VJC 6/16/17 CAC 6/13/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G113	A. BUILDING _____ B. WING _____	C 04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-217 MAPLE AVENUE	217 MAPLE AVENUE NEVADA, IA 50201

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W 000	INITIAL COMMENTS At the time of the investigation of incident #67131-I deficiencies were cited at W153 and W249.	W 000		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure staff intervened and immediately reported allegations of abuse to the administrator per the facility policy. In addition, the facility failed to report an allegation of abuse to the Department according to state law. This affected 1 of 1 client during the investigation of incident #67131-I (Client #1). Findings follow: 1. Record review on 4/24/17 revealed a facility internal investigation packet, completed 3/23/17. The packet contained a copy of an e-mail sent by Direct Support Associate (DSA) A to the Habilitative Coordinator (HC), the Program Coordinator (PC) and the Direct Support Manager (DSM) on 3/12/17. The e-mail noted concerns regarding DSA B's treatment of clients at the home, and specifically noted DSA B failed to offer Client #1 breakfast and sent him/her back to his/her bedroom so she didn't have to "deal with a behavior." Additional record review revealed a written	W 153	W153 STAFF TREATMENT OF CLIENTS Mosaic will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, staff will be retrained on the Adult Abuse and Reporting Reasonable Suspicion Policy regarding intervening and reporting allegations of abuse/neglect immediately to the supervisor. Policy will be reviewed annually with employees. Additionally, supervisors will meet with direct reports monthly during coaching to review any concerns. Person(s) Responsible: Program Coordinator	05/09/17

POC 6/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol Maurer		5/11/17

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 153	Continued From page 1	W 153		

statement signed by DSA A on 3/21/17. The statement noted Client #1 came out of his/her bedroom on 3/11/17 at approximately 8:00 a.m. and DSA B directed him/her back to his/her room continuously. She wrote the redirection lasted for 2 and 1/2 hours. DSA A's documentation revealed DSA B failed to offer Client #1 breakfast on 3/11/17. Continued record review revealed another written statement by DSA A signed on 3/21/17. The statement noted on the morning of 3/12/17, DSA B again consistently directed Client #1 to his/her bedroom without offering him/her breakfast.

Record review on 4/24/17 revealed the facility Adult Abuse and Reporting Reasonable Suspicion of a Crime policy. The document read, "Any employee who observes or suspects abuse, observes or reasonably suspects a crime, neglect, exploitation or mistreatment of a person served shall intervene immediately on the person's behalf to ensure safety and shall report the incident immediately following guidelines in this policy and procedure." The policy noted staff should report to the DSM, PC, HC, Associate Director or Executive Director.

When interviewed on 4/24/17 at 3:20 p.m., DSA A confirmed DSA B failed to offer Client #1 breakfast on 3/11/17 and 3/12/17. She stated she sent an e-mail to the DSM on 3/12/17 regarding the incidents.

When interviewed on 4/26/17 at 11:15 a.m., the PC confirmed staff should report incidents of suspected abuse immediately.

2. When interviewed on 4/25/17 at 9:34 a.m., DSA C stated she witnessed DSA B push Client

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#1 into a chair and when he/she got up and walked to the kitchen, DSA B shoved Client #1 into the living room. She couldn't recall the exact date of the incident but stated she failed to report the incident until a few days later.

3. Record review on 4/25/17 revealed an e-mail sent by the DSM to the PC and the HC on 2/14/17. The e-mail noted DSA C approached her on the morning of 2/14/17 to report DSA B pushed and shoved Client #1 on 2/11/17.

Further record review revealed e-mails from the HC and Associate Director (AD) requesting the DSM make further inquiries into the allegation. An e-mail to the HC from the DSM dated 2/14/17 at 9:09 a.m. noted DSA C demonstrated what she saw by pushing the DSM across the living room to a recliner, then pushed the DSM into the chair. A summary statement signed by the HC on 2/25/17 noted the DSM followed up with staff and conducted re-training.

When interviewed on 4/25/17 at 11:58 a.m., the DSM recalled the HC directed her to speak with DSA B regarding an allegation she pushed/shoved Client #1.

When interviewed on 4/25/17 at 11:25 a.m. the HC confirmed DSA C alleged DSA B pushed Client #1 into a chair on 2/11/14 but failed to report the incident until 2/14/17. She stated she reported the incident to the AD who determined the incident only required re-training of staff. She confirmed the facility failed to report the incident to the Department.

