STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G167	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS At the time of investigation #65968-I concerns were identified in the area of Governing Body and Management's failure to implement sufficient strategies to prevent client elopement resulting in the determination of an Immediate Jeopardy (IJ). The facility was notified at 1:10 p.m. on 2/14/17. A plan was provided which included increased level of supervision, use of additional alarm system, staff training and increased supervision of staff. The IJ was removed at 4:20 p.m on 2/14/17. Standard-level deficiencies were cited at W104, W234 and W249. In addition, #64735-I was investigated. State Standard 50.7(2) was cited due to failure to report the facility's evacuation.	W 000	See attached POC 3/31/17	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews and record review, the facility failed to maintain minimal compliance with the Condition of Participation (CoP) - Governing Body and Management. The governing body failed to establish sufficient safeguards to prevent elopement and ensure staff consistently followed the level of supervision. These findings led to a determination of Immediate Jeopardy. Findings follow:	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelli M Kuehling	Associate Director	3/9/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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W 102	Continued From page 1 Cross reference W104: Based on observation, interviews and record review the facility failed to ensure sufficient strategies and safeguards in place to prevent client elopement. Cross reference W249 Based on interviews and record review the facility failed to consistently implement Individual Program Plan (IPP) strategies regarding client supervision.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure sufficient strategies and safeguards were in place to prevent client elopement which led to the determination of Immediate Jeopardy. This affected 1 of 1 client involved in investigation 65968-I (Client #1). Findings follow: See W249 for additional information. Record review on 2/13/17 revealed the following: a. An Investigation Initiation Form, dated 2/4/17, documented on 2/3/17 Client #1 left the facility while other clients and staff ate in the dining room. Staff completed checks every 5 - 10 minutes according to staff interviews. The client had been prompted to come to the meal, but	W 104		

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W 104	Continued From page 2 refused. Supervisory staff were notified the client was missing at 5:39 p.m. Police were contacted and assisted with the search. The client was found in an abandoned house six houses from the facility and returned at approximately 7:25 p.m. Nursing completed an assessment, including vitals, which were normal. A two centimeter cut on the pad of his/her right ring finger was treated with antibiotic ointment. Client #1 returned fully clothed, including shoes and jacket. Alarms were placed on the exit doors of the facility on 2/3/17. b. Client #1's Individual Support Plan (ISP), last updated 11/15/16, documented the client should stay within staff's line of sight at all times and stay in the same room or area as Client #1, except when Client #1 was in a bathroom or his/her bedroom. When in a bathroom or his/her bedroom, staff should check on the client at least every 10 minutes. On 2/7/17 the program revision included staff watching the hallway when Client #1 was in the bathroom or bedroom and continuing to check on the client every 10 minutes. Consent had also been obtained to place alarms on the three exit doors of the facility. c. An investigation report, dated 2/10/17, documented Client #1 left the facility prior to 5:39 p.m. during supper and was gone for approximately five hours. Staff were unaware the client left and did not know his/her whereabouts. It was determined the client unlocked the pantry door and exited through the window. Staff initiated a search and police were notified. The client was gone until 10:19 p.m., when he/she arrived at the house of a former staff member. The client had apparently been to the Shopko store, stolen items, and according to the police	W 104		

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W 104	Continued From page 3	W 104		

waved a pellet gun in the store. Police determined the client had stolen approximately $335.00 of merchandise and charges would be pressed. Upon return to the facility, the client was transported to Mercy hospital for evaluation. The findings of the investigation determined, staff had been watching the client closely, but left the area briefly to turn off the alarm while Qualified Intellectual Disability Professional (QIDP) A entered the facility.

d. Client #1, a 16 year-old with diagnoses of: oppositional defiant disorder; mild intellectual disability; schizoaffective disorder; hypothyroidism; insomnia; attention deficit hyperactivity disorder, and autism. The client moved to 825 Ashwood on 8/19/2015.

According to Weather Underground the temperature on 2/3/17 was 16 degrees Fahrenheit (F). On 2/10/17 the temperature was 32 degrees F.

