

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

<b>Number</b> 6208		Fine amount reduced by 35% to \$3,900.00 on August 11, 2016 pursuant to Iowa Code Section 135C.43A		<b>Report Date</b> July 22, 2016	
<b>Facility Name</b> Mosaic 825 Ashwood		<b>Survey Dates</b> June 27-29, 2016			
<b>Facility Address</b> 825 South 7 <sup>th</sup> Street		61084-I			
<b>City</b> Forest City, IA. 50436		HL			
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction Date</b>	
64.60	<p>481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.</p> <p>Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.</p> <p>This rule is intended to implement Iowa Code Section 135C.2(3).</p> <p><b>DESCRIPTION:</b></p> <p><b>483.410 Governing Body and Management</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on staff interviews and record review, the facility failed to maintain substantial Governing Body and Management. The facility failed to consistently develop effective measures to ensure safety and supervision of clients and ensure adequate training of staff. These findings led to a determination of Immediate Jeopardy. Findings follow:</p> <p>Cross Reference W104. The Governing Body failed to consistently develop effective measures to ensure safety and supervision of clients and ensure adequate training of staff.</p>	I	\$6000.00	Upon Receipt	
W102					

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<b>W104</b>	<p>Cross Reference W189. The facility failed to provide and document adequate staff training to ensure client safety and supervision.</p> <p><b>483. 410(a)(1)Governing Body</b>  <b>The governing body must exercise general policy, budget, and operating direction over the facility.</b></p> <p>Based on interviews and record review the facility governing body failed to consistently develop effective measures to ensure safety and supervision of clients and ensure adequate training of staff. This affected 1 of 1 client (Client #1) involved in investigation 61084-I. Finding follows:</p> <p>Record review on 6/27/16 revealed the following:</p> <p>1. a. General Events Report, dated 6/23/16, documented around 4:30 p.m. staff became concerned Client #1 had not returned home from day services. Mosaic Investigation Report, dated 6/24/16, documented Client #1 had been left on the transit van after returning to Forest City from attending day services at Opportunity Village in Clear Lake. Qualified Intellectual Disabilities Professional (QIDP), who was the on-call executive at the time of the incident, received a phone call on 6/23/16 at 4:44 p.m. stating Client #1 had not returned to the facility and staff did not know the client's whereabouts. Staff contacted Opportunity Village and confirmed Client #1 was not there. Staff also attempted to call the transit number, but was unable to reach anyone. The QIDP contacted another individual who rode the same vehicle and confirmed Client #1 had been on the van. The QIDP also checked another home to determine if the client had been dropped off at</p>			

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	<p>another residence but the client was not there. The QIDP again spoke to staff and determined they needed to check the van the client had ridden on. At approximately 5:15 p.m. Direct Support Associate (DSA) A went to the location of the vehicle and found Client #1 sitting in the van. She talked the client through the process of going to the driver's side and unlocking the van.</p> <p>b. Nursing Assessment on 6/23/16 revealed at 6:20 p.m. vitals were: Temperature (T) -98.1, Blood pressure (B/P) 141/90, pulse (P) was 104 and Respirations (R) were at 20. At 8:50 p.m. vitals were again taken and T-96.4, BP-129/86, P-78 and R-18. Water infused with electrolytes (Propel) was provided to the client. The client drank 16 ounces of Propel at 5:45 p.m. and at 6:30 p.m. No other injuries were observed. The client appeared alert and oriented. On-call physician was also notified with recommendation to monitor for signs and symptoms of dehydration.</p> <p>c. Client #1's diagnoses included: Moderate Intellectual Disability, Cerebral Palsy, Hemiplegic (left side), Cognitive deficit due to old cerebral infarction (stroke at birth), shunt and hydrocephalus with history of seizure disorder, disruptive behavior Disorder, Pervasive developmental Disorder, Depression. Behavior Modifying Medications include Guanfacine; Risperdal and Fluoxetine. The Human Rights Assessment, dated 11/30/15, documented Client #1 rode the transit bus, driven by a Mosaic staff to Opportunity Village to work but did not require a staff to ride with him/her.</p> <p>d. According to AccuWeather.com the temperature on</p>			

