investigation are reviewed and documented.</p> <p>3. Peer to Peer incidents will be investigated and reviewed at Safety Committee.</p> <p>4. Peer to Peer incidents will be investigated and reviewed at Safety Committee.</p>	04/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>The investigation was not thorough as evidenced by:</p> <p>There were no interviews with staff and clients.</p> <p>There was no review of client D's plans.</p> <p>There were no corrective actions to prevent future incidents.</p> <p>2. A BDS report dated 2/1/25 indicated the following:</p> <p>"... On 1/31/25 [client A] became agitated while waiting for her mother to arrive for a scheduled visit, who was running behind schedule. While upset, [client A] struck [client D] on the top of his head with a closed fist. Staff quickly redirected [client A]. A short time later while still upset, [client A] grabbed [client D's] hair and pulled his hair jerking his head to the side. Staff again redirected [client A]. As [client A's] agitation continued to escalate throughout the evening, Staff requested police and paramedic assistance to attempt to have [client A] taken to the Emergency Room for a psychological evaluation. Her mother refused, came to the home, and took [client A] out for dinner. Mosaic informed her mother that an emergency meeting will be scheduled to address [client A's] psychological needs. Plan to Resolve: Mosaic will conduct a peer to peer investigation, arrange an emergency IDT (interdisciplinary Team) meeting. Follow the individual's BSP (Behavior Support Plan), provide emotional support, and ensure and security of individuals with increased training for de-escalation. ..."</p> <p>An investigation dated 2/13/25 indicated the following: "...Conclusion and Recommendations: At the emergency IDT meeting, [mom] gave us a list of things [client A] likes to do at home. She also brought a Velcro calendar to show me that</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>she uses it with [client A] at home. She said [client A] thrives with this calendar. QIDP will work with [mom] to get pictures that mean something to [client A] to put on one. QIDP will also get a calendar for the home and Velcro pieces with clip art until we have better pictures. [Mom] will bring over chair cushions for the rocking chair she has for [client A] and bring it to the home for her use. [Mom] has told her job that she no longer works Mondays and Fridays to prevent behaviors on the days that she is used to being picked up. Staff are no longer to tell [client A] that her mom is coming that day. [Client A] seems to know without the staff telling her. Staff will still refrain from telling her that her mom is coming later. [Mom] will call 30 minutes before her arrival so staff can get [client A] ready. [Nurse] recommended looking into [client A's] birth control and seeing if the doctor would prescribe her birth control without the placebo week to prevent her from having PMS (premenstrual syndrome). [Mom] said she is aware the [client A] struggles with behaviors about 7 days before her period. Staff reports that showers help calm [client A] down. This will be relayed to all staff. [Mom] also suggested seeing if the psychiatric doctor would increase her Duloxetine (used to treat mood disorder). [Client A] has been on this medication for a while and has had good results with it.</p> <p>Corrective Actions to Take Place: We are implementing several things to prevent this from escalating this far again. [Mom] wants emergency services called for her behaviors only if she or her husband cannot make it and [client A] is harming herself or others. The team agreed that this would be a last resort. ... "</p> <p>The investigation was not thorough as evidenced by:</p> <p>There were no interviews with staff and clients.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>There was no review of the client's plans.</p> <p>3. A BDS report dated 3/7/25 indicated the following:</p> <p>"... On 2/28/25, [client A] came out of her bedroom and hit her housemate [client B] in the front of her head, open-handed, three times. While upset, [client A] hit a housemate [client C] on the top of his head with a closed fist. The staff quickly redirected [client A]. No injuries were noted from this incident. Plan to Resolve: Follow the individual's BSP, provide emotional support, and ensure the safety and security of individuals. ..."</p> <p>An investigation dated 3/12/25 indicated the following: "...Conclusion and Recommendations: Work on getting next BSP complete and train staff. ... Corrective Actions to Take Place: track behaviors in [client A's] behavior tracker. Bring results to her next psychiatrist appointment. ... "</p> <p>The investigation was not thorough as evidenced by:</p> <p>There were no interviews with staff and clients.</p> <p>There was no review of the clients' plans.</p> <p>There were no corrective actions to prevent future incidents.</p> <p>4. A BDS report dated 3/7/25 indicated the following:</p> <p>"... On 3/5/25, [client C] was eating at the dining room table. When he finished, he tried offering [client A] his chair so she could sit and eat. [Client C] attempted to provide it to her three times. On the third time, [client A] hit him on his head with an open hand. The staff redirected [client A]. [Client C] made crying noises for 2-3 seconds and then offered to shake [client A's] hand. [Client A] shook hands with him. No injuries were noted from this incident. Plan to Resolve: Provide</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>emotional support and ensure the safety and security of individuals. ..."