Observations on 2/14/17 revealed an abandoned house approximately 8 lots (2 vacant lots and 6 other houses) from the facility. The house was on the same side of the street as the facility. Shopko was located approximately .2 miles off Highway 69 on Highway 9. The store was approximately 1.1 miles southwest of the facility. When interviewed on 2/13/17 at 2:55 p.m., QIDP B stated she investigated Client #1's elopement on 2/3/17. At approximately 5:30 p.m. she was notified by Direct Support Associate (DSA) A Client #1 was missing. When asked about the client's supervision level, staff stated the client had been in his/her bedroom and checked by staff every 5-10 minutes. She drove around the area, including the area where a past staff lived,

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W 104	Continued From page 4 but did not locate the client. Because the client had not been found, she went to the facility and contacted the police. Another staff was out looking for Client #1 accompanied by Client #2. Client #2 was familiar with Client #1's favorite places and heard the client discuss where he/she might go. She stated other staff were contacted and assisted with the search. A picture of the client was provided to the police department and the family was contacted. About two hours after leaving the facility, the police located Client #1 in a vacant house on the same street as the facility, and returned the client to the facility. The client was completely clothed including shoes and jacket. Nursing was contacted and completed an assessment. QIDP B stated she notified the appropriate people regarding the client's return. As a result of the incident, door alarms were installed that evening on the front and back doors. She stated the client was aware he/she would be moving to another facility and maybe felt he/she had nothing to lose by running away. QIDP B stated she had a recent experience with the client, in which he/she expressed some odd information such as glass could not hurt him/her because he/she was an alien. She felt because Client #1 had other behavioral issues along with the strange verbalizations, and he/she should be evaluated through the Emergency Room (ER). When interviewed on 2/14/17 at 4:05 p.m., QIDP C stated she was notified on 2/10/17 by DSA B Client #1 was missing from the facility. She contacted the Administrator on-call, the Investigation Coordinator, Associate Director, and the police. She was told by the police they did not have the manpower to assist with the search but would monitor for the client while on patrol. She called in many staff to help with the search and	W 104		

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W 104	Continued From page 5 continued for several hours until she was notified by QIDP A the client had been located. She returned to the facility and began interviews with staff as QIDP A assisted Client #1. QIDP C talked with staff about the client's supervision level and it appeared it had been followed as they were monitoring the hallway and completing checks. She also talked with the police the following day and was informed the client had stolen some items from Shopko and charges would be pressed. QIDP C also understood Client #1 had run around the store with a pellet gun. Since the police were unsure if the pellet gun belonged to the client or the store, she checked with the family and they had no property missing therefore the gun belonged to the store. DSA B determined Client #1 unlocked the pantry door and had gone out the window of the room without staff knowledge. On 2/15/17 at 11:55 a.m., QIDP C clarified she was unaware at the time of the investigation staff should have supervised the hallway when the client was in his/her bedroom/bathroom. She stated when staff left the area briefly to open the door for QIDP A they would not have been able to supervise the hallway. When interviewed on 2/13/17 at 3:20 p.m., DSA B stated he worked on 2nd shift when both Client #1's elopements occurred. During the first incident on 2/3/17, Client #1 was discovered missing when everyone was in the dining room eating supper. He recalled he checked on the client at approximately 5:00 p.m. while assisting another client to the restroom. He also recalled DSA A checked on the client once during supper and then again when she discovered the client was missing. Client #2 told him Client #1 had wanted him/her to leave also so they could go to	W 104		