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	<p>6/23/16 was 70 degrees Fahrenheit in Forest City, Iowa.</p> <p>2. When interviewed on 6/27/16 at 4:10 p.m. Client #1 stated he/she rode with the same driver when going to Opportunity Village and returning to Forest City on 6/23/16. When they returned to Forest City after being picked up at Opportunity Village, the driver dropped off several people while he/she was still in the van. The van also stopped at the gas station and driver put in gas. Client #1 thought the driver went downtown and stopped, but was unsure about this. The client stated the driver never looked in the back of the van or walked through the van. Client #1 stated he/she was on the van a long time and was hot. He/she was not too upset, just hot. When Client #1 got home, he/she got something to drink and took a shower. Client #1 stated he/she went with staff and found a cell phone to use for emergency situations and was going to learn how to use it. Client #1 stated he/she did not how to open the van doors; therefore DSA A had to tell him/her how to open the van door.</p> <p>3. When interviewed on 6/27/16 at 3:05 p.m. Licensed Practical Nurse (LPN) stated she was at Client #1's home after 4:00 p.m. to complete medication pass. She stated staff became concerned around 4:30 p.m. the client had not returned home. Staff contacted transit office and the on-call supervisor. When they were still unable to locate the client, DSA A went to the area where the vans were parked and found the client on the van. The LPN completed an assessment and recalled during the first set of vitals, they were slightly elevated. The LPN provided the client water with Propel added to provide electrolytes. She also contacted the on-call physician and was told to</p>			

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	<p>watch for signs of dehydration including headache, nausea and vomiting. She stated the client was generally quiet, but was extremely quiet until he/she ate/drank fluids and took a shower. The LPN stated the client appeared to return to his/her normal self and became more verbal.</p> <p>4. When interviewed on 6/27/16 at 3:25 p.m. DSA A stated she had been assigned to work with Client #1 on 6/23/16. She stated the client normally arrived home between 3:00-3:30 p.m. from day services, but had been later a couple of times arriving between 4:00- 4:30 p.m. DSA A stated staff generally knew when Client #1 arrived home because he/she would go to the kitchen to get a snack. Around 4:30 p.m. they had decided to eat early because everyone wanted to go on an outing after supper. DSA A stated this was the time when they became concerned Client #1 had not arrived home, because she knew transportation services did not run after 4:30 p.m. Staff checked the client's bedroom, contacted the on-call executive, transit office and the day services site. DSA A received a call from the on-call executive after she had checked with other clients and drop-off sites, and decided the van should be checked. DSA A stated since she was located closest to the van, she would check the vehicle. She drove to the location of the vehicle (a couple of blocks) and when she turned the corner in the parking lot she could see Client #1's head in the van, and he/she appeared to be looking around. DSA A stated this occurred at approximately 5:15 p.m. She verbally prompted the client to sit in the driver's seat to open the door of the vehicle. DSA A stated it took at least two prompts to have him/her sit in the seat and at least two prompts to open the door of the vehicle. They returned to</p>			

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	<p>Client #1's home. The client appeared sweaty and was provided water with added electrolytes. DSA A stated Client #1 was very shy and would not necessarily say something to a driver. She stated the transit driver had been late before and she had not become alarmed until supper had been prepared and realized Client #1 still had not returned. She stated the driver did not normally contact the facility if they were going to be late and did not walk the client to their door or check in with staff. During additional interview at 4:00 p.m. DSA A stated Client #1 should be checked on every 30 minutes while in his/her bedroom, but the client generally came out prior to the time frame. She was unsure of what Client #1 wore, but thought he/she had shorts on.</p> <p>5. When interviewed on 6/27/16 at 3:45 p.m. DSA B stated when he completed supper preparation on 6/23/16 he heard Client #1 had not returned home from Day Services. Staff checked the client's bedroom between 4:30 p.m. and 4:40 p.m. and then contacted the on-call supervisor when the client could not be located in the home. He stated he had not been concerned because Client #1's arrival time varied and could be anywhere between 3:00 p.m. and 4:00 p.m. but was aware transportation services did not run after 4:30 p.m. He also contacted the Opportunity Village Store and Campus and determined the client was not at either location. DSA B was informed the on-call executive was checking other places and when she contacted the facility after not finding the client, it was decided to check the van. DSA A went to the location of the vehicle and found Client #1 in the vehicle. DSA B stated the client appeared tired when he/she returned to the house. DSA B stated he was</p>			

