

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

PRINTED: 09/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
W 000	INITIAL COMMENTS During the annual survey, the investigation of self-reported Incident #70158-I was also conducted. A deficiency was cited at W249 as a result. The annual survey resulted in deficiencies cited at W440. Iowa Administrative Code Chapter 50.9(3)c and 50.9(4) were also cited. See state form 2567. 483.440(d)(1) PROGRAM IMPLEMENTATION	W 000	Sel attached POC 9/30/17	
W 249	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 record review, the facility failed to consistently ensure implementation of individual program plans (IPPs) as written. This affected 1 of 1 Client (Client #1) Identified in investigation #70158-I. Findings follow: Record review on 8/14/17 revealed a General Event Reports (GER) dated 8/14/17 at 2:29 p.m. The report completed by Direct Support Associate (DSA) A, documented: "(Staff) took (Client #1) to get a haircut not realizing they didn't take debit cards. (They) went to the gas station and (Client	W 249		

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Debra Slidewa, AD

TITLE

(X6) DATE

9/25/17

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.

✓ 9/29/17 OK

MOSAIC Forest City
825 Ashwood
Forest City, IA 50436

PLAN OF CORRECTION ANNUAL SURVEY & INVESTIGATION

Survey Date: 8/14/17 – 8/17/17

Investigation #70158-I

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

1. Staff received a written disciplinary action for not following BSP.
2. The QIDP will retrain DSAs on each person's BSP and formal/informal programs.
3. The QIDP will monitor program implementation through monthly observations as well as monthly goal data collection to prevent the recurrence of this deficiency.
4. Completion Date: 9/30/17

W 440 483.470(i)(1) EVACUATION DRILLS:

1. The Direct Support Supervisors will be retrained on the drill schedule by the Direct Support Manager.
2. The Direct Support Supervisors will be responsible for running all drills in the home they supervise and will no longer delegate this out to direct support associates.
3. The Associate Director will review the drill forms, monthly, to prevent recurrence of this deficiency.
4. Completion Date: 9/30/17

C 206 01-50.9(3)c BACKGROUND CHECKS:

1. Background audit was completed at the corporate office [REDACTED] on all employees hired August 2016 to current.
2. A new SING has been attached to employee hire file for those that did not have it.
3. Human Resource Generalist will be contacted by the corporate office once background checks are completed. The Human Resource Generalist and State Human Resources Manager will ensure and monitor in ADP (electronic hiring system) on an ongoing basis that new hires have completed background checks and hire within 30 days to prevent recurrence of this deficiency. If not hired within 30 days the SING will be run, again, prior to hire.
4. Completion Date: 9/30/17

C 209 01-50.9(4) BACKGROUND CHECKS:

1. Background audit was completed at the corporate office [REDACTED] on all employees hired August 2016 to current.
2. A new SING has been attached to employee hire file for those that did not have it.
3. Human Resource Generalist will be contacted by the corporate office once background checks are completed. The Human Resource Generalist and State Human Resources Manager will ensure and monitor in ADP (electronic hiring system) on an ongoing basis that new hires have completed background checks and hire within 30 days to prevent recurrence of this deficiency. If not hired within 30 days the SING will be run, again, prior to hire.
4. Completion Date: 9/30/17

MD Ludwig, AD

9/25/17

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

PRINTED: 09/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>#1) got a drink and cash back... (Staff) parked on a hill. (Client #1) said (he/she) wanted to stay in the car. (Staff) walked into the salon and when she saw the lady wasn't at the front desk (a minute at most) she went back out to get (Client #1) and shut off the van. (Staff) reached over (Client #1) to grab the keys and apparently (the van) wasn't in park so the van rolled down hill in reverse. (The) driver side door was open with (staff's) back to the door. (Staff) ran with the van (she was between open door and (Client #1)) The passenger side door... hit a pole (hyperextending) the door making it not able to shut. (The) van kept rolling and finally stopped when it hit the backside of a truck. (Staff was able to move the vehicle so it wasn't in the middle of the road. (When) parked police showed up and took information... staff called the home to have some one come (get Client #1)."</p> <p>Additional record review revealed DSAA's statement to the facility of events, dated 8/15/17. The statement recounted, Client #1 and DSAA pulled up to pay for his/her haircut; since they didn't take debit they had to go get cash. Client #1 told DSAA he/she did not want to go inside. She left the van running and quickly ran inside. When she saw it would be a bit because the lady was doing a haircut, she went to get (Client #1). DSAA documented this as a minute at most. She opened Client #1's door and told him/her he/she would have to go in because it would be a bit. She reached over Client #1 to shut the van off and pull the keys. As soon as she turned the key, the van began to roll backwards. The door was open and she stood between the door and Client #1. The van rolled back two parking spaces before it hit a pole. DSAA continued to run with the van. The van then crossed a four</p>	W 249		

