

OK 10/17/17

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

PRINTED: 10/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/27/2017
NAME OF PROVIDER OR SUPPLIER MOSAIC-1000 1ST STREET SE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FIRST STREET SE CLARION, IA 50525		
(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	W 000	See attached POC 10/10/17		
W 249	<p>As a result of the investigation of incident #70830-I, a deficiency was cited at W249. 483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff implemented client Behavior Support Plans (BSP) as written, which resulted in a client elopement. This affected 1 of 1 client (Client #1) involved in investigation #70830-I. Finding follows:</p> <p>Record review on 9/21/17 revealed facility internal investigation, initiated 8/25/17. According to the internal investigation, on 8/25/17 at approximately 1:30 p.m. Client #1 and his/her peers returned to the facility from day services. After assisting all individuals into the facility, Direct Support Associate (DSA) A turned to assist another individual and when she turned back around, she observed the living room door open and Client #1 not present in the facility. According to the document, DSA A immediately went outside and found Client #1 by the van in the facility driveway. DSA A assisted Client #1 back into the facility and turned the door alarm on. The internal</p>	W 249			

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

TITLE

(X6) DATE

Macey Jean...

Associate Director

10/16/17

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.

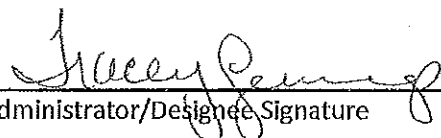
OK 10/17/17

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

Mosaic 1000 1st St SE
Clarion, IA 50525

Investigation #70830-I
Date: 9/21/17-9/27/17

Deficiency	Plan of Correction	Date of Completion
W 249 483.440(d)(1) PROGRAM IMPLEMENTATION	The QIDP and Home Manager retrained on the individual's BSP focusing on the importance of the door alarms and provided clarity on expectations and reporting procedures.	Upon Receipt
	The QIDP will monitor programming and policies through weekly observations to assure that programming and policies are being completed correctly and consistently to prevent recurrence of this deficiency. This will be documented in a data report on Therap attached to the individual's BSP.	Upon Receipt
	Door alarm checks will be completed daily by staff and through observations by the QIDP and the Home Manager.	Upon Receipt
	The QIDP and Home Manager will explore door alarm options and purchase the one identified as the best fit for the home.	Upon Receipt

	<u>Associate Director</u>	<u>10/16/17</u>
Administrator/Designee Signature	Title	Date

