STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G676	A. BUILDING -- B. WING	03/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/28/23 Facility Number: 009969 Provider Number: 15G676 AIM Number: 200129000 At this Emergency Preparedness survey, Mosaic was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 5 certified beds. All 5 beds are certified for Medicaid. At the time of the survey, the census was 5. Quality Review completed on 03/30/23	E 0000		
E 0031 Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Pemberton	Executive Director	04/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants.	E 0031	E031: Mosaic will ensure that IDOH "via https:gateway.isdh.in.gov or incidents@isdh.in.gov", Indiana Bureau of Development Disability Services and Indiana Protective and Advocacy Services are included in the locations Emergency Preparedness Plan in the contact listing in the case of	04/28/2023

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	Findings include: Based on record review and interview on 03/28/23 between 10:35 a.m. and 11:44 a.m. with the Program Manager the emergency preparedness plan did not address the following items: 1) IDOH via https:gateway.isdh.in.gov or incidents@isdh.in.gov 2) Indiana Bureau of Development Disability Services 3) Indiana Protective and Advocacy Services Based on interview concurrent with record review with the Program Manager it was stated this policy did not contain information concerning the aforementioned items above listed as 1, 2 and 3 listed above. Furthermore, the Program Manager. added all current information he was aware of for the facility Emergency Preparedness program was supposed to be contained within the folder he provided for record review. Findings were discussed with the Program Manager at exit conference.		an emergency event. Staff will be trained on EPP Mosaic will monitor annual EPP trainings by QIDP	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

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	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or	E 0039	E039: Mosaic will complete an annual facility based functional exercise and document the exercise findings, results and needed improvements. Mosaic will hold an additional annual exercise of choice in the form of a tabletop exercise and document findings, results and needed improvements. Drills be trained on with staff 4/28 by Quality Coordinator Drill will be monitored at monthly safety committee.	04/28/2023

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Program Manager on 03/28/23 between 10:35 a.m. and 11:45 a.m., the following was not available for review: a) No documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency. b) No documentation of an additional annual exercise of choice: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster drill, a tabletop exercise, or a workshop. Based on interview at the time of records review, the Program Manager stated the documentation was potentially at the main office hub, but was unable to be found at the time of the survey. This finding was reviewed with the Program Manager during the exit conference.			
K 0000 Bldg. 01				

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	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/28/23 Facility Number: 009969 Provider Number: 15G676 AIM Number: 200129000 At this Life Safety Code survey, Mosaic was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor, as well as heat detection within the unused attic space. The facility has a capacity of 5 and had a census of 5 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.6. Quality Review completed on 03/30/23	K 0000		
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information,			

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	along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on observation and interview, the facility failed to ensure 1 of 1 portable electric space heaters were used in a safe condition to limit fire development. LSC 33.1.1.3 the provisions of Chapter 4, General, shall apply. LSC 4.1.1 a goal of this Code is to provide an environment for the occupants that is reasonably safe from fire by the following means: (1) Protection of occupants not intimate with the initial fire development. (2) Improvement of the survivability of occupants intimate with the initial fire development. This deficient practice could affect all clients and staff. Findings include: Based on observation during a tour of the facility with the Program Manager on 03/28/23 between 11:45 a.m. and 12:17 p.m., in the garage office, there was one electric space heater in use in a way that would not limit fire development due to the following: a) The electric space heater was not equipped with a tip over shut off. The condition would allow the space heaters to stay on when knocked over and applying heat directly to the floor or walls. b) There was no maintenance program for the space heaters according to manufacturer's recommendations. c) There was no policy on the use of space heaters for group homes. Based on interview at the time observation, the Program Manager acknowledged the space heater and stated they are prohibited in the facility and no documentation of a policy or maintenance	K S100	Mosaic will remove the space heater, cited in the finding, from the property. Mosaic will ensure that no space heater will be brought onsite or used at the location in accordance with LSC Space heaters have all been removed Purchasing cards will be monitored to ensure no space heaters are purchased.	04/21/2023

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	program were available for review at time of survey. It was removed upon observation. Findings were discussed with the Program Manager at exit conference.			
K S341 Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels were protected. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 03/28/23 between 11:45 a.m. and 12:17 p.m., the	K S341	Mosaic will take measures to ensure the fire alarm panel stays locked and that the key is stored in a secure environment to ensure no unauthorized use occurs in accordance with section This will take place in each home. This will be monitored by Quality Assurance.	04/28/2023

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	fire control panel located in the laundry area next to the garage was in a cabinet but the door to the cabinet was unlocked and the key unable to be located. This condition does not protect the fire alarm system against unauthorized use. Based on interview at the time of observations, the Program Manager agreed the cabinet door to the fire control panel was not properly secured. Staff was initially unable to find the key for the cabinet, however the key was discovered near the end of the tour and secured. The finding was reviewed with the Program Manager during the exit conference.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70,	K S345	K0345: Mosaic will ensure that an annual fire alarm inspection is completed each year and the documentation of the inspection is made available for viewing onsite. K0345: Mosaic will ensure that a smoke detector sensitivity test is completed at least once every two years and that documentation of the test is	04/28/2023

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	National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review with the Program Manager on 03/28/23 between 10:35 a.m. and 11:45 a.m., an annual fire alarm funtional inspection was unavailable for review at the time of survey. Based on interview at the time of record review, the Program Manager stated they had a change in leadership and documentation of an annual fire alarm report could have been misplaced or at the main office hub. Findings were discussed with the Program Manager at exit conference 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants.		made available for viewing onsite. This will be monitored by the QIDP and Quality Coordinator.	