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

PRINTED: 09/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 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)
W 249	<p>Continued From page 2</p> <p>way intersection and curved a little. It crossed the road and hit a truck. She shut the door as well as she could before she moved the van to a parking spot so it wasn't in the middle of the road. Police showed up and took her information. No citation was given. She guessed the van rolled 30 yards or so.</p> <p>When interviewed on 8/15/17 at 12:00 p.m. DSA A explained she took Client #1 to get a haircut. The salon did not take debit cards, so they went to get \$20 cash from the gas station. When they returned to the salon she pulled back in front, with the passenger side parallel to the sidewalk, and parked on the hill. She left the van running and left the van in drive unknowingly. She had the passenger side door open and when she shut the van off it began to roll backwards. The door hit a light pole bending the door back. The van rolled across the intersection and hit a parked truck. DSA A guess the van rolled approximately 30 yards or so.</p> <p>Record review on 8/15/17 revealed Client #1's Individual Support Plan, dated 7/26/17. The Plan stated under Safety in the Community section: Staff are with Client #1 at all times when he/she is in the community. The plan further stated Staff are with him/her at all times to keep him/her safe. Further record review of the ISP meeting revealed a Mosaic Human Right Assessment form. The form, dated 6/1/17, included a section Supervision: The report stated Client #1 received 24 hour supervision in the community.</p> <p>Continued record review revealed Client #1, age 28, had diagnoses including, but not limited to: moderate intellectual disability, major depressive disorder, autistic disorder, impulse disorder,</p>		W 249	

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

PRINTED: 09/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 3 epilepsy and recurrent seizures, and attention deficit hyperactivity disorder. When interviewed on 8/16/17 at 3:30 p.m. the Program Coordinator and Qualified Intellectual Disability Professional (QIDP) stated Client #1 should be supervised at all times when in the community. DSA should not have left Client #1 unsupervised and should not have left the van running.	W 249		
W 440	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure quarterly fire drills conducted on each shift. This potentially affected 7 of 7 clients residing in the 825 facility. Finding follows: Record review on 8/14/17 of facility fire drills conducted between August 2016 and July 2017 revealed a third shift fire drill was completed on 11/15/16. Another third shift drill did not get completed until 4/5/17. The facility failed to complete a fire drill on the third shift during January, February or March of 2017. When interviewed on 8/14/17 at 12:45 p.m., the Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) confirmed the facility failed to ensure quarterly fire drills were conducted on the third shift.	W 440		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 951825	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 206	<p>01-50.9(3)c Background Checks</p> <p>481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks.</p> <p>50.9(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.</p> <p>c. If a person being considered for employment has been convicted of a crime. If a person being considered for employment in a facility has been convicted of a crime under a law of any state, the department of public safety shall notify the facility that upon the request of the facility the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure criminal background checks were thoroughly completed when a possible hit occurred. This potentially affected 7 of 7 clients residing in the facility. Finding follows:</p> <p>Record review on 8/14/17 of facility criminal background checks, revealed Staff B's Single Contact License and Background Check (SING).</p>	C 206		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 951825	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 206	<p>Continued From page 1</p> <p>The report, timestamped 12/16/16, directed, "Initiate record check evaluation process by completing form 2310 and submitting to DHS..." for the child abuse registry. Further record review revealed no further evaluation completed by the facility.</p> <p>Additional record review revealed Staff B's date of hire 1/2/17.</p> <p>When interviewed on 8/14/17 the director of human resources confirmed the facility failed to complete the necessary evaluations for Staff B prior to hire. Upon discovery during the annual survey the facility completed the checks and the employees were cleared to work.</p>	C 206		
C 209	<p>01-50.9(4) Background Checks</p> <p>481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks.</p> <p>50.9(4) Validity of background check results. The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure criminal background checks were completed within 30 days of hire. This potentially affected 7 of 7 clients residing in the facility. Finding follows:</p> <p>Record review on 8/14/17 of facility criminal background checks, revealed Staff A was hired</p>	C 209		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 951825	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-825 ASHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 209	<p>Continued From page 2</p> <p>on 5/28/17. Further record review revealed Single contact License and Background Check (SING) completed 4/14/17.</p> <p>When interviewed on 8/14/17 the Director of Human Resources confirmed the facility failed to complete a SING check no more than 30 days prior to hire.</p>	C 209		

OK

Citation
Mosaic in North Iowa
IA. Dept. of Inspections and Appeals
Health Facilities Division

Mosaic 825 South 7th Street
Forest City, IA 50436

Investigation #6634
Date: 8/14/17 – 8/17/17

Deficiency	Plan of Correction	Date of Completion
W 249 483.440(d)(1) PROGRAM IMPLEMENTATION	<p>The QIDP will review each person's BSP with the DSAs at 825 Ashwood.</p> <p>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.</p>	Upon Receipt Upon Receipt
50.9(3) 50.9(4) BACKGROUND CHECKS	<p>Background audit was completed at the corporate office by Mallory Walter on all employees hired August 2016 to current.</p> <p>A new SING has been attached to employee hire file for those that did not have it.</p>	Upon Receipt Upon Receipt
	<p>Human Resource Generalist will be contacted by the corporate office once background checks are completed. The Human Resource Generalist and State Human Resources Manager will ensure and monitor in ADP (electronic hiring system) on an ongoing basis that new hires have</p>	Upon Receipt

	completed background checks and hire within 30 days to prevent recurrence of this deficiency. If not hired within 30 days the SING will be run, again, prior to hire.	
--	---	--

Janka Ludwig AD

Administrator/Designee Signature

Title

9/25/17

Date