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W 104	Continued From page 6	W 104		

the vacant house. DSA B had Client #1 show him which house they had discussed. They walked around the house calling the client's name. He also walked around the house again after returning Client #2 to the facility. He did not see any movement in the house, but did not enter the home because it appeared to be unsafe. When he returned to the facility the police had arrived and they were able to discuss different locations where Client #1 could be, including the vacant home. Police did locate Client #1 at the vacant home. After returning to the facility, Client #1 ate supper and nursing completed an assessment. He could not recall what the client wore. DSA B stated at the time of the incident, staff should have checked on Client #1 every 10 minutes when he/she was in his/her bedroom/bathroom. Following the incident, door alarms were placed. On 2/10/17, upon arrival to work he noticed Client #1 and Client #2 talked and as he checked on them, they stopped talking. Client #2 told DSA B Client #1 planned to escape through another client's window on third shift. Client #1 also talked about going through the pantry room window, which was located across from his/her bedroom. DSA B stated he watched Client #1 closely throughout the afternoon and texted the Direct Support Manager (DSM) information about the client's threats. When Client #1 was in his/her bedroom, he/she would look out the door to see if anyone was watching. DSA B stated the only time he did not have eyes on Client #1's hallway was when QIDP A arrived at the home. He left briefly (10-15 seconds) to deactivate the alarm, let the staff in, and reactivate the alarm. QIDP A stayed for approximately 10-15 minutes (approximately 5:20 p.m.) and he walked with her past Client #1's bedroom and deactivated the alarm so she could leave. Once he turned the

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W 104	Continued From page 7 alarm back on, he went to the dining room to give DSA C the alarm keys. DSA B stated he went to Client #1's bedroom and discovered the client had left the bedroom. He notified the executive on-call and also searched the house. The police were contacted and other staff were notified to assist with the search. He determined Client #1 had gone out the pantry room window, as he found the door unlocked and the window open. DSA B stated he was in a mandatory class when he was notified the client had been found. He was told the client had gone to Shopko, stolen clothing, and changed while at the store. DSA B recalled it was a warmer evening, but probably damp due to melting snow. When interviewed on 2/13/17 at 4:10 p.m., DSA A stated on 2/3/17 clients and staff were in the dining room, except for Client #1. DSA B checked on the client in his/her bedroom when the meal started. Approximately 10 minutes later, she went to the client's bedroom and asked him/her if he/she wanted to eat. Client #1 said he/she did not want to eat. After Client #2 finished eating, she followed him/her, as they must maintain eyesight of the client. Since Client #2 lived next to Client #1, she checked on him/her and saw he/she was not in the bedroom. She searched the house and notified the executive on-call. She stayed in the facility to monitor other clients and was made aware when the client returned to the facility. On 2/10/17 she observed DSA B monitoring Client #1's hallway closely. She last saw the client around 5:00 p.m. and heard the client was missing at approximately 5:30 p.m. DSA A was aware DSA B continued to monitor the hallway and door alarms had been placed on all the exit doors. She stated Client #1 easily picked the locks of	W 104		

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W 104	Continued From page 8 doors using a gift card. She observed the opened window in the pantry and assumed the client exited the facility through the window. She stated they have since installed blocks on all the windows and staff completed frequent checks on the client and monitor the hallway where his/her bedroom was located. Client #1 was aware he/she was not staying at the facility, wanted to leave, and was trying to run away. When interviewed on 2/14/17 at 3:15 p.m. DSA C stated on 2/10/17 she recalled interacting with Client #1 in the kitchen around 4:00 p.m. The client asked for a peanut butter and jelly sandwich because he/she was not feeling well and wanted to go to bed. She asked the client if he/she was alright and the client responded he/she just wanted to eat and go to bed. She did not see the client after that due to supper preparations but did observe DSA B monitoring the hallway. When interviewed on 2/14/17 at 9:10 a.m., Community Member and former staff at 825 Ashwood stated Client #1 came to her home on 2/10/17. She notified the facility immediately after the client came inside the house. The client was cold, dirty, and the bottom of his/her pants were wet. Client #1 had a coat on and carried two backpacks. Client #1 appeared dazed and talked about how no one loved him/her and about an aunt being on the moon with the uncle trying to kill him/her. She communicated the information to staff, as she felt the client was probably hallucinating. Client #1 also talked about walking around the river and slipping, which she explained was a very dangerous place to be. She stated she lived about three blocks from Shopko, off Highway 9 and Client #1 had been to her	W 104		

