8/18/17 OK 8/18/17

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

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 07/19/2017

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 The investigations of self-reported incidents #65658-I and 69239-I were conducted 7/13/17 - 7/19/17: Incident # 65658-I resulted in a deficiency cited at W186. Incident #69239-I resulted in a deficiency cited at W189.	W 000	POC 7/19/17	
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently ensure sufficient staff available to provide services and supports to clients as necessary. This affected 6 of 6 clients (Client #1 - Client #6). Findings follow: Record review on 7/13/17 revealed the facility's summary of an incident occurring 5/19/17. According to the facility's inquiry, Client #3 ate lunch, as Direct Support Associate (DSA) B sat across from him/her and assisted another client. DSA B reported Client #3 began to cough and she encouraged Client #3 to continue to cough. Client #3 never appeared unable to get air, but	W 186	W186 DIRECT CARE STAFF The facility will provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, staff will be retrained on Mosaic's General Work Guidelines Policy which specifies when it is appropriate to take breaks. Additionally, staff will be retrained on meal and diet supports to ensure safety during mealtimes. This will be monitored through daily oversight of the schedule by the Direct Support Supervisor and at least monthly active treatment and meal observations. Person(s) Responsible: Habilitative Manager	07/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Mau | TITLE: Exec. Director | (X6) DATE: 8/18/17

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 186	Continued From page 1	W 186		

did turn red. DSA B went to the outside door to get staff to assist. DSA C came into the home and implemented the Heimlich maneuver on Client #3. Client #3 spit some food out, and appeared to swallow the rest. Client #3's lunch consisted of beef stroganoff, cooked carrots, and shredded pineapple. Staff reported the client's diet was followed and food cut into bite sized pieces. Staff reported two of the three scheduled staff were outside smoking when the incident occurred.

Record review revealed a General Event Report (GER), dated 5/19/17. The report, completed by DSA C, documented at approximately 12:20 p.m. Client #3 began to choke while eating lunch. The report continued, "... staff tried the (Heimlich maneuver) on (him/her) and what was in (his/her) mouth (he/she) got up but swallowed it, staff tried to get (him/her) to spit it out..." The report document the incident occurred at 12:20 p.m. The report noted the client was taken to the emergency room (ER) to be seen. Further review of the GER revealed the Program Manager (PM), noted on 5/191/7 at 3:05 p.m., "Staff should be available to assist during meals and encourage (Client #3) to slow down and drink liquids."

When interviewed on 7/13/17 at 12:00 p.m. DSA B recalled clients sat at lunch. DSA B knew Client #1, Client #3, and Client #6 were definitely at lunch, as they sat with her. She reported Client #1 ate independently and drank after his/her meal; Client #3 required prompting to slow down while eating, but ate independently at the time; Client #6 required bite sized pieces and was spoon fed by staff. She believed Client #5 to also be in the dining area, but could not recall for sure what Client #2, Client #4, and Client #5 did. DSA

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W 186	Continued From page 2 B sat near Client #6 at the table, and Client #3 sat across from them. DSA B reported Client #3 ate beef stroganoff with ground beef pieces. Client #3 began to cough, and DSA B encouraged him/her to continue to do so. The client struggled with the cough, but never gasped for air. She could see food coming up, and went to get DSA C from the patio area where she was with DSA A. DSA C entered the dining room and performed the Heimlich maneuver on Client #3. DSA B reported something, food or vomit, came up during the Heimlich maneuver and Client#3 swallowed it. DSA B reported there were three staff on duty at the time. DSA A and DSA C were outside on a break at the time of the incident. DSA A reported frequently two of three staff will take break at the same time, though not usually during meals, leaving one staff to monitor three clients. When interviewed on 7/13/17 at 10:40 a.m., DSA A reported once lunch was prepared, she and DSA C went outside to smoke. She stated she was not aware DSA B gave the clients their food. She recalled being outside about five minutes, and as she came into the home DSA B told her Client #3 was choking. DSA A completed the Heimlich maneuver on Client #3. Client #3 appeared to spit up some food, chew it , and swallow it. She stated she did not believe Client #3 actually choked on his/her food, as there was no redness of the face, no struggle, and only a minor cough. DSA A reported protocol is for the client to be evaluated at the emergency room (ER) after the Heimlich maneuver is used. The nurse was called and the client was transported to the ER by DSA C. DSA A reported Client #3 generally ate independently. DSA A stated it takes three staff to assist with mealtimes.	W 186		