</p> <p>An investigation dated 3/6/25 indicated the following: "...Conclusion and Recommendations: Staff need to watch for signs of irritation for [client A]. Be sure to put in Behavior Tracker. Corrective Actions to Take Place: Follow BSP. Watch for signs of irritation to prevent further incidents. ... "</p> <p>The investigation was not thorough as evidenced by:</p> <p>There were no interviews with staff and clients.</p> <p>There was no review of the client's plans.</p> <p>There were no corrective actions to prevent future incidents.</p> <p>5. A BDS report dated 3/7/25 indicated the following:</p> <p>"... On 3/1/25, [client A] was in her room watching her television. She came out of her bedroom and hit [client B] in the front of her head, open handed. The staff quickly redirected [client A]. No injuries were noted from this incident. Plan to Resolve: Follow the individual's BSP, provide emotional support, and ensure the safety and security of individuals. ..."</p> <p>An investigation dated 3/12/25 indicated the following: "...Conclusion and Recommendations: Follow BSP. ... Corrective Actions to Take Place: Behavior Tracking. ... "</p> <p>The investigation was not thorough as evidenced by:</p> <p>There were no interviews with staff and clients.</p> <p>There was no review of client A's plans.</p> <p>There were no corrective actions to prevent future incidents.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "The clients should be safe in the home. All staff should be following the ANE (Abuse, Neglect and Exploitation) policy. Investigations should include what happened, review for documents, interviews from staff and clients and how to prevent reoccurrence."</p> <p>An interview with the Associate Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "No clients should be getting hit by other peers. Staff should be following the policy. The investigations should include interviews with staff and clients, date and time of incident, if any injuries occurred, who was involved in the incident and a plan to prevent reoccurrences."</p> <p>The facility's Policy and Procedure on ANE dated 5/25/23 was reviewed on 3/24/25 at 1:01 pm and indicated the following "... To affirm that Mosaic in Indiana prohibits abuse, neglect, or exploitation of the individuals the agency serves and to inform employees of their responsibilities as mandatory reporters. As identified in the Organization Wide Policy and Procedure Manual, Mosaic in Indiana will do everything reasonably possible to provide for the safety and well-being of each client.</p> <p>Abuse, neglect and exploitation of clients are strictly prohibited.... Investigation: The agency will conduct an investigation on all alleged incidents of abuse, neglect, or exploitation...All ANE allegations must be fully investigated, and all BDDS mandatory components included as part of the investigation. Mandatory components for investigations and reviews as addressed in this policy include:</p> <p>a. A clear statement indicating why the</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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 0153  Bldg. 00	<p>investigation/review is being conducted along with the nature of the allegation/event (e.g., allegation of neglect, etc.).</p> <p>b. A clear statement of the event or alleged event in a time-line format including what, where, and when the event happened or is alleged to have happened.</p> <p>c. Identification by name and title of all involved parties or alleged involved parties</p> <p>d. Signed and dated statements from all involved parties, including all actual and potential witnesses to the event or alleged event.</p> <p>e. A statement describing all records and other document review associated with the event or alleged event.</p> <p>f. Copies of all records and other documents reviewed that provide evidence supporting the findings of the investigation or review.</p> <p>g. If there are any discrepancies/conflicts between the evidence gathered, the discrepancy is resolved and/or explained.</p> <p>h. A determination if rights have been violated, if services and/or care were not provided or were not appropriately provided, if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed.... A definitive description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation or review, including completion dates for each corrective action. ...."</p> <p>This federal tag relates to complaint #IN00455941.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>Based on record review and interview for 2 of 2</p>	W 0153	1. State reportable incidents will	04/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>sample clients (A and B), plus 1 additional client (C), the facility failed to immediately report 2 allegations of abuse and neglect for clients A, B and C, to the Bureau of Disabilities Services (BDS) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 3/24/25 at 12:24 pm.</p> <p>1. A BDS report dated 3/7/25 indicated the following:          "... On 2/28/25, [client A] came out of her bedroom and hit her housemate [client B] in the front of her head, open-handed, three times. While upset, [client A] hit a housemate [client C] on the top of his head with a closed fist. The staff quickly redirected [client A]. No injuries were noted from this incident. Plan to Resolve: Follow the individual's BSP, provide emotional support, and ensure the safety and security of individuals. ..."          The incident occurred on 2/28/25 and was reported to BDS on 3/7/25. The incident wasn't reported within 24 hours.