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	Findings include: Based on record review from with the Program Manager between 10:35 a.m. and 11:44 a.m. on 03/28/23, no documentation was available for review to show smoke detector sensitivity had been tested with in the last two years. A fire alarm inspection report dated 01/07/21 showed a smoke detector sensitivity test was performed and should have been conducted again on 01/07/23. Based on interview at the time of record review, the Program Manager acknowledged that the sensitivity testing for the fire alarm system was overdue and was unsure if it had been conducted. Findings were discussed with the Program Manager at exit conference.			
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a written fire watch policy for when the fire alarm system is out of service for more than four hours in a 24-hour period. This deficient practice could affect all occupants when occupied. Findings include:	K S346	Mosaic has a "Fire/Sprinkler System Outage and Continuous Fire Watch" policy that will be followed as needed and kept in the documentation records onsite available for viewing.	04/28/2023

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	Based on records review with the Program Manager on 03/28/23 between 10:35 a.m. and 11:44 a.m., a written fire watch policy for when the fire alarm system is out of service for more than four hours in a 24-hour period was not available for review. Based on interview at the time of record review, the Program Manager stated the facility does have a fire watch policy, but documentation was unable to be found at the time of the survey. The finding was review with the Program Manager during the exit conference.		This plan will be reviewed with staff and added to the EPP plan. QIDP and Quality Coordinator will ensure this is being completed.	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25,			

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	section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the			

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	automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Program Manager on 03/28//23 between 10:35 a.m. and 11:44 a.m., a weekly valve and gauge for the dry sprinkler system had one week done on 03/09/23, but no other inspection documentation could be	K S353	K0353: Mosaic will ensure implement a weekly sprinkler gauge and valve check inspection and inspection form that will be kept onsite and maintained weekly in accordance with Section 5.2.4.2. Prior documentation cannot be found nor created. K0353: Mosaic will complete repairs eliminating the gaps between the ceiling and the escutcheon plates in the closet area of bedroom #1 and #2 in accordance with 8.5.4.1.1. to ensure no gaps are present. K0353: Mosaic will ensure that quarter 1, 3 & 4 sprinkler inspections are completed and that records are kept onsite available for review and observation. These documents will be added to the EPP binder Quality Assurance and QIDP will ensure these forms are in the binder ongoing.	04/28/2023

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	found regarding inspections for the past 51 weeks. Based on interview at the time of record review, the Program Manager agreed that no documentation could be found and would follow up with the responsible party. This finding was reviewed with the Program Manager at the exit conference. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all clients and staff. Findings include: Based on observation with the Program Manager on 03/28/23 between 11:45 a.m. and 12:17 p.m., two sprinkler heads located in the closet area of bedroom #1 and bedroom #2 had a one-inch gap between the ceiling and the escutcheon plate. Based on interview at the time of observation, the Program Manager agreed that there were holes next to both sprinkler heads. Findings were discussed with the Program Manager at exit conference. 3. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of			

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	physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff. Findings include: Based on record review with the Program Manager on 03/28/23 between 10:35 a.m. and 11:44 a.m., there was no first, third, and fourth quarter sprinkler inspections available for review. Based on interview at the time of observation, the Program Manager stated that inspections are sent to the main office and was unable to locate them at the time of the survey. Findings were discussed with the Program Manager at exit conference.			
K S354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to			

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	service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written fire watch policy for when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Program Manager from 10:35 a.m. to 11:44 a.m. on 03/28/23, written fire watch policy documentation for when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period was not available for review. Based on interview at the time of record review, the Program Manager stated the facility had a fire watch policy, but documentation could not be located at the time of the survey. This findings was discussed with the Program Manager at exit conference.	K S354	K0354: Mosaic has a "Fire/Sprinkler System Outage and Continuous Fire Watch" policy that will be followed as needed and kept in the documentation records onsite available for viewing. This will be moved onsite by the Quality Coordinator. This will be reviewed at least annually by ED or VPO.	04/28/2023
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 light switch junction box located in bedroom #1 was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This	K S511	K0511: Mosaic will ensure that all switch and outlet junction boxes are covered with the correct plates eliminating any potential of exposed wiring.	04/28/2023

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(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
	deficient practice could affect one client. Findings include: Based on observations on 03/28/23 between 11:45 a.m. and 12:17 p.m. during a tour of the facility with the Program Manager, there was one electrical light switch junction box located in bedroom #1 next to the door with exposed wires because the switch was not covered with a plate. Based on interview at the time of each observation, the Program Manager acknowledged the missing cover for the switch in the bedroom and said he would make sure a cover was provided as soon as possible. Findings were reviewed with the Program Manager at exit conference.		Maintenance staff will be reviewing in each home. This will be discussed at safety committee regularly.	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G676	A. BUILDING 01 B. WING	03/28/2023

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	e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 12 of 12 shifts. This deficient practice affects all staff and clients. Findings include: Based on records review with the Program Manager on 03/28/23 between 10:35 a.m. and 11:44 a.m., no fire drill documentation was able to be found at the time of survey. During an interview at the time of observation, the Program Manager stated that fire drill documentation are submitted and handed in at the main office and were most likely not in the facility for review. The finding was discussed with the Program Manager at exit conference.	K S712	K0712: Mosaic will ensure that fire drills will be completed at least quarterly for each shift. Documentation of drills will be kept/made available for review onsite. Drill training is taking place 4/28/23 This will be monitored by QIDP and Quality Coordinator Drills will be discussed at Safety Committee.	04/28/2023