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

PRINTED: 09/12/2017
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
	16G118	A. BUILDING ______ B. WING ______	C 08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1031 SHAGBARK DRIVE	1031 SHAGBARK DRIVE NEVADA, IA 50201

(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 Investigations #69632-I and #69686-I were conducted on 8/16/17-8/22/17. Investigation #69632-I resulted in a deficiency cited at W474. Investigation #69686-I resulted in a standard-level of deficiency written at W249. Also cited was Iowa Administrative Code (IAC) Chapter 50.7(4). See State Form.	W 000		
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 observations, interviews and record reviews, the facility failed to ensure clients received needed supports and services as outlined in the Individual Support Plan (ISP). This affected 1 of 1 clients reviewed during investigations #69686-I (Client #1). Findings follow: 1. Record review on 8/16/17 revealed Client #1's GER, dated 7/20/17 indicated on 7/17/17, "There were on two staff members on duty today both were busy with other residents. CMA had walked in to the medication room to start noon	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 249	Continued From page 1	W 249		

medication pass when they looked out the window and seen (Client #1) sitting in their car."

Further record review revealed summary of inquiry dated 7/21/17, "(DSA/CMA A) said that she was not aware of the proper protocol and did not know it needed to be reported. (DSS B) became aware of the event during a conversation they were having on Wednesday and asked her to do a GER. She didn't ask details on the event and didn't know when it had occurred. She said that her thoughts have been more occupied with another individual who is going into hospice. (Program Manager) said that he first became aware of it when he was talking to (DSA D) on Tuesday, but that he thought (DSA D) was talking about something that had happened a year ago and that he either wasn't listening carefully or he should have asked questions. He was notified by (DSS B) about the GER being completed and put two and two together. He then acknowledges he forgot about it because he got busy with other stuff and that is should have been reported up right away."

Additional record review revealed the following:
a. The diagnosis of Client #1, age 25 at the time of the incident, included: profound intellectual disabilities, anxiety disorder, autistic disorder, cerebral palsy, impulse disorder, and intermittent explosive disorder.

b. Client #1's Behavior Support Plan dated 5/1/17 indicated targeted behaviors included elopement. The definition of elopement included, "leaving the house without staff assistance." The plan also indicated, "(Client #1) has a history of elopement. To help staff be aware when (Client #1) is outside, there are door chimes on exits, and a

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W 249	Continued From page 2 siren on the sensory room door as this is where (Client #1) has spent much of (his/her) time. It is important for staff to be aware of where (Client #1) is at all times. (Client #1) has a history of leaving the house and sitting in staff's vehicles, staff need to keep their vehicles locked. (Client #1) should be encouraged to use the buttons by the exits for communication to staff that (he/she) wants to go outside." c. Client #1's ISP Plan dated 4/4/17 indicated, "I do not have street safety skills. I need physical assistance to read signs, monitor traffic, etc. in the community. I have a history of leaving the house unsupervised (elopement). Staff should keep their vehicles at my house locked so I cannot enter them as in the past I have sat in cars in the parking lot of my home. There is a door chime/alarm on the exits of my house so that staff are alerted if I were to exit out of it unattended. There are buttons by each outside door so I can tell people I want to go outside and they can safely observe me outside." d. Client #1's Acknowledgement Report for his/her BSP indicated DSA/CMA A was trained on 5/2/17 and DSA D was trained on 5/6/17. e. Facility policy/procedure for Driving Vehicles for Mosaic dated 3/17/17 included, "All vehicles parked on Mosaic property must be locked at all times. This includes all Mosaic vehicles, employee vehicles, contractors, parents/guardians, other visitors, etc." On 8/16/17, the surveyor followed the path staff believed Client #1 to have followed during his/her elopement. The surveyor walked out the east side door from the sensory room in the house to	W 249		

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where the staff believed the car parked. The distance was approximately 25 feet.

According to website, wunderground.com, on 7/17/17 at 10:53 a.m. the temperature was 75.9 degrees Fahrenheit (F).

Observations on 8/16/15 at 2:15 p.m. revealed Client #1 ambulated around his/her home independently. Client #1 wore shorts. Client #1 did not wear a shirt, nor did he/she wear socks and shoes.

When interviewed on 8/16/17 at 2:58 p.m. QIDP reported the door chimes were removed approximately the beginning of June for a trial period. She stated she discussed elopement and the use of the door chimes several times with staff. QIDP asked staff to document elopements from 5/1/17 to 5/31/17. According to QIDP, they did not have a problem with elopements and she wanted to remove the restriction if the alarms were not necessary. After Client #1's elopement, the facility turned the door alarms back on.