</p> <p>2. A BDS report dated 3/7/25 indicated the following:          "... On 3/1/25, [client A] was in her room watching her television. She came out of her bedroom and hit [client B] in the front of her head, open handed. The staff quickly redirected [client A]. No injuries were noted from this incident. Plan to Resolve: Follow the individual's BSP, provide emotional support, and ensure the safety and security of individuals. ..."          The incident occurred on 3/1/25 and was reported to BDS on 3/7/25. The incident wasn't reported within 24 hours.</p>		<p>be submitted within 24 hours of knowledge</p> <p>2. Incident tracking will include date of knowledge and date of submission to allow for follow up with staff on late reports.</p> <p>3. All supervisors will be retrained on state reportable guidelines</p> <p>4. Quality Coordinator reviews incident tracking and presents data at Safety Committee.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>3. A BDS report dated 3/7/25 indicated the following: "... On 3/5/25, [client C] was eating at the dining room table. When he finished, he tried offering [client A] his chair so she could sit and eat. [Client C] attempted to provide it to her three times. On the third time, [client A] hit him on his head with an open hand. The staff redirected [client A]. [Client C] made crying noises for 2-3 seconds and then offered to shake [client A's] hand. [Client A] shook hands with him. No injuries were noted from this incident. Plan to Resolve: Provide emotional support and ensure the safety and security of individuals. ..." The incident occurred on 3/5/25 and was reported to BDS on 3/7/25. The incident wasn't reported within 24 hours.</p> <p>4. A BDS report dated 3/11/25 indicated the following: "...On 3/9/25, [client B] was in the bedroom. When staff came in to assist [client B], there was blood on the back of [client B's] head. EMS (Emergency Medical Services) was called to assess her head, and they discovered it was from her picking her head. They didn't need to take her to the hospital. Staff cleaned the wound as tolerated. ..." The incident occurred on 3/9/25 and was reported to BDS on 3/11/25. The incident wasn't reported within 24 hours.</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "All BDS incident reports should be submitted within 24 hours."</p> <p>An interview with the Associate Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "The BDS incident reports should be submitted within 24 hours of knowledge. We have</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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 0154  Bldg. 00	<p>changed our tracking system to make sure they are submitted."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>Based on record review and interview for 2 of 2 sample clients (A and B), plus 2 additional clients (C and D), the facility failed to conduct thorough investigations for allegations of abuse and neglect for clients A, B, C and D.</p> <p>Findings include:</p> <p>The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 3/24/25 at 12:24 pm.</p> <p>1. A BDS report dated 1/26/25 indicated the following: "... On 1/26/25, [client D] was sitting by the front door. He was hit on his head several times by [client B]. Staff redirected [client B] and checked [client D] for injuries. None were noted at the time. Staff ensured [client D's] safety by moving him next to staff so staff could intervene if needed. Plan to Resolve: [Client D] will be given emotional support and staff will continue to observe [client D] for injuries. He will be administered PRN (as needed) medications for pain. ...."</p> <p>An investigation dated 1/28/25 indicated the following: "...Conclusion and Recommendations: [Client B] hit [client D] multiple times unprovoked. Redirection only for a little amount of time since [client B] is not a client at this time. QIDP (Qualified Intellectual Disability Professional) will</p>	W 0154	<p>1. Peer to Peer Abuse Investigation forms were updated to include all mandatory parts of an investigation.</p> <p>2. The new peer to peer investigation form will be used for all investigations moving forward to ensure all parts of the investigation are reviewed and documented.</p> <p>3. Peer to Peer incidents will be investigated and reviewed at Safety Committee.</p> <p>4. Peer to Peer incidents will be investigated and reviewed at Safety Committee.</p>	04/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>follow up with superiors to see how Mosaic handles the situation. Corrective Actions to Take Place: QIDP will follow up with supervisor to find out the best options to handle the situation. Keep [client D] and [client B] separated. ... "</p> <p>The investigation was not thorough as evidenced by:</p> <p>There were no interviews with staff and clients.</p> <p>There was no review of client D's plans.</p> <p>There were no corrective actions to prevent future incidents.</p> <p>2. A BDS report dated 2/1/25 indicated the following:</p> <p>"... On 1/31/25 [client A] became agitated while waiting for her mother to arrive for a scheduled visit, who was running behind schedule. While upset, [client A] struck [client D] on the top of his head with a closed fist. Staff quickly redirected [client A]. A short time later while still upset, [client A] grabbed [client D's] hair and pulled his hair jerking his head to the side. Staff again redirected [client A]. As [client A's] agitation continued to escalate throughout the evening, Staff requested police and paramedic assistance to attempt to have [client A] taken to the Emergency Room for a psychological evaluation. Her mother refused, came to the home, and took [client A] out for dinner. Mosaic informed her mother that an emergency meeting will be scheduled to address [client A's] psychological needs. Plan to Resolve: Mosaic will conduct a peer to peer investigation, arrange an emergency IDT (interdisciplinary Team) meeting. Follow the individual's BSP (Behavior Support Plan), provide emotional support, and ensure and security of individuals with increased training for de-escalation. ..."