STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G676	A. BUILDING 00 B. WING	10/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey and the investigation of complaint #IN00437799 completed on 8/6/24. This visit was in conjunction to the investigation of complaint #IN00442576. Complaint #IN00437799: Not corrected. Survey Dates: 10/8, 10/9, 10/10 and 10/11/24 Facility Number: 009969 Provider Number: 15G676 AIM Number: 200129000 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/21/24.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 2 sample clients (A), plus 2 additional clients (C and D), the facility failed to implement its written policies and procedures to prevent neglect of client A and to prevent peer to peer aggression for clients A, C and D. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed	W 0149	149 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 1. Mosaic has increased the staffing in the home and retrained staff on redirection activities for client A. 2. Mosaic has increased the staffing in the home and upgraded the locks in the home.	11/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirsten Terrell	Quality Coordinator	11/01/2024

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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	on 10/8/24 at 7:16 pm. 1. A BDS report dated 9/2/24 indicated the following: "On 9/2/24 [client C] and [client D] was (sic) scratched on the back of his neck by [client A]. Staff redirected [client A]. Scratch was less than 3 inches. ..." This incident affected clients C and D. An investigation dated 9/3/24 indicated the following: "... There needs to be 2 staff present during busy times. [Client A] needs to be engaged in activities she enjoys. We purchased fidget toys, sandbox and working on getting a new rocking chair." 2. A BDS report dated 9/28/24 indicated the following: "On 9/28/24 [client A] went outside of her home. The staff was assisting another individual with personal care at the same time. [Client A] was redirected by the neighbor back to the group home before the staff was able to go outside to assist. ..." An investigation dated 10/4/24 indicated the following: "... [Staff #3] said she never heard door alarm but it was on and had been on for the whole shift. I also asked her if she saw any outside doors that were left open. She also said no that she did not recall seeing this. [Staff #3] informed me that she is deaf. ... [Staff #3] is not allowed to be a single staff at the group home anymore and is in the process of getting her hearing looked into. " An interview with the Associate Director (AD)/Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/10/24 at 12:22 pm. The AD/QIDP stated, "Staff should be		B. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; 1. This deficiency has the potential to affect all the residents. Mosaic has increased the staffing in the home and retrained staff on redirection activities for client A. 2. This deficiency has the potential to affect all the residents. Mosaic has increased the staffing in the home and upgraded the locks in the home. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 1. Mosaic has increased the staffing in the home and retrained staff on redirection activities for client A. 2. Mosaic has increased the staffing in the home and upgraded the locks in the home. D. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	following the Abuse Neglect and Exploitation (ANE) policy. " An interview with the Quality Coordinator (QC) was conducted on 10/10/24 at 1:50 pm. The QC stated, "The staff should be following the ANE policy. We have still been having peer to peer behaviors and elopement concerns. I can't think of any changes to any of the plans that have been made." The facility's Policy and Procedure on ANE dated 5/15/19 was reviewed on 10/10/24 at 10:51 am and indicated the following "... Policy Statement: ...A. People receiving services from Mosaic have the same rights, benefits, and privileges guaranteed to all citizens by the United States laws and Constitution, and the laws of the states in which they reside. At all times, people supported shall be regarded and treated with dignity and respect. Mosaic prohibits abuse, neglect and exploitation of any person we support. B. This policy applies to abuse, neglect and exploitation regardless of where it occurs or is alleged to have occurred, whether it occurs under Mosaic's provision of service or not. This policy applies regardless of whether the person alleged to have committed such action is an employee, contractor, volunteer, family member, member of the general public, or another person who receives services from Mosaic or any other service provider." This federal tag relates to complaint #IN00437799. This deficiency was cited on 8/6/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		put into place; 1. The direct support supervisor will have a house meeting before 11/10/24 to retrain all Woodmont staff on different redirection activities to engage client A and to prevent peer-to-peer aggression. 2. The locks have been upgraded by the maintenance. E. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names). Administrator F. COMPLETION DATE 11/10/24	

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W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 2 sample clients (client A), plus 2 additional clients (clients C and D), the facility failed to ensure effective corrective measures were developed and implemented regarding client A scratching clients C and D. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and related investigations were reviewed on 10/8/24 at 7:16 pm. The review indicated the following: A BDS report dated 9/2/24 indicated the following: "On 9/2/24 [client C] and [client D] was (sic) scratched on the back of his neck by [client A]. Staff redirected [client A]. Scratch was less than 3 inches. ..." This incident affected clients C and D. An investigation dated 9/3/24 indicated the following: "...Findings and recommendations: Staff to try to stay in between [client C] and [client A]. Keep [client A] engaged in activities she enjoys." An interview with the Associate Director (AD)/Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/10/24 at 12:22 pm. The AD/QIDP stated, "We have talked with a Behavior Consultant (BC), but we have not added anything to her plan. We have implemented double staffing in the home to assist with behaviors." An interview with the Quality Coordinator (QC)	W 0157	157 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 3. Mosaic has increased the staffing in the home and retrained staff on redirection activities for client A. 4. Mosaic has increased the staffing in the home and upgraded the locks in the home. B. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; 3. This deficiency has the potential to affect all the residents. Mosaic has increased the staffing in the home and retrained staff on redirection activities for client A. 4. This deficiency has the potential to affect all the residents. Mosaic has increased the staffing in the home and upgraded the locks in the home. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 3. Mosaic has increased the staffing in the home and retrained staff on redirection activities for	11/10/2024

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	was conducted on 10/10/24 at 1:50 pm. The QC stated, "The staff should be following the ANE policy. I can't think of any changes to any of the plans that have been made." This federal tag relates to complaint #IN00437799. This deficiency was cited on 8/6/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		client A. 4. Mosaic has increased the staffing in the home and upgraded the locks in the home. D. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 3. The direct support supervisor will have a house meeting before 11/10/24 to retrain all Woodmont staff on different redirection activities to engage client A and to prevent peer-to-peer aggression. 4. The locks have been upgraded by the maintenance. E. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names). Administrator F. COMPLETION DATE 11/10/24	