When interviewed on 8/16/17 at 1:58 p.m. DSA/CMA A reported on 7/17/17, her and DSA D were the only two staff working. According to DSA/CMA A, it was a normal day and she assisted Client #4 in the bathroom at approximately 10:30 a.m. to 10:45 a.m., while DSA D assisted another client another bathroom. DSA/CMA A stated she assisted Client #4 for approximately 5 minutes. When she was finished in the bathroom, DSA/CMA A walked to the medication room to start administering medication. DSA/CMA A looked out the medication room window, noticed her car door was open, and Client #1 sat inside. She stated

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W 249	Continued From page 4 the weather was nice and Client #1 wore shorts, no shirt, socks, or shoes. DSA/CMA A explained was off work for the month of June until 7/10/17. DSA/CMA A stated the facility turned off the door alarms while she was gone. She recalled someone at the office turned the alarms off. According to DSA/CMA A, she just got a new keyless entry car. She stated her car keys were in the medication room and believed the keys were close enough to the car, the car unlocked. DSA/CMA A now keeps her car keys in the basement stairway. She stated she had training to keep her vehicle locked. According to DSA/CMA A, Client #1 did not have an elopement program. She stated elopement was part of his/her program a long time ago, but did not believe elopement was still in the program. When Client #1 attempts to elope, they should write program notes. DSA/CMA A also stated Client #1 used to have a program to push a communication device to communicate his/her want to go outside. In response to Client #1's elopement, DSA/CMA A stated the facility turned the door alarms back on. She also stated she received a reminder to keep a closer eye on Client #1. DSA/CMA A identified Client #1 attempts to elope approximately 4 times a week, although had not attempted to elope yet this week. DSA/CMA A described when Client #1 attempts to elope it was usually out the front door and goes to the van. DSA/CMA A stated 5 feet out the front door is considered an elopement. DSA/CMA A indicated this incident was the first time she knows of where Client #1 eloped from the side door and found Client #1 in a vehicle. DSA/CMA A showed the surveyor where she parked the day of the incident. When interviewed on 8/16/17 at 2:40 p.m.,	W 249		

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W 249	Continued From page 5 DSA/CMA A reported she did not report the incident of elopement immediately. DSA/CMA A stated she did not know whom to notify of the incident. She also stated she completed a GER a couple days after the incident. DSA/CMA A took surveyor out to her car; her car door was unlocked. When interviewed on 8/21/17 at 12:35 p.m. DSA D reported someone told him he gave another client a shower when Client #1 eloped. DSA D found out about the elopement after the incident happened, possibly after lunch. DSA/CMA A seemed blown away she found Client #1 in her car. He originally believed he assisted Client #4 with his/her bath, but he/she usually gets a bath around 9:00 a.m. DSA D stated Client #6 showers around 11:00 a.m. and Client #1 eloped around lunchtime. He stated he and DSA/CMA A were only two staff on duty, which happened more frequently in the last year. According to DSA D, he assisted Client #4 for approximately 10 to 15 minutes. DSA D did not know if Client #1 was in the house before he assisted Client #4. DSA D also did not know where DSA/CMA A was, he stated she could have been toileting another client. DSA D reported the facility turned the door alarms off. According to DSA D, Client #1 usually never goes out. He stated Client #1 opened the door occasionally, but will go a few weeks without opening the door. DSA D explained how they could not always get out in the community when 2 staff are working, so they take van rides. DSA D stated if Client #1 was not watching T.V. he/she will sit in the recliner in the sensory room. According to DSA D, Client #1 sat in the sensory room most mornings. DSA D stated since the incident, the facility retrained him on Client #1's programs and locked vehicles. According to DSA	W 249		

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W 249	Continued From page 6 D, Client #1's programs did not contain elopement, although elopement may be in the program now. DSA D identified the facility turned off the alarms because there were no issues for a long time. DSA D thought it was uncalled for to turn off the alarms and it did not make sense. DSA D explained the missing person/elopement process. DSA D did not know Client #1's supervision level. He stated Client #1 is good and is usually somewhere where staff can see him/her. When Client #1 gets a t-shirt, he/she needs to go for a ride or take for a walk. DSA D believed Client #1 possibly wanted to get out of the house. DSA D stated if he knew DSA/CMA A was in the bathroom, he would have poked his head out to check on clients. He stated there should not be 2 staff in the bathroom, one staff should ensure other clients are kept safe. When interviewed on 8/21/17 at 1:10 p.m. QIDP confirmed the facility failed to follow Client #1's behavior support. She stated staff should know Client #1's whereabouts at all times. She also stated staff needed to lock their vehicles at all times.	W 249		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff consistently provided food consistent with identified client needs. This affected 1 of 1 Client (Client #1) identified as a result of facility self-reported incident #69632-I.	W 474		

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W 474	Continued From page 7	W 474		

Finding follows:

Record review on 8/16/17 revealed the following:

a. Client #1's General Event Report (GER) dated 7/4/17 completed by (Direct Support Associate (DSA) B) indicated, "(Client #1) was eating and there was a piece of hamburger that didn't get pureed. (He/she) choked and another staff came up behind (him/her) and did the (Heimlich maneuver) on (Client #1). (He/she) spit out (a chunk) of hamburger. Staff immediately took (him/her) to the ER. Staff DSA B documented, "They listened to (his/her) chest and said we did a good job with (him/her). (He/she) [lungs] sounds clear." RN noted, "Received call at 12:34pm to report client was transported to hospital due to choking incident. Call received at 2:24pm from (Direct Support Supervisor (DSS) A) to report client home from ER. No abnormal findings. No new orders."

b. Client #1's Health Supports dated 5/1/17, indicated, "...Regular Diet, Regular Portions, Puree Consistency with Thin Liquids..."

c. Client #1's Dietary Guidelines and Need to Know Information included, "My food is pureed and my drinks are regular consistency..."