</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>An investigation dated 2/13/25 indicated the following: "...Conclusion and Recommendations: At the emergency IDT meeting, [mom] gave us a list of things [client A] likes to do at home. She also brought a Velcro calendar to show me that she uses it with [client A] at home. She said [client A] thrives with this calendar. QIDP will work with [mom] to get pictures that mean something to [client A] to put on one. QIDP will also get a calendar for the home and Velcro pieces with clip art until we have better pictures. [Mom] will bring over chair cushions for the rocking chair she has for [client A] and bring it to the home for her use. [Mom] has told her job that she no longer works Mondays and Fridays to prevent behaviors on the days that she is used to being picked up. Staff are no longer to tell [client A] that her mom is coming that day. [Client A] seems to know without the staff telling her. Staff will still refrain from telling her that her mom is coming later. [Mom] will call 30 minutes before her arrival so staff can get [client A] ready. [Nurse] recommended looking into [client A's] birth control and seeing if the doctor would prescribe her birth control without the placebo week to prevent her from having PMS (premenstrual syndrome). [Mom] said she is aware the [client A] struggles with behaviors about 7 days before her period. Staff reports that showers help calm [client A] down. This will be relayed to all staff. [Mom] also suggested seeing if the psychiatric doctor would increase her Duloxetine (used to treat mood disorder). [Client A] has been on this medication for a while and has had good results with it.</p> <p>Corrective Actions to Take Place: We are implementing several things to prevent this from escalating this far again. [Mom] wants emergency services called for her behaviors only if she or her husband cannot make it and [client A] is harming herself or others. The team agreed that this would</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>be a last resort. ..."</p> <p>The investigation was not thorough as evidenced by: There were no interviews with staff and clients. There was no review of the client's plans.</p> <p>3. A BDS report dated 3/7/25 indicated the following: "... On 2/28/25, [client A] came out of her bedroom and hit her housemate [client B] in the front of her head, open-handed, three times. While upset, [client A] hit a housemate [client C] on the top of his head with a closed fist. The staff quickly redirected [client A]. No injuries were noted from this incident. Plan to Resolve: Follow the individual's BSP, provide emotional support, and ensure the safety and security of individuals. ..."</p> <p>An investigation dated 3/12/25 indicated the following: "...Conclusion and Recommendations: Work on getting the next BSP complete and train staff. ... Corrective Actions to Take Place: track behaviors in [client A's] behavior tracker. Bring results to her next psychiatrist appointment. ... "</p> <p>The investigation was not thorough as evidenced by: There were no interviews with staff and clients. There was no review of the clients' plans. There were no corrective actions to prevent future incidents.</p> <p>4. A BDS report dated 3/7/25 indicated the following: "... On 3/5/25, [client C] was eating at the dining room table. When he finished, he tried offering [client A] his chair so she could sit and eat. [Client C] attempted to provide it to her three times. On the third time, [client A] hit him on his head with</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>an open hand. The staff redirected [client A]. [Client C] made crying noises for 2-3 seconds and then offered to shake [client A's] hand. [Client A] shook hands with him. No injuries were noted from this incident. Plan to Resolve: Provide emotional support and ensure the safety and security of individuals. ...."</p> <p>An investigation dated 3/6/25 indicated the following: "...Conclusion and Recommendations: Staff need to watch for signs of irritation for [client A]. Be sure to put in Behavior Tracker. Corrective Actions to Take Place: Follow BSP. Watch for signs of irritation to prevent further incidents. ...."</p> <p>The investigation was not thorough as evidenced by: There were no interviews with staff and clients. There was no review of the client's plans. There were no corrective actions to prevent future incidents.</p> <p>5. A BDS report dated 3/7/25 indicated the following: "... On 3/1/25, [client A] was in her room watching her television. She came out of her bedroom and hit [client B] in the front of her head, open handed. The staff quickly redirected [client A]. No injuries were noted from this incident. Plan to Resolve: Follow the individual's BSP, provide emotional support, and ensure the safety and security of individuals. ...."</p> <p>An investigation dated 3/12/25 indicated the following: "...Conclusion and Recommendations: Follow BSP. .... Corrective Actions to Take Place: Behavior Tracking. ...."