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	<p>unsure if the client would be able to open the van door independently. He knew the client could open the door to a personal vehicle (car) but not sure if Client #1 would have had an opportunity to learn to open van doors. He could not recall specifically what the client wore, but thought he/she had on shorts or pants with a t-shirt.</p> <p>6. When interviewed on 6/27/16 at 3:55 p.m. DSA C stated on 6/23/16 at approximately 4:30 p.m. she went to Client #1's bedroom to get the client for supper, but the client was not in his/her bedroom. She informed DSA A and DSA B the client was not in his/her bedroom and DSA B went into the client's room and checked under the covers. Since the client was not in his/her room they began placing phone calls to try and locate Client #1. She stated the client liked to spend time in his/her room alone and thought it had been possible Client #1 came into the house and went directly to his/her bedroom. DSA C thought the client should be checked on every hour when in his/her bedroom. She stated Client #1 normally returned home by 3:30 p.m. but had been late other times. DSA C stated drivers do not let staff know if they are running late on their routes.</p> <p>7. When interviewed on 6/27/16 at 4:30 p.m. the QIDP stated on 6/23/16 at 4:44 p.m. she received a call from DSA B Client #1 had not returned home from day services at Opportunity Village. She instructed staff to call transit and Opportunity Village. She contacted a person who also rode in the van to verify Client #1 was on the vehicle returning to Forest City. Once the information had been verified, she also went to another site where the client would be moving to. When she verified the client was not</p>			

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	<p>at any alternate location, she talked to DSA A by phone and decided to check the van. Since DSA A was located closest to the vehicle she would leave immediately to check the van. She was contacted by DSA A at 5:15 p.m. Client #1 had been found inside the vehicle. Nursing staff assessed the client and the guardian was also notified. The QIDP stated she initiated and completed the investigation into the situation. She stated the client was very quiet and would not draw attention to him/herself. The QIDP did not know specifically how often Client #1 should be checked while in the home and thought it would be between every 15 - 30 minutes. The QIDP did feel staff should have been concerned prior to 4:45 p.m. Client #1 had not returned home. She felt if the client had not returned home by 4:00 p.m. staff should have done follow-up. The QIDP stated the staff did not have any specific guidelines to follow if a client were late but appropriately called the on-call executive to provide notification of the situation.</p> <p>8. When interviewed on 6/28/16 at 8:30 a.m. the Transit Driver (TD) stated she began employment around 5/1/16. At the beginning of her employment she had a chauffeur's license and was only able to drive less than 15 passenger vehicles. She practiced in the larger vehicles with another driver present. She obtained a Commercial Driver's License (CDL) on 6/21/16 and on 6/23/16 she began driving a larger vehicle independently. The TD stated while the clients assigned to the route were generally consistent, there were situations when a person did not ride or would be added to the route. She stated she had only transported Client #1 one other time during her training but confirmed she picked up the client at Opportunity Village</p>			

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	<p>in Clear Lake on the afternoon of 6/23/16. She thought the client sat in the 2<sup>nd</sup> or 3<sup>rd</sup> row from the back on the driver's side. The TD stated she made several stops to drop off clients, but could not recall all the specifics and stated the information would be listed on her transit sheet. She also remembered when she dropped off a client she made a comment about it being her last stop. The TD stated she then stopped for gas and returned the van to the location where they stored vehicles. She said she clocked out at 4:07 p.m., talked with another staff until 4:15 p.m. The TD then returned to the vehicle because she had forgotten her purse, but still did not realize Client #1 was on the van. The TD stated as a driver she would be given a list of people to transport daily. While she had never been trained, she had seen the driver should place a check by the client's name when they were picked up. Also, when the client reached their destination at the end of the route i.e. returning home, the driver should cross off their name. The TD stated she did not cross anyone's name off the list at the end of the route because if she had, she would have seen Client #1's name. The TD stated she had been told to walk through the vehicle at the end of a route. She stated she did not complete this step either therefore, did not realize Client #1 was still on the van. She could not recall reviewing a training sheet with anyone but had ridden with other drivers observing different routes.</p> <p>9. When interviewed on 6/28/16 at 9:20 a.m. the Transit Manager (TM) stated on 6/23/16 at approximately 4:45 p.m. she was notified Client #1 had not returned home from Opportunity Village in Clear Lake. She contacted another driver who had no information and then contacted</p>			