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W 186	Continued From page 3 When interviewed on 7/13/17 at 12:30 p.m., DSA C recalled Client #3 sat at the table eating while the rest of the clients were done. DSA C and DSA A went outside to smoke at the end of the meal. When they came in, DSA B told them Client #3 was choking. DSA C stated it was typical for two staff to break at the same time. She stated they went out the patio door and left the door open, so they could hear into the home. Record review revealed Client #3, age 36, had diagnoses including: severe intellectual disability, epilepsy, congenital malformation of nervous system, encephalopathy. Client #3's health supports noted he/she had compromised chewing ability and required a small portions, regular diet with food cut into bite sized pieces. Review of hospital records revealed Client #3 arrived at the ER on 5/19/17 at 1:01 p.m. The reports summarized the client presented to ER for evaluation after a choking episode. The report noted the client to have been his/her normal self since the incident. Discharge instructions included continuing current plan of care and a recommendation for endoscopy if problems continued. Continued record review revealed the following: a. Client #1's health supports noted he/she had a diagnosis of dysphagia and required prompts to take small bites and small sips. Client #1's nutritional assessment, dated 3/8/17, recommended prompts to swallow and slow down while eating and/or drinking and prompts/encouragement to take smaller bites and/or smaller sips.	W 186		

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W 186	Continued From page 4 b. Client #2 did not eat by mouth. c. Client #4's health supports noted he/she required encouragement to take small bites and sips and only one bite of food at a time during meals. Client #4's speech therapy evaluation, dated 5/10/17, noted he/she required prompts to eat and drink slowly. d. Client #4's individual data noted he/she required use of a posey belt when up walking due to unsteadiness. Observations on 7/13/17 from 11:15 a.m. - 12:25 a.m. revealed each time the client was observed to stand and begin walking, staff hurried to his/her side. Staff walked with Client #4 and prompted him/her to sit. e. Client #5's health supports documented Client #5 required one on one (1:1) assistance during mealtimes. f. Client #6's nutritional assessment, dated 9/14/16, recommended physical assistance as needed for scooping food and verbal encouragement as needed to eat. Continued record review revealed the facility's policy outlining general work guidelines. Procedures included: Employees may take no more than two short (5 minute) breaks during their shift that will not interfere with the needs of people in service. In situations where there is more than one person on duty, breaks should not be taken at the same time. When interviewed on 7/14/17 at 10:05 a.m., the Program Manager (PM) stated it was not acceptable for two staff to break at one time.	W 186		

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W 186	Continued From page 5 When interviewed on 7/13/17 at 8:30 a.m., the Habilitation Manager (HM) reported five of six clients ate meals in the home. She stated at least two staff would be required to assist with this. The HM reported two staff were on break together when the incident occurred. She confirmed this was not appropriate.	W 186		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff consistently demonstrated the necessary skills and knowledge to ensure the safety of clients. This affected 1 of 1 client (Client #5) identified as a result of facility self-reported incident #69239-I. Finding follows: Record review on 7/13/17 revealed the facility's summary regarding an incident occurring 7/5/17. On 7/5/17 at approximately 1:50 p.m., Staff assisted Client #2 to the main office. Direct Support Associate (DSA) A and Direct Support Supervisor (DSS) A assisted two clients from the rear of the van using the rear entry wheelchair lift. DSA A removed the tie downs of the first client (Client #2) and assisted him/her onto the lift. DSS A lowered the lift and took the client into the building, leaving the lift on the ground. DSA A removed the tie downs from Client #5's wheelchair and began to move him/her toward	W 189	W189 STAFF TRAINING PROGRAM The facility will provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. The facility will ensure staff consistently demonstrate the necessary skills and knowledge to ensure the safety of clients. Staff will be retrained on Mosaic's Driving Vehicles for Mosaic Policy which states that the lift will be left in the "up" position when unattended. Specifically, staff will be retrained that, when an employee assists people served into a building / home, the lift will be secured in the "up" position prior to assisting a person into the building / home. Staff will also be retrained on looking first before pushing a person served onto the lift to ensure safety. This will be monitored by monthly vehicle tie down and lift use observations. Person(s) Responsible: Habilitative Manager	07/19/17