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W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure client A had a vision exam completed. Findings include: Client A's record was reviewed on 10/9/24 at 11:53 am. Client A did not have a vision exam to review. The residential identifier list reviewed on 10/10/24 at 3:00 pm dated 10/10/24 indicated client A was admitted to the group home on 4/1/24. An interview with the Registered Nurse (RN) was conducted on 10/11/24 at 8:30 am. The RN stated, "[Client A's] vision exam was never scheduled. A vision exam should be completed within the first two months of placement." An interview with the Associate Director (AD)/Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/10/24 at 12:22 pm. The AD/QIDP stated, "To my knowledge [client A's] vision has not been scheduled. It should have been completed within 30 days of placement." An interview with the Quality Coordinator (QC) was conducted on 10/10/24 at 1:50 pm. The QC stated, "[Client A's] vision exam was not scheduled. I thought it was done but we are getting it scheduled." This deficiency was cited on 8/6/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	W 0323	323 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 1. Mosaic will ensure all new admissions have a vision exam schedule upon admission. Client A had a vision exam appointment on 10/29/24. B. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; 1. This deficiency has the potential to affect all the residents. Mosaic will ensure all new admissions have a vision exam schedule upon admission. Client A had a vision exam appointment on 10/29/24. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 1. Mosaic will ensure all new admissions have a vision exam schedule upon admission. Client A had a vision exam appointment on 10/29/24. D. What measures will be put into	11/10/2024

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	9-3-6(a)		place or what systemic changes will the facility make to ensure that the deficient practice does not recur; How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 1. The Associate Director will follow and complete an admissions checklist with every new client upon their admission to Mosaic. The checklist will include scheduling a vision exam. E. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names). Administrator F. COMPLETION DATE 11/10/2024	
W 0351 Bldg. 00	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure client A's dental exam was completed within 30 days of admission.	W 0351	351 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 2. Mosaic will ensure all new	11/10/2024

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	Findings include: Client A's records were reviewed on 10/9/24 at 11:53 am. Client A's record did not include evidence of a dental evaluation. The residential identifier list reviewed on 10/10/24 at 3:00 pm dated 10/10/24 indicated client A was admitted to the group home on 4/1/24. An interview with the Registered Nurse (RN) was conducted on 10/11/24 at 8:30 am. The RN stated, "[Client A's] dental exam was never scheduled. A dental exam should be completed within the first two months of placement." An interview with the Associate Director (AD)/Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/10/24 at 12:22 pm. The AD/QIDP stated, "We found a dentist and calls were supposed to have been made but I don't think it's been completed. It should have been completed within 30 days of placement." An interview with the Quality Coordinator (QC) was conducted on 10/10/24 at 1:50 pm. The QC stated, "[Client A's] dental exam was not scheduled. I thought it was done but we are getting it scheduled." This deficiency was cited on 8/6/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		admissions have a dental exam schedule upon admission. Client A has a dental exam appointment scheduled for 12/16/24. B. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken; 2. This deficiency has the potential to affect all the residents. Mosaic will ensure all new admissions have a dental exam schedule upon admission. Client A has a dental exam appointment scheduled for 12/16/24. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 2. Mosaic will ensure all new admissions have a dental exam schedule upon admission. Client A has a dental exam appointment scheduled for 12/16/24. D. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;	

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			2. The Associate Director will follow and complete an admissions checklist with every new client upon their admission to Mosaic. The checklist will include scheduling a dental exam. E. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names). Administrator F. COMPLETION DATE 11/10/2024	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Based on observation and interview for 1 of 2 sampled clients (A) plus 2 additional clients (C and D), the facility failed to ensure the clients' medications were stored in a secure manner. Findings include: Observations were conducted in the group home on 10/8/24 from 2:50 pm to 4:15 pm. Clients A, C and D were present in the group home for the duration of the observation period. Client B was on a visit with her mother during the observation. On 10/8/24 at 3:32 pm staff #2 unlocked the	W 0382	382 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 1. Mosaic will ensure the medication cart is locked when staff steps away from the cart. B. How the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken;	11/10/2024

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	medication cart and washed his hands. Staff #2 walked out of the medication room leaving the medication cart unlocked for 3 minutes. At 3:37 pm staff #2 brought client C into the medication room and administered his medication. At 3:40 pm staff #2 left the medication room and took client C into the living room. Staff #2 left the medication cart unlocked for 24 seconds. Staff #2 was not able to see the medication room when he left the room. An interview with staff #2 was conducted on 10/8/24 at 4:04 pm. Staff #2 stated, "I should have locked the medication cart when I left the room." An interview with the Registered Nurse (RN) was conducted on 10/11/24 at 8:30 am. The RN stated, "The medication should be stored under lock and key in the medication cart." An interview with the Associate Director (AD)/Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/10/24 at 12:22 pm. The AD/QIDP stated, "The medication should be locked in the medication cart. If they need to leave the room the medication cart should be locked up again." An interview with the Quality Coordinator (QC) was conducted on 10/10/24 at 1:50 pm. The QC stated, "The medication should be locked at all times. If staff need to walk out of the room everything should be locked back up." This deficiency was cited on 8/6/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)		1. This deficiency has the potential to affect all the residents. Mosaic will ensure the medication cart is locked when staff steps away from the cart. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 1. Mosaic will ensure the medication cart is locked when staff steps away from the cart. D. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 1. The Associate Director will be making reminder signs and placing them on the medication carts stating the carts need to be locked at all times. E. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	

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