When interviewed on 8/16/17 at 1:40 p.m. DSA C reported a lot going on because of July 4th. DSA C stated she pureed food for lunch. DSA C pureed the grilled hamburger with the bun, ketchup, mustard, and beef broth. Client #2 had a problem and she left the food to help him/her. When DSA C went back to the food, she felt like she did not need to do anything with it. DSA C put the pureed hamburger on the plate and

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W 474	Continued From page 8	W 474		

pureed the rest of the meal. They had potato salad and corn on the cob. DSA C stated she took the corn off the cob. DSA C explained they tried to have the clients eat at the same time. DSA C indicated Client #1 drank thin liquids with a straw. Client #1 did not need assistance to eat, but needed reminders to slow down. DSA C stated Client #1 liked to save his/her liquids for the end of the meal. DSA C remembered DSA D sat at the table with Client #1 while he/she ate and DSA C and Client #3 finished the other plates. DSA B administered medications. Client #1 started to cough, DSA D jumped up and administered the Heimlich maneuver, and DSA B took Client #1 to the hospital. When Client #1 returned from the hospital, they said he/she was fine. DSA C reported the incident should not have happened. She stated she is more careful now. DSA C explained how she always took the food out of the blender with a spatula and missed the piece of meat. DSA C stated the facility retrained her and gave her a corrective action.

When interviewed on 8/16/17 at 1:54 p.m. DSA/CMA B reported she sat at the table, between Client #1 and Client #4; Client #5 sat across from her. DSA/CMA B stated DSA D walked by the table when Client #1 choked and administered the Heimlich maneuver. According to DSA/CMA B a chunk came out. She took Client #1 to the hospital where he/she spit out another small piece of meat. The hospital said he/she sounded clear and discharged Client #1. DSA/CMA B trusted her co-workers to puree the food properly and did not check Client #1's food before he/she ate.

When interviewed on 8/21/17 at 12:35 p.m. DSA D reported Client #1 choked and he administered

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the Heimlich maneuver. According to DSA D, Client #1 coughed and breathed when choking. He stated he was gentle but firm and a piece of meat came out. DSA D remembered Client #1 sat at the end of the big table and DSA C and CMA/DSA B sat with him/her. Client #3, Client #4, and Client #5 also sat at the big table. According to DSA D, Client #1's diet consisted of pudding consistency and believed thin liquids. DSA D stated Client #1 did not need prompts to slow down or take a drink; Client #1 ate well on his/her own. DSA D stated they all received information about choking after the incident.

When interviewed on 8/16/17 at 1:10 p.m., Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility failed to follow Client #1's diet.

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C 147	50.7(4) Additional notification	C 147		

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(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure incident of elopement reported immediately to the State agency. This affected 1 of 1 client reviewed during investigation #69686-I (Client #1). Finding follows:

See CMS-2567 W249 for additional information.

Record review revealed the following:
a. Client #1's General Event Report (GER) dated 7/20/17 indicated on 7/17/17, "There were on two staff members on duty today both were busy with other residents. CMA had walked in to the medication room to start noon medication pass when they looked out the window and seen (Client #1) sitting in their car."

b. Summary of inquiry dated 7/21/17, "(DSA/CMA A) said that she was not aware of the proper protocol and did not know it needed to be reported. (DSS B) became aware of the event during a conversation they were having on Wednesday and asked her to do a GER. She didn't ask details on the event and didn't know when it had occurred. She said that her thoughts

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C 147	Continued From page 1	C 147		

have been more occupied with another individual who is going into hospice. (Program Manager) said that he first became aware of it when he was talking to (DSA D) on Tuesday, but that he thought (DSA D) was talking about something that had happened a year ago and that he either wasn't listening carefully or he should have asked questions. He was notified by (DSS B) about the GER being completed and put two and two together. He then acknowledges he forgot about it because he got busy with other stuff and that is should have been reported up right away."

c. Facility Policy/Procedure for Incidents and Injuries dated 4/2/17, directed, "A GER must be completed by any employees who observe or identify injury or potential injury of a person, an injury of unknown origin, significant behavior incident (resulting in injuries, assault, property destruction, elopement, police involvement, or other atypical behavior)... Reporting procedures for DIA (ICF/ID) and DHS (HCBS) will be followed per their specific licensure and/or certification ..."

When interviewed on 8/16/17 at 2:40 p.m. Direct Support Associate/Certified Medication Aide (DSA/CMA) A confirmed she did not report the incident immediately. DSA/CMA A stated she did not know whom to notify of the incident. She also stated she completed a GER a couple days after the incident.

When interviewed on 8/21/17 at 1:10 p.m. Qualified Intellectual Disabilities Professional (QIDP) acknowledged DSA/CMA A failed to report Client #1's elopement, resulting in a late report to DIA on 7/20/17.