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W 189	Continued From page 6 the lift. DSA A did not notice the lift still in the down position, and Client #5 fell to the ground while in his/her wheelchair. Staff immediately assisted and called 911. The client was transported to the emergency room (ER). Client #1 was released from the ER with no new diagnosis. When interviewed on 7/13/17 at 12:30 p.m., DSA A recalled after lunch she took Client #1 and two others to the main office. When they reached the office, she parked the van, so the rear of the van faced the main office building. DSS A and Program Manager (PM) A came out to assist with the clients. DSS A ran the lift from the ground. DSA A removed Client #2's tie downs and placed him/her on the lift. DSS A lowered the client, while DSA A removed Client #5's tie downs. DSA A reported she heard the lift operating, the heard DSS A say she would be right back. DSA A thought the lift was in the up position. DSA A explained Client #5 face into the van as she began to move him/her towards the lift. He/she began to the fall and she realized the lift was not in the up position. Client #5's front wheels hit the overhang of the lift (hangs out of van) and then he/she went backwards. DSA A explained Client #5's wheelchair handlebars hit the ground, and prevented his/her head from hitting the ground. DSA A stated it happened very quickly, but she attempted to hold the wheelchair, or at least lessen the fall. DSA A state the wheelchair lift is usually in the up position before a client is taken into a building. She stated she did not look to ensure the lift was up, she just assumed it was. When interviewed on 7/18/17 at 12:50 p.m. DSS A stated DSA C brought three clients up to the main office. She was asked to assist in bringing	W 189		

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W 189	Continued From page 7	W 189		

the clients in. She recalled as they approached the van, she noticed a client sat in the front seat. She assisted that client from the van and as they walked toward the rear of the van, the Program Manager (PM) stated he would assist the client into the building. DSS A explained when she reached the rear of the van, the PM had opened the doors and began to lower the lift. DSA C removed the tie downs for the first client and placed him/her onto the lift. DSS A lowered the client on the lift. She stated it was terribly hot that particular day and she did not want the client to sit in the heat. She told DSA C she would take the client into the building and be right back. She noted when she told DSA C this, DSA C had not yet begun removing the tiedowns on Client #5's wheelchair. DSS A headed toward the door with the other client, when she heard DSA C yell out. She turned and saw Client #5 had fallen backwards from the lift. She noted DSA C attempted to slow and/or hold the wheelchair. DSS A stated she does not usually assist with getting clients on and off the van. She stated she left the lift down, but did communicate to DSA C she was taking the client inside and would be right back.

When interviewed on 7/14/17 at 10:05 a.m., the PM recalled DSA A brought three clients to the main office. He assisted Client #6, who sat in the front seat, to walk into the office. As he returned to the area after assisting Client #6, he noticed DSS A pushed Client #2 in and had a panicked look on her face. She looked back toward the van, and he looked over to see Client #5 laying on the ground in his/her wheelchair. He explained the wheelchair wheels touched the back bumper and DSA A held the front wheels, appearing to attempt to lift the chair up, or hold it

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W 189	Continued From page 8 in place. The PM stated the expectation was for the lift to be returned to the up position before leaving the area. He stated it would also be the expectation for staff to check the area before placing a client onto a lift. Record review revealed Client #5, age 69, had diagnoses including, but not limited to: profound intellectual disability, down syndrome, osteoporosis without current pathological fracture, anemia, and heart failure. According to Client #5's individual data, he/she required a manual wheelchair with seatbelt and footrests. Continued record review revealed hospital records for Client #5's visit to the emergency room on 7/5/17. The report noted Client #5 presented in the ER after he/she rolled backward off of a van lift in a wheelchair. Staff reported the client did not hit his/her head. The physical exam noted the client's neck did not appear to be painful with palpation over cervical spinous process. The exam further noted the client appeared alert and had some occasional jerking movements of extremities. Records indicated no imaging tests were completed. Assessment noted the final diagnoses as fall with no injury, and gave no further orders. Record review revealed Mosaic's policy, "Driving Vehicles for Mosaic," approved 4/4/17. The policy included direction for wheelchair lifts and directed, "Lifts will be left in the "up" position when unattended. Specifically, when an employee assists people served into a building/home, the lift will be secured in the "up" position prior to assisting a person into the building/home."	W 189		

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W 189	Continued From page 9 Observation on 7/13/17 at 12:50 p.m. revealed the van with wheelchair lift used the day of the incident. The van could carry three wheelchairs. The hydraulic wheelchair lift was operated via remote, which hung to on the right rear door. When in the down position, a plate overhung the rear of the van, approximately 8-10 inches. The length from the van to the ground with the lift in the down position measured approximately 2.5 feet. When interviewed on 7/13/17 at 9:00 a.m. the Habilitative Manager (HM) reported Client #5 sustained no injuries as a result of the fall from the van. The client was taken to the local ER and released with no new diagnosis. The facility completed neurological checks every two hours and the client received ibuprofen or acetaminophen every six hours while awake for a few days. The HM reported staff are trained to put the lift back into the up position before they leave the area. She reported they would also expect staff to check the area before pushing a client onto a lift.	W 189		