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W 104	Continued From page 9 house before due to providing a Host Home for a former roommate. She stated they maintained a good relationship with the client since leaving her position at the facility. When interviewed on 2/14/17 at 2:05 p.m., Licensed Practical Nurse (LPN) A stated she completed an assessment on Client #1 following his/her elopement on 2/3/17. She stated vitals were normal and the client had a small cut on the right finger, which she treated with antibiotic ointment. When asked how the client sustained the cut, Client #1 stated he/she broke a window to get into the vacant house. LPN A explained to the client the importance of cleaning injuries so they would not get infected. When interviewed on 2/14/17 at 3:00 p.m., LPN B stated she attempted to do an assessment following Client #1's elopement on 2/10/17. She stated the client refused vital signs, but she was able to assess his/her hands/feet with no noted problems. Due to the mental condition of the client, she received an order to transport the client to the ER. When paramedics arrived to transport the client, they again assessed the client but were unable to get the client's vital signs. When interviewed on 2/14/17 at 2:45 p.m., the Direct Support Manager (DSM) stated she was notified by text regarding Client #1's elopement on 2/3/17. She assisted with the search and returned to the facility when the client was found. The DSM prompted the client to wash his/her hands and did not notice any changes with the client, as he/she made jokes and bragged about the adventure. She was notified again by text about Client #1's elopement on 2/10/17. The	W 104		

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W 104	Continued From page 10 DSM stated she had been texted earlier by staff about the client's threats to leave through another client's window. She asked the staff to let the other client know what might happen. The DSM stated at the time of the elopement, staff should have been supervising the hallway if Client #1 was in his/her bedroom/bathroom. Staff should also have completed 10 minute checks. She stated they probably did not take the threats of elopement as seriously as they should have. The client had been made aware the agency was pursuing alternate placement and had also told staff he/she would be going home. When interviewed on 2/13/17 at 2:15 p.m. QIDP A stated Client #1's level of supervision had always been to be in staff's line of sight when in the central areas and 5-10 minute checks when in the bedroom. She stated after the first elopement, staff were to watch the hallway when Client #1 was in his/her bedroom or bathroom. Staff were trained on this as well, as the placement of door alarms on the back doors (2) and front door. Client #1's bedroom window only opened two inches, due to window blocks in place. An empty room located across from Client #1's bedroom contained pantry items and should have been locked at all times. She stated the client did know how to get into locked areas using a gift card to open the lock. With guardian permission, the gift card was removed but Client #1 was able to use playing cards and could still open locked areas. She did find out after the second incident Client #1 talked about leaving the house, but to her knowledge a supervisor was not aware of his/her threats as the supervision level could have possibly been changed. Client #1's current ISP did not contain any information or direction to staff regarding threats of elopement	W 104		

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and acknowledged the ISP should contain the information. After the 2nd incident, the staff assignment/pairings were changed and Client #1's staff would not carry the keys to the alarms so they would not be distracted. QIDP C stated staff came to the front door and deactivated the alarm so she could enter the facility. This was the only time staff did not have eyes on the hallway, but it might have been the opportunity for Client #1 to leave the facility. She did not see Client #1 while in the facility and was told by staff the client had eaten early and wanted to go to bed. QIDP A did not see the client because he/she would get upset and appeared staff were completing the necessary checks. She stated following the incident, blocks were put on all the windows of the house.

When interviewed on 2/13/17 at 12:45 p.m., the Associate Director stated alarms were placed on the exit doors following the first incident, as well as increasing the client's supervision including monitoring the hallway when the client was in his/her bedroom. She stated following the second incident window blocks were placed on all the windows of the facility. They discussed alarms on all the windows, but did not feel this would be a feasible solution. Staff assignments were also changed and the responsibility of who would carry the key to the alarms was established. She stated the facility had been working on discharge for the client as they did not feel the client was appropriately placed.

