#### DEPARTMENT OF HEALTH AND HUMAN SERVICES ARINTED: 10/12/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 16G113 B. WING 09/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE MOSAIC-217 MAPLE AVENUE NEVADA, IA 50201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 000 **INITIAL COMMENTS** W 000 Investigation of #70935-I resulted in a determination of Immediate Jeopardy (IJ), due to concerns with client safety. The facility was notified of the IJ on 9/20/17 at approximately 1:45 The facility responded with corrective actions to address the identified problems and system. practices. The IJ was removed on 9/21/17. The facility was found to be out of compliance with the following Condition of Participation (CoP) - Facility Staffing A condition-level deficiency was cited at W158. Standard-level deficiencies were cited at W159 and W194. W 158 483,430 FACILITY STAFFING W 158 W158 FACILITY STAFFING The facility will ensure that specific facility The facility must ensure that specific facility staffing requirements are mel. The facility staffing requirements are met. will provide adequate staff training to ensure staff competency to manage client behavioral needs and monitor individual This CONDITION is not met as evidenced by: program plans as necessary to ensure Based on interviews and record reviews, the client safety. Specifically, staff will be retrained on Behavior Support Programs. facility failed to maintain minimal compliance with This will be monitored by weekly Condition of Participation (CoP) Facility Staffing. observations in the home to ensure The facility failed to implement a staff training competency of staff. system to adequately manage client behavioral needs. A finding of immediate Jeopardy (IJ) Person(s) Responsible: clients' health and safety was declared on Program Manager 10/12/17 9/20/17, which was removed on 9/21/17. Cross reference W159: Based on interviews and record reviews, Qualified Intellectual Disability Professional (QIDP) failed to adequately develop

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPAIER KEPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A, BUILDING COMPLETI				
		16G113	B. WING		**************************************		25/2047
		100110	12: \		DEPT INDOPERS OFFI DEATE TO CODE	U911	25/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MOSAIC-2	217 MAPLE AVENUE			21	7 MAPLE AVENUE		
WOOMIG-2	III WAI LE AVENUE	*		NE	EVADA, IA 50201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	JD PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B GROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
W 159	interviews and record provide adequate star competency with corr implementation of Ind 483.430(a) QIDP  Each client's active traintegrated, coordinate qualified intellectual of This STANDARD is a Based on observation review, the facility Querofessional (QIDP) and coordinate client programs to address affected 1 of 1 client if of #70935-1 (Client #10, Record review of farevealed Client #10, Record review	I program plans as client safety.  1: Based on observations, review, the facility failed to ff training to ensure staff ect and consistent ividual program plans.  eatment program must be ad and monitored by a lisability professional. Not met as evidenced by: ns, interviews and record alified Intellectual Disability ailed to adequately monitor services and develop safety concerns. This involved in the investigation of production of professional safety concerns. This involved in the investigation of production of professional and professional safety concerns on professi	W 1		W159 QIDP Each client's active treatment prograwill be integrated, coordinated and monitored by a Qualified Intellectual Disability Professional (QIDP). The will adequately monitor and coordinctient services and develop programaddress safety concerns. Specifical QIDP will be retrained on completing Comprehensive Assessments and Motivational Assessments and programplementation of behavior support This will be monitored through mon review of Individual Service Plans a monthly QIDP reports and observation the home  Person(s) Responsible: Program Manager	old QIDP pate ns to ally, the ger plans. thly	10/12/17