Record review of the facility Adult Abuse and Reporting Reasonable Suspicion of a Crime

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W 153	Continued From page 3 policy on 4/25/17 revealed the following: "The associate director or executive director are the designated employee to immediately make all reports of alleged abuse to the appropriate state agency." The document directed notification to the state agency would occur within 24 hours of the allegation.	W 153		
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 interviews and records review, the facility failed to ensure staff implemented needed supports and services as directed by the Individual Program Plan (IPP). This affected 2 clients identified during the investigation of incident # 67131-I (Client #1, and Client #3). Findings follow: 1. Record review on 4/24/17 revealed an internal investigation of staff failure to offer Client #1 breakfast on 3/11/17 and 3/12/17. Further record review revealed Client #1's Meal Schedule Individual Support Plan (ISP). The ISP noted Client #1 had a history of refusing meals and needed structure to his/her schedule to ensure adequate nutrition. Teaching Method 2 directed	W 249	W249 PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client will 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. Specifically, staff will be retrained on plans and programs and ensure staff implement needed supports and services as directed by the ISP. This will be monitored through monthly meal, active treatment, and program observations. Person(s) Responsible: Program Coordinator	06/09/17

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W 249	Continued From page 4 staff to encourage Client #1 to follow a meal schedule, offering breakfast from 8:00 a.m. - 10:00 a.m. Implementation of the ISP included staff prompts to Client #1 to come to the table for the meal and to let him/her know how much time he/she had before the meal was over. When interviewed on 4/24/17 at 2:20 p.m., Direct Support Associate (DSA) B confirmed she failed to prompt Client #1 to eat breakfast on 3/11/17 and 3/12/17. She said Client #1 liked to sleep in until 10:00 a.m. She acknowledged if he/she got up before 10:00 a.m., she directed him/her back to his/her room. She noted if Client #1 wanted to eat, he/she would just go to the kitchen, so she didn't prompt him/her to come to the table for breakfast between 8:00 a.m. and 10:00 a.m. on 3/11/17 and 3/12/17. When interviewed on 4/24/17 at 3:20 p.m., DSA A confirmed she worked with DSA B on 3/11/17 and 3/12/17 and witnessed her failure to prompt Client #1 to come to the table for breakfast. She confirmed she, too, failed to prompt him/her to eat breakfast. When interviewed on 4/25/17 at 11:15 a.m., the Direct Support Manager (DSM) stated staff should encourage Client #1 to come to the table to eat, encourage him/her to help with meal preparation, let him/her know when a meal is ready and let him/her know how much time is left to eat. She said staff directing him/her to his/her bedroom was not part of the Meal Schedule ISP. When interviewed on 4/25/17 at 3:10 p.m., the Qualified Intellectual Disability Professional (QIDP) confirmed staff should encourage Client #1 to eat and participate in meal preparation	W 249		

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W 249	Continued From page 5 every day. She further confirmed redirecting him/her back to bed was not consistent with his/her programming. 2. Record review on 4/24/17 revealed an e-mail sent by DSA A to the Habilitative Coordinator (HC), PC and DSM on 3/12/17. DSA A wrote "(Client #3) was also man handled and wasn't needed to be." Further record review on 4/25/17 revealed an e-mail sent by DSA D to the DSM and PC on 3/13/17 at 12:42 a.m. DSA D indicated DSA B tipped Client #3's wheelchair back and shook it to scoot him/her back in the chair on 3/12/17. Record review on 4/25/17 revealed Client #3's ISP completed on 1/9/17. The plan noted Client #3 used a wheelchair when he/she felt weak. The ISP noted Client #3 needed consistency in staff to support him/her to be comfortable around them and trust them. When interviewed on 4/24/17 at 3:20 p.m., DSA A confirmed she saw DSA B tilt Client #3's wheelchair back and shake it to reposition him/her on 3/12/17. When interviewed on 4/25/17 at 1:05 p.m., DSA D confirmed she saw DSA B tilt Client #3 back in his/her wheelchair and shake the chair to move him/her back in the seat. She recalled Client #3 held the arms of the chair and looked around wide eyed. She confirmed he/she may have been frightened or uncomfortable. She confirmed he/she is unsteady and tenses up at any movement. When interviewed on 4/25/17 at approximately	W 249		

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W 249	Continued From page 6 3:48 p.m., the QIDP confirmed tilting and shaking Client #3 in his/her wheelchair would startle him/her. She acknowledged the such behavior would not be consistent with Client #3's ISP to support him/her.	W 249		