On 2/14/17 at 1:15 p.m. the facility was notified of Immediate Jeopardy (IJ), due to concerns with the supervision of Client #1 and adequate interventions to address elopement behavior. The AD confirmed the client's level of supervision

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W 104	Continued From page 12 should be increased, as well as, further staff training of the supervision level and also increase the presence of supervisors in the facility to ensure the supervision level would be followed.	W 104		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on interviews, and record review, the facility failed to ensure written program plans consistently provided clear directives to address targeted issues. This affected 1 of 1 client (Client #1) involved in investigation 65968-I. Findings follow: See W104 for additional information. Record review on 2/13/17 revealed the following: a. An Investigation Initiation Form, dated 2/4/17. The form documented on 2/3/17 Client #1 left the facility while other clients/staff ate in the dining room. Staff had been completing checks every 5 - 10 minutes according to staff interviews. The client had been prompted to come to the meal but refused. Supervisory staff were notified the client was missing at 5:39 p.m. Police were also contacted and assisted with the search. The client was found in an abandoned house six houses from the facility and returned at approximately 7:25 p.m. Nursing completed an assessment including vitals which were normal. A two centimeter cut of the pad of his/her right ring finger was treated with antibiotic ointment. Client #1 returned fully clothed including shoes	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 13 and jacket. Alarms were placed on the exit doors of the facility on 2/3/17. b. Client #1's Individual Support Plan (ISP), updated 11/15/16, documented the client should stay within staff's line of sight at all times. The ISP also directed staff to stay in the same room or area as Client #1 except when Client #1 was in a bathroom or his/her bedroom. When in these locations, staff should check on the client at least every 10 minutes. On 2/7/17 the program revision included staff should watch the hallway when Client #1 was in the bathroom or bedroom and continue to check on the client every 10 minutes. Consent had also been obtained to place alarms on the three exit doors of the facility. The ISP failed to contain any information regarding threats of elopement. c. On 2/10/17 an investigation report documented Client #1 left the facility prior to 5:39 p.m. during supper and was gone for approximately five hours. Staff were unaware the client left and did not know his/her whereabouts. It was determined the client unlocked the pantry door and exited through the window. Staff initiated a search and police were notified. The client was gone until 10:19 p.m. when he/she arrived at the house of a former staff member. The client apparently had been to the Shopko store, had stolen items, and according to the police waved a pellet gun in the store. Police determined the client had stolen approximately $335.00 of merchandise and charges would be pressed. Upon return to the facility, the client was transported to Mercy hospital for evaluation. In the findings of the investigation it was determined, staff had been watching the client closely but left the area briefly to turn off the	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 14 alarm while Qualified Intellectual Disability Professional (QIDP) A entered the facility. When interviewed on 2/13/17 at 2:15 p.m. QIDP A confirmed Client #1's current ISP did not contain any information or direction to staff regarding threats of elopement and acknowledged the ISP should contain the information. She confirmed the program had not been revised to include strategies to address threats of elopement. QIDP A stated she would revise the client's program to include steps staff should take when the client threatened to elope.	W 234		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to consistently implement Individual Program Plan (IPP) strategies regarding client supervision. These findings constituted an Immediate Jeopardy to the client's health and safety. This affected 1 of 1 client involved in the investigation of 65968-I (Client #1). Finding follows: See W104 for additional information.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 15 Record review on 2/13/17 revealed the following: a. An Investigation Initiation Form, dated 2/4/17, documented on 2/3/17 Client #1 left the facility while other clients and staff ate in the dining room. Staff completed checks every 5 - 10 minutes according to staff interviews. The client had been prompted to come to the meal, but refused. Alarms were placed on the exit doors of the facility on 2/3/17. b. Client #1's Individual Support Plan (ISP), last updated 11/15/16, documented the client should stay within staff's line of sight at all times and stay in the same room or area as Client #1, except when Client #1 was in a bathroom or his/her bedroom. When in a bathroom or his/her bedroom, staff should check on the client at least every 10 minutes. On 2/7/17 revisions to Client #1's ISP included staff watching the hallway when Client #1 was in the bathroom or bedroom and continuing to check on the client every 10 minutes. Consent had also been obtained to place alarms on the three exit doors of the facility. c. An investigation report, dated 2/10/17, documented Client #1 left the facility prior to 5:39 p.m. during supper and was gone for approximately five hours. Staff were unaware the client left and did not know his/her whereabouts. It was determined the client unlocked the pantry door and exited through the window. Staff initiated a search and police were notified. The client was gone until 10:19 p.m., when he/she arrived at the house of a former staff member. The findings of the investigation determined, staff had been watching the client closely, but left the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 16 area briefly to turn off the alarm while Qualified Intellectual Disability Professional (QIDP) A entered the facility. d. Client #1, a 16 year-old with diagnoses of: oppositional defiant disorder; mild intellectual disability; schizoaffective disorder; hypothyroidism; insomnia; attention deficit hyperactivity disorder, and autism. The client moved to 825 Ashwood on 8/19/2015. According to Weather Underground the temperature on 2/3/17 was 16 degrees Fahrenheit (F). On 2/10/17 the temperature was 32 degrees F. Observations on 2/14/17 revealed an abandoned house approximately 8 lots (2 vacant lots and 6 other houses) from the facility. The house was on the same side of the street as the facility. Shopko was located approximately .2 miles off Highway 69 on Highway 9. The store was approximately 1.1 miles southwest of the facility. When interviewed on 2/13/17 at 3:20 p.m., DSA B stated he worked on 2nd shift when both Client #1's elopements occurred. During the first incident on 2/3/17, Client #1 was discovered missing when everyone was in the dining room eating supper. He recalled he checked on the client at approximately 5:00 p.m. while assisting another client to the restroom. He also recalled DSA A checked on the client once during supper and then again when she discovered the client missing. DSA B stated at the time of the incident, staff should have checked on Client #1 every 10 minutes when he/she was in his/her bedroom/bathroom. Following the incident, door alarms were placed. On 2/10/17, upon arrival to	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 17 work he noticed Client #1 and Client #2 talked and as he checked on them, they stopped talking. Client #2 told DSA B Client #1 planned to escape through another client's window on third shift. Client #1 also talked about going through the pantry room window, which was located across from his/her bedroom. DSA B stated he watched Client #1 closely throughout the afternoon and texted the Direct Support Manager (DSM) information about the client's threats. When Client #1 was in his/her bedroom, he/she would look out the door to see if anyone was watching. DSA B stated the only time he did not have eyes on Client #1's hallway was when QIDP A arrived at the home. He left briefly (10-15 seconds) to deactivate the alarm, let the staff in, and reactivate the alarm. QIDP A stayed for approximately 10-15 minutes (approximately 5:20 p.m.) and he walked with her past Client #1's bedroom and deactivated the alarm so she could leave. Once he turned the alarm back on, he went to the dining room to give DSA C the alarm keys. DSA B stated he went to Client #1's bedroom and discovered the client had left the bedroom. When interviewed on 2/13/17 at 4:10 p.m., DSA A stated on 2/3/17 clients and staff were in the dining room, except for Client #1. DSA B checked on the client in his/her bedroom when the meal started. Approximately 10 minutes later, she went to the client's bedroom and asked him/her if he/she wanted to eat. Client #1 said he/she did not want to eat. After Client #2 finished eating, she followed him/her, as they were required to maintain eyesight of the client. Since Client #2 lived next to Client #1, she checked on him/her and saw he/she was not in the bedroom. She searched the house and	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