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	<p>the TD. The TD confirmed Client #1 had been on the van but could not recall where she had dropped the client off at. The TM was unable to communicate directly with staff at the house, therefore went to check the vehicle and then to Client #1's home where she learned the client had been located in the van. The TM stated Client #1 had been in the vehicle over an hour unattended because the fuel receipt documented the driver fueled up at 3:50 p.m. and the driver punched out at 4:07 p.m. She stated drivers were trained on the job as well as training for their CDL license. The TM stated the TD had been trained to place a check by the client's name when picking up a client and should cross the client's name off when they reach their final destination. Also, drivers were told to walk through their vehicles to ensure everyone is off, trash picked up and windows closed. She confirmed the TD failed to complete both of these steps. She further stated drivers have an Orientation Checklist which documented training and if the form had been completed, it would be located in the employee's file.</p> <p>10. Additional record review revealed the following:</p> <p>a. Review of the rider list dated Thursday, 6/23/16, included Client #1. The TD placed a check on the left side of the client's name but no check was located on the right side. Other clients listed on the form had checks by their names on the right side as well as the left side of their name but no names were crossed off.</p> <p>b. The Daily driver Log, dated 6/23/16, listed Client #1 would be transported from his/her home address to the Day services site and would return from the day services</p>			

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	<p>site to his/her home address.</p> <p>c. Incident Report completed by the Transit Driver on 6/24/16 stated the driver had forgotten Client #1 on the bus. The driver documented she gassed the vehicle prior to punching out at 4:07 p.m. She visited with another staff until 4:15 p.m. and went back to the bus obtained her purse and left to go home. Her supervisor contacted her at 5:15 p.m. inquiring about the location of Client #1's drop off. The driver documented she picked up Client #1 at the Day Services site and he/she came to Forest City with other clients from the area.</p> <p>d. The TM included a narrative as a part of the facility investigation which included information regarding the TD's training and employment. The documented stated the TD had been shown to put a check mark next to the person's name when getting on the bus in the morning, then in the afternoon again when getting on the bus and then put a line or cross them off when they arrived at their destination. She had also been told to check the vehicle at the end of the day for lost items, windows open or garbage by completing an actual physical bus check. No documentation of the training could be located in the employees file.</p> <p>When interviewed on 6/28/16 at 10:10 a.m. the Habilitation Coordinator (HC) confirmed a better system needed to be established to document transportation of clients because the current system failed to provide adequate information. She stated she would work with the TM to develop a new checklist and train staff immediately. The HC stated the TD should not have driven independently until all training</p>			

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<b>W189</b>	<p>had been completed and documented. The HC also confirmed staff should have been aware earlier the client had not returned home from day services. She further confirmed there were no specific procedures addressing the issue when a client failed to return to the facility at a normal time. The HC stated the facility would develop a procedure staff should follow if a client did not return at their normal time and be immediately trained on the procedure.</p> <p><b>483.430 e (1) STAFF TRAINING PROGRAM</b>  <b>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</b></p> <p>Based on interviews and record review the facility failed to provide and document adequate staff training to ensure client safety and supervision. This affected 1 of 1 client involved in investigation 61084-I. Finding follows:</p> <p>See W104 for additional information.</p> <p>1. a. When interviewed on 6/28/16 at 8:30 a.m. the Transit Driver (TD) stated she began employment around 5/1/16. At the beginning of her employment she had a chauffeur's license and was only able to drive less than 15 passenger vehicles. She had practiced in the larger vehicles with another driver present. She obtained a Commercial Driver's License (CDL) on 6/21/16 and on 6/23/16 she began driving a larger vehicle independently. The TD stated while the clients assigned to the route were generally consistent, there were situations when a person did not ride or would be added to the route. She stated</p>			

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Administrator

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Date

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Health Facilities Division  
Citation**