</p> <p>The investigation was not thorough as evidenced</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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 0210  Bldg. 00	<p>by: There were no interviews with staff and clients. There was no review of client A's plans. There were no corrective actions to prevent future incidents.</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "The clients should be safe in the home. All staff should be following the ANE (Abuse, Neglect and Exploitation) policy. Investigations should include what happened, review for documents, interviews from staff and clients and how to prevent reoccurrence."</p> <p>An interview with the Associate Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "No clients should be getting hit by other peers. Staff should be following the policy. The investigations should include interviews with staff and clients, date and time of incident, if any injuries occurred, who was involved in the incident and a plan to prevent reoccurrences."</p> <p>This federal tag relates to complaint #IN00455941.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure client B had a vision exam conducted within the first 30 days of placement.</p> <p>Findings include:</p>	W 0210	<p>1 Vision Exam is scheduled.</p> <p>2. Vision appointment paperwork will be collected at Transition meetings or scheduled post-admission meeting within 30 days. This is added to the Admissions Checklist.</p>	04/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 1703 WOODMONT DR 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
W 0226  Bldg. 00	<p>Client B's records were reviewed on 3/25/25 at 3:12 pm. Client B's admission date was 2/25/25.</p> <p>Client B's record did not include evidence of a vision evaluation.</p> <p>An interview with the nurse was not conducted due to the nurse being terminated this week.</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "All medical appointments should be completed within the first 30 days of placement."</p> <p>An interview with the Associate Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "We need to get a vision exam completed. It should have been done within 30 days of placement."</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to ensure client B had an Individualized Support Plan (ISP) prepared, completed, and implemented within 30 days of admission.</p> <p>Findings include:</p> <p>Client B's records were reviewed on 3/25/25 at 3:12 pm. Client B's admission date was 2/25/25.</p> <p>During client B's record review, there was no Individualized Support Plan (ISP) to review.</p> <p>During the survey, the facility did not provide documentation of client B's ISP.</p>	W 0226	<p>3. Admission Committee was created and will review all transition documents prior to admission to ensure completion of all required documents.</p> <p>4. Admission Committee was created and will review all transition documents prior to admission to ensure completion of all required documents.</p> <p>Appointments will be tracked on an Appointment tracker and will be reviewed at least monthly by Health Service Associates.</p> <p>1. ISP will be completed within 30 days of admission for new admits.</p> <p>2. All ISP due dates were audited to ensure completion of new admits within 30 days.</p> <p>3. QIDP will be retrained on ISP requirements of ISP completion</p> <p>4. ISP tracking is created and will be monitored monthly by Quality Coordinator.</p>	04/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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 0351  Bldg. 00	<p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "We currently don't have an ISP. We had her 30 day meeting yesterday. We are working on completing her ISP."</p> <p>An interview with the Associate Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "We don't have an ISP completed. The ISP should be implemented within 30 days of placement."</p> <p>9-3-4(a)</p> <p>483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE</p> <p>Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure client B's dental exam was completed within 30 days of admission.</p> <p>Findings include:</p> <p>Client B's records were reviewed on 3/25/25 at 3:12 pm. Client B's admission date was 2/25/25. Client B's record did not include evidence of a dental evaluation.</p> <p>An interview with the nurse was not conducted due to the nurse being terminated this week.</p> <p>An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 3/28/25 at 1:04 pm. The QIDP stated, "All medical appointments should be completed within the first 30 days of placement."</p>	W 0351	<p>1 Dental Exams will be scheduled within 30 days of admission</p> <p>2. Dental appointment paperwork will be collected at Transition meetings or scheduled post-admission meeting within 30 days. This is added to the Admissions Checklist.</p> <p>3. Admission Committee was created and will review all transition documents prior to admission to ensure completion of all required documents.</p> <p>4. Admission Committee was created and will review all transition documents prior to admission to ensure completion of all required documents.</p>	04/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G676	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER  MOSAIC		STREET ADDRESS, CITY, STATE, ZIP COD 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
	An interview with the Associate Director (AD) was conducted on 3/28/25 at 2:03 pm. The AD stated, "We need to get a dental exam completed. It should have been done within 30 days of placement."  9-3-6(a)		Appointments will be tracked on an Appointment tracker and will be reviewed at least monthly by Health Service Associates.	