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W 249	Continued From page 18 notified the executive on-call. She stayed in the facility to monitor other clients and was made aware when the client returned to the facility. On 2/10/17 she observed DSA B monitoring Client #1's hallway closely. She last saw the client around 5:00 p.m. and heard the client was missing at approximately 5:30 p.m. DSA A was aware DSA B continued to monitor the hallway and door alarms had been placed on all the exit doors. She stated Client #1 easily picked the locks of doors using a gift card. She observed the opened window in the pantry and assumed the client exited the facility through the window. When interviewed on 2/13/17 at 2:55 p.m., QIDP B stated she investigated Client #1's elopement on 2/3/17. At approximately 5:30 p.m. she was notified by Direct Support Associate (DSA) A Client #1 was missing. When asked about the client's supervision level, staff stated the client had been in his/her bedroom and checked by staff every 5-10 minutes. About two hours after leaving the facility, the police located Client #1 in a vacant house on the same street as the facility, and returned the client to the facility. Following the incident, door alarms were installed that evening on the front and back doors. When interviewed on 2/ 15/17 at 11:55 a.m., QIDP C stated she was unaware at the time of the investigation staff should have supervised the hallway when the client was in his/her bedroom/bathroom. She stated when staff left the area briefly to open the door for QIDP A they would not have been able to supervise the hallway. When interviewed on 2/14/17 at 2:45 p.m., the Direct Support Manager (DSM) stated at the time	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G167	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 19 of the elopement, staff should have been supervising the hallway if Client #1 was in his/her bedroom/bathroom. Staff should also have completed 10 minute checks. She stated they probably did not take the threats of elopement as seriously as they should have. The client had been made aware the agency was pursuing alternate placement and had also told staff he/she would be going home. When interviewed on 2/13/17 at 2:15 p.m. QIDP A stated Client #1's level of supervision had always been to be in staff's line of sight when in the central areas and 5-10 minute checks when in the bedroom. She stated after the first elopement, staff were to watch the hallway when Client #1 was in his/her bedroom or bathroom. Staff were trained on this as well, as the placement of door alarms on the back doors (2) and front door. Client #1's bedroom window only opened two inches, due to window blocks in place. An empty room located across from Client #1's bedroom contained pantry items and should have been locked at all times. She stated the client did know how to get into locked areas using a gift card to open the lock. With guardian permission, the gift card was removed but Client #1 was able to use playing cards and could still open locked areas. She did find out after the second incident Client #1 talked about leaving the house, but to her knowledge a supervisor was not aware of his/her threats as the supervision level could have possibly been changed. Client #1's current ISP did not contain any information or direction to staff regarding threats of elopement and acknowledged the ISP should contain the information. After the 2nd incident, the staff assignment/pairings were changed and Client #1's staff would not carry the keys to the alarms	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G157	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