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<b>Facility Name</b> Mosaic 825 Ashwood		<b>Survey Dates</b> June 27-29, 2016		
<b>Facility Address</b> 825 South 7 <sup>th</sup> Street		61084-I		
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	<p>she had only transported Client #1 one other time during her training but confirmed she picked up the client at Opportunity Village in Clear Lake on the afternoon of 6/23/16. She thought the client sat in the 2<sup>nd</sup> or 3<sup>rd</sup> row from the back on the driver's side. The TD stated she made several stops to drop off clients, but could not recall all the specifics and stated the information would be listed on her transit sheet. She also remembered when she dropped off a client she made a comment about it being her last stop. The TD stated she then stopped for gas and returned the van to the location where they store vehicles. She said she clocked out at 4:07 p.m., talked with another staff until 4:15 p.m. The TD then returned to the vehicle because she had forgotten her purse, but still did not realize Client #1 was on the van. The TD stated as a driver she would be given a list of people to transport daily. While she had never been trained, she had seen the driver should place a check by the client's name when they were picked up. Also, when the client reached their destination at the end of the route i.e. returning home, the driver should cross off their name. The TD stated she did not cross anyone's name off the list at the end of the route because if she had, she would have seen Client #1's name. The TD stated she had been told to walk through the vehicle at the end of a route. She stated she did not complete this step either therefore, did not realize Client #1 was still on the van. She could not recall reviewing a training sheet with anyone but had ridden with other drivers observing different routes.</p> <p>b. When interviewed on 6/28/16 at 9:20 a.m. the Transit Manager (TM) stated on 6/23/16 at approximately 4:45 p.m. she was notified Client #1 had not returned home</p>			

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	<p>from Opportunity Village in Clear Lake. She contacted another driver who had no information and then contacted the TD. The TD confirmed Client #1 had been on the van but could not recall where she had dropped the client off at. The TM was unable to communicate directly with staff at the house, therefore went to check the vehicle and then to Client #1's home where she learned the client had been located in the van. The TM stated Client #1 had been in the vehicle over an hour unattended because the fuel receipt documented the driver fueled up at 3:50 p.m. and the driver punched out at 4:07 p.m. She stated drivers were trained on the job as well as training for their CDL license. The TM stated the TD had been trained to place a check by the client's name when picking up a client and should cross the client's name off when they reach their final destination. Also, drivers were told to walk through their vehicles to ensure everyone is off, trash picked up and windows closed. She confirmed the TD failed to complete both of these steps. She further stated drivers have an Orientation Checklist which documented training and if the form had been completed, it would be located in the employee's file.</p> <p>c. When interviewed on 6/28/16 at 10:10 a.m. Human Resources Generalist stated the only training documented the transit driver completed had been Mandatory Reporting on 5/1/16. She stated if there had been other training completed the information would have been provided by her supervisor (TM).</p> <p>2. Record review revealed the following:</p> <p>a. The TM included a narrative as a part of the facility</p>			

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	<p>investigation which included information regarding the TD's training and employment. The documented stated the TD had been shown to put a check mark next to the person's name when getting on the bus in the morning, then in the afternoon again when getting on the bus and then put a line or cross them off when they arrived at their destination. She had also been told to check the vehicle at the end of the day for lost items, windows open or garbage by completing an actual physical bus check. No documentation of the training could be located in the employees file.</p> <p>b. Review of the rider list dated Thursday, 6/23/16, included Client #1. The TD placed a check on the left side of the client's name but no check was located on the right side. Other clients listed on the form had checks by their names on the right side as well as the left side of their name but no names were crossed off.</p> <p>c. The Daily driver Log, dated 6/23/16, listed Client #1 would be transported from his/her home address to the Day services site and would return from the day services site to his/her home address.</p> <p>d. Form entitled Region 2 Transit Driver Orientation Checklist. The form included staff should be trained on completing reports and a post trip inspection at the completion of a trip. No completed training sheet could be located in the Transit Driver's employee file.</p> <p>e. Review of the Transit Bus Driver Job Description stated the driver should maintain accurate daily trip logs, complete all records daily and follow reporting procedures as required. No signed job description could be located in</p>			

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	<p>the TD's employee file.</p> <p>When interviewed on 6/28/16 at 10:10 a.m. the Habilitation Coordinator (HC) confirmed the TD should not have driven alone until all training had been completed and documented.</p> <p><b>FACILITY RESPONSE:</b></p>			

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