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	08/20/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/20/24 Facility Number: 009969 Provider Number: 15G676 AIM Number: 200129000 At this Emergency Preparedness survey, Mosaic was found 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 4. Quality Review completed on 08/23/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/20/24 Facility Number: 009969 Provider Number: 15G676 AIM Number: 200129000 At this Life Safety Code survey, Mosaic was found not in compliance with Requirements for	K 0000		

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

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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	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 4 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 2.0. Quality Review completed on 08/23/24			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview, the facility failed to maintain weekly and monthly sprinkler system inspection documentation for 11 of 12 months 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 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be	K S353	K0353 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 1. Mosaic will ensure monthly gauge and valve checks are completed for the home's sprinkler system at least monthly. 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	10/04/2024

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	inspected monthly. Section 3.3.18 states 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. This deficient practice could affect all clients in the facility. Findings include: Based on record review with the Quality Coordinator on 08/20/24 between 10:41 a.m. and 11:50 a.m., there was no documentation of a weekly gauge and valve check for the weeks prior to 08/12/24. The facility has a dry sprinkler system. Based on observation of the sprinkler riser room between 11:52 a.m. and 12:09 p.m., the sprinkler riser contained three gauges and approximately two control valves. Based on interview at the time of record review, the Quality Coordinator confirmed the missing inspections and further stated that the company has trained house staff to conduct the weekly inspections. She clarified that the facility staff began a system to record and document the checks to make sure they are not missed, however no documentation before 08/12/24 is able to be located at the time of the survey. The finding was reviewed with the Quality Coordinator during the exit conference.		potential to affect all residents. Mosaic will ensure monthly gauge and valve checks are completed for the home's sprinkler system at least monthly. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 1. Mosaic will ensure monthly gauge and valve checks are completed for the home's sprinkler system at least monthly. D. What measures will be put into place or what systemic changes the facility will 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 maintenance lead will keep a spreadsheet of the monthly gauge and valve checks in the home. 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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			Administrator F. COMPLETION DATE 10/4/2024	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect all clients and staff. Findings include: Based on observation during a tour of the facility with the Quality Coordinator on 08/20/24 between 11:52 a.m. and 12:09 p.m., a space heater was located out in the water heater/utility closet adjacent to the garage. The space heater was in use and was plugged into a power strip which was plugged into the wall. Based on interview at the time of observation, the Quality Coordinator confirmed that the space heater was plugged into a power strip and further agreed that it should not have been plugged into the power strip and should be plugged directly into the wall. The finding was discussed with the Quality Coordinator at exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99,	K S511	K0511 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 power strip is secured to the wall. Mosaic will also remove the space heater from the room. This was completed on 8/28/2024. 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 residents. Mosaic will ensure the power strip is secured to the wall. Mosaic will also remove the space heater from the room. This was completed on 8/28/2024. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 1. Mosaic will ensure the power strip is secured to the wall.	10/04/2024

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	Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could all clients and staff. Findings include: Based on observation with the Quality Coordinator on 08/20/24 between 11:52 a.m. and 12:09 p.m., a power strip was located in the water heater/utility closet adjacent to the garage. The power strip was plugged into a space heater and water softener appliance which was dangling by the power cord and unsecured. Based on interview at the time of observation, the Quality Coordinator agreed that the power strip was dangling, unsecured, and further stated that she would contact maintenance to resolve the issue. This finding was reviewed with the Quality Coordinator during the exit conference.		Mosaic will also remove the space heater from the room. This was completed on 8/28/2024. D. What measures will be put into place or what systemic changes the facility will 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 quality coordinator will do quarterly house walk-throughs to ensure the power strip remains secured and the space heated is not in the room or plugged into a power strip. 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 10/4/2024	
K S712	NFPA 101 Fire Drills			

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Bldg. 01	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 1 of 12 shifts. This deficient practice affects all staff and clients. Findings include: Based on record review with the Quality Coordinator on 08/20/24 between 10:41 a.m. and 11:50 a.m., documentation for a third shift fire drill for the first quarter (January-March) of 2024 was unable to be reviewed at the time of the survey. Based on interview at the time of record review, the Quality Coordinator acknowledged that the documentation for the fire drill was missing. She further stated that the company has implemented a schedule for drills in which staff are supposed to follow so that fire drills aren't missed, however she was unsure why a third shift drill wasn't conducted. The finding was reviewed with the Quality Coordinator at exit conference.	K S712	K0712 A. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; 1. Mosaic will ensure that first, second, and third shift fire drills are run at least once a quarter. 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 residents. Mosaic will ensure that first, second, and third shift fire drills are run at least once a quarter. C. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S): 1. Mosaic will ensure that first, second, and third shift fire drills are run at least once a quarter. D. What measures will be put into place or what systemic changes the facility will 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	10/04/2024

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			put into place; 1. The Quality Coordinator will track all fire drills to ensure that they are done and documented at least once per shift per quarter. This will be tracked on a spreadsheet that is updated monthly by the Quality Coordinator. 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 10/4/2024	