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W 249	Continued From page 20 so they would not be distracted. QIDP A stated staff came to the front door and deactivated the alarm so she could enter the facility. This was the only time staff did not have eyes on the hallway, but it might have been the opportunity for Client #1 to leave the facility. She did not see Client #1 while in the facility and was told by staff the client had eaten early and wanted to go to bed. QIDP A did not see the client because he/she would get upset and appeared staff were completing the necessary checks. She stated following the incident, blocks were put on all the windows of the house. When interviewed on 2/15/17 at 11:50 a.m., the Associate Director confirmed staff failed to consistently follow Client #1's level of supervision. Due to staff leaving the area to assist another staff into the facility, they failed to maintain supervision of the hallway. On 2/14/17 at 1:15 p.m. the facility was notified of Immediate Jeopardy (IJ), due to concerns with the supervision of Client #1 and adequate interventions to address elopement behavior. The AD confirmed the client's level of supervision should be increased, as well as, further staff training of the supervision level and also increase the presence of supervisors in the facility to ensure the supervision level would be followed. The immediate jeopardy was removed at 4:20 p.m.	W 249		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	951825	A. BUILDING: _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 145	50.7(2) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(2) When damage to the facility is caused by a natural or other disaster. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to notify the Iowa Department of Inspections and Appeals (DIA) within 24 hours (or next business day) when evacuation of the facility occurred due to disaster. This affected 7 of 7 clients involved in investigation 64735-I. (Clients #1 - #7) Finding follows: Record review of Client #1's General Event Report (GER), dated 12/19/16, documented on 12/18/16 the client hit a fire extinguisher against a lock in the kitchen area breaking the fire extinguisher. Due to foam throughout the kitchen the building was evacuated and the clients went next door to the adjacent facility (835 S 7th Street). The facility self-report on 12/20/16 documented due to the cleaning company not completing the job, clients remained at 835 Ashwood until 12/20/16. The report provided corrective action that cleaning would be finished on 12/20/16. Also, future incidents regarding environmental issues which required evacuation would result in staying at a hotel to avoid double capacity and ensure overall safety. Going forward, incidents would be reported to the Associate Director rather than the Qualified	C 145		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	951625	A. BUILDING: _____ B. WING _____	C 02/16/2017

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MOSAIC-825 ASHWOOD	825 S 7TH STREET FOREST CITY, IA 50436

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C 145	Continued From page 1 Intellectual Disability Professional (QIDP). When interviewed on 2/13/17 at 2:00 p.m. QIDP A stated she became aware of an incident on 12/18/16 of a client breaking a fire extinguisher resulting in foam throughout the kitchen. The Associate Director had contacted her and requested she contact a cleaning company. Since she did not have immediate access to the information, the decision was made to have maintenance staff make the contact. QIDP A was aware the clients had moved to the house next door for the night (835 South 7th Street). The next day, after the cleaning company had been there, they assessed the environment and decided to keep the clients out of the home for another night. She stated she did not think about contacting the Department of Inspections and Appeals at the time but did call on 12/20/16 between 8:00 a.m. and 9:00 a.m. QIDP A stated the clients slept in the main area of the facility, some went to school during the day, and no problems or concerns occurred. When interviewed on 2/14/17 at 1:25 p.m. the Associate Director stated there had been a miscommunication between the QIDP and herself about notification to DIA regarding the evacuation of the facility. She stated she implemented new direction to staff, in the event of a possible evacuation at 825 due to discharge of the fire extinguisher, the Associate Director would be contacted to determine appropriate placement, coordination with maintenance staff and notification to DIA. She confirmed the facility failed to make an immediate report to DIA regarding the evacuation of clients.	C 145		

LK 3/14/17 CAC 3/14/17

MOSAIC Forest City
825 Ashwood
Forest City, IA 50436
PLAN OF CORRECTION
Incident 64735-I & 65968-I

Investigation Date: 2/13/17 – 2/16/17

Investigation 65968-I:

W 102 483.410 GOVERNING BODY AND MANAGEMENT:
W 104 483.410(a)(1) GOVERNING BODY:

1. The QIDP will review the Elopement Policy and WanderGuard Procedure with the DSAs at 825 Ashwood.
2. The QIDP will review each person's level of supervision at 825 Ashwood.
3. The Home Manager and QIDP will monitor programming and policies through monthly observations to assure that programming and policies are being completed correctly and consistently to prevent recurrence of this deficiency.
4. Completion Date: Upon Receipt

W 234 483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN:

1. The QIDP will review each person's ISP with the DSAs at 825 Ashwood.
2. The Home Manager and QIDP will monitor programming and policies through monthly observations to assure that programming and policies are being completed correctly and consistently to prevent recurrence of this deficiency.
3. Completion Date: 3/31/17

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION:

4. The QIDP will review each person's BSP with the DSAs at 825 Ashwood.
5. The Home Manager and QIDP will monitor programming and policies through monthly observations to assure that programming and policies are being completed correctly and consistently to prevent recurrence of this deficiency.
6. Completion Date: Upon Receipt

Investigation 64735-I:

C 145 50.7(2) DAMAGES TO FACILITY CAUSED BY A NATURAL OR OTHER DISASTER:

1. A Fire Extinguisher Procedure was put into place at 825 Ashwood that includes the Associate Director reporting to DIA immediately following any incident in which the fire extinguisher would go off and people would need to evacuate their home to prevent recurrence of this deficiency.
2. The QIDP trained the DSM and DSAs at 825 Ashwood on this procedure to prevent recurrence of this deficiency.
3. Completion Date: Upon Receipt

Tonya Ludwig, AD 3/14/17