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_\_ C 16G113 B. WING 09/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 217 MAPLE AVENUE MOSAIC-217 MAPLE AVENUE NEVADA, IA 50201 SUMMARY STATEMENT OF DEFICIENCIES m PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY W 159 Continued From page 2 W 159 DSA B also assisted another client. She said Client #1 left the house without staff knowledge. A neighbor came to the facility and told them she had found one of their clients. A facility nurse assessed Client #1 the next morning and found no physical injuries. When interviewed on 9/20/17 at 9:30 a.m. the Neighbor said she lived across the street from the Maple Ave home. She left her house between 8:00 and 8:15 p.m. on 9/10/17 and headed west on Maple Ave in her vehicle. She said it was dark and she almost hit Client #1 with her vehicle, about two blocks west of the facility. Client #1 was walking in the street, toward the side of the road. The road is somewhat narrow in that area. with no shoulder and no parking. She said it was a regularly traveled road. The Neighbor pulled over and spoke to Client #1. She realized the client had some type of disability. Client #1 came over to her vehicle and she prompted the client to get in, thinking it was safer than being in the road. Client #1 sat in the driver's seat and honked the horn. The Neighbor talked to the client, but determined the client was unable to speak. She assumed the client lived at the group home across the street from her home. She called the police and when the officer showed up, he stayed with the client and she walked back to the group home to inform the staff. A staff person accompanied her back to the vehicle. The client wore a shirt, pants, a hat and was barefoot. The Neighbor said it was a little cool outside at the time. The Neighbor reported she discovered Client #1 on Maple Avenue, about two blocks west of the facility. Maple Avenue is a two lane residential street, with no posted speed limit sign. The location where Client #1 was found is about two blocks from a 4-lane highway.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		16G113	B, WING		1	C /25/2017
	ROVIDER OR SUPPLIER 217 MAPLE AVENUE			STREET ADDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE NEVADA, IA 50201		
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W 159	A Story County Sherif indicated they receive regarding a person wi According to the sherif was with the client was with the client was with the client was with the client was of the state. The facility by 8:30 p.m.  According to the state conditions in the Neva 8:00 p.m. and 8:30 p.m. skies and a temperature degrees Fahrenheit.  Client #1 had a Person 03/2017. According to typically went to bed a should provide hourly 6:00 a.m.  Additional interviews a the facility had knowle elopements from a pri repeated attempts to gothe current facility; how develop programming There were two staff put the Maple Avenue facility was non-ver communication. He/S independently, but we occasional unsteading with the staff put the staff pu	It's Office event report d a phone call at 8:17 p.m. th special needs found, ff's office report, an officer 8:20 p.m., while the woman vas going to the group home client was returned to the  climatologist the weather ada, lowa area between m. on 9/10/17 were clear are of approximately 70  mal Schedule, dated the schedule, Client #1 around 10:00 p.m. and staff checks from 10:00 p.m. to  and record reviews revealed dge of Client #1's history of or facility and of Client #1's go outside without staff at wever, the facility failed to to address the behavior. The facility are clients at a still the control of the incident.  It had diagnoses including: ability, Lennox-Gausaut order and spina bifida. bal without functional	W 18	59		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1		LE CONSTRUCTION			e survey Pleted
		16G113	B. WING					C
NAME OF F	ROVIDER OR SUPPLIER			<del></del>	OTDET AND DESCRIPTION		09	/25/2017
				1	STREET ADDRESS, CITY, STATE, ZIP CODE			
MOSAIC-	217 MAPLE AVENUE			3	217 MAPLE AVENUE			
				1	NEVADA, IA 50201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
W 159	from another agency, seizure disorder, Clies that relayed a video o	Due to an uncontrolled nt #1 had a visual monitor f the client's bed to a small nom, which allowed staff to	V	159				
	Record review on 9/20 Comprehensive Funct dated 4/14/17. A sect behavior issues. Undi without notifying other "Total" was checked. To checked for the follow uses crosswalks, uses with strangers. When asked on 9/20/1 the meaning of "Total," would need total staff The client would try to assistance. She said total staff assistance to	O/19 revealed Client #1's cional Assessment (CFA), ion of the CFA addressed er the category of "Leaves s/elopes", the box for The box for "Total" was also ing areas: uses sidewalks, straffic lights, and cautious 17 at 1:20 p.m. to explain the QIDP said Client #1 assistance not to elope, elope, if not for total staff Client #1 would also need				. ,		
	said she had worked for about one year, in the filled in at the Maple Atmonth, approximately. She said she assisted bathroom around 7:30 go pass medications a didn't know DSA C left in the bathroom and the She then assisted Clie saw the client get into covers over him/her. D	3-4 times as of 9/10/17. another client in the p.m. when DSA C left to t another house. DSAA . DSAA assisted the client en helped the client to bed, nt #1 to bed. She said she bed and she pulled the DSAA then assisted another ds, DSAA sat in the living						

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maybe around 7:30 p.m. (she had estimated between 7:40 p.m. to 8:00 p.m. when questioned by the facility within a day of the incident). When asked how often she should have checked on Client #1 after he/she went to bed, DSAA said she should have checked the client about every two hours. She knew of the video monitor in the living room, but said she had not looked at it prior to the neighbor woman coming to the door.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		16G113	B. WNG			į .	C /25/2017
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	, 000	PAULUTT.
	A / D. T. D. T			2	17 MAPLE AVENUE		
WOSAIC-	217 MAPLE AVENUE			N	IEVADA, IA 50201		
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W 159	Continued From page	6	w	159	- The state of the		
	p.m. DSAA said she o	erview on 4/20/17 at 1:50 didn't know of Client #1					
		on book. When asked if		1			
	there was any way for	Client #1 to communicate		1			
	that ne/sne wanted to didn't know of anythin	go outside, DSAA said she					
	didn't know of anythin	g.	İ	-			
,	When interviewed on	9/20/17 at 10:45 a.m. DSA		Ì			
	B sald he worked the	PM shift on 9/10/17, along			1		
		C. DSA C left the facility			•		
		ass medications at another					
		shed passing medication at		-			
		when DSA C left. He was en the medication room and					
		room, administering Client		i			
		breathing treatment. DSAA					
	assisted clients to bed						
		B assisted Client #2 to		- 1			
	bed. The client used a	Hoyer lift and took some					
		lient #2's room when the	1.	1			
		e to the facility. DSA B went		ĺ		1	
	to the living room and	DSA A told him Client #1				,	
		vent with the woman to get he did not hear the door					
		e was in Client #2's room					
		and there was a pumping					
		the client's room, which					
		e sound of the door chime.					ļ
	DSA B said no staff pe					1	
		ared responsibility for the					
		filled in at the Maple Ave		ļ			
	home since late July a			1			
		mes, DSA B said he did not		}			
		history of elopement, but try to go outside without		}			
		nought Client #1 was in bed		}			
		ent. Once in bed, staff		-			
		t #1 every one to two hours.		Ì			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		16G113	B. WING			1	C /25/2017
	ROVIDER OR SUPPLIER 217 MAPLE AVENUE			217	REET ADDRESS, CITY, STATE, ZIP CODE MAPLE AVENUE VADA, IA 50201	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	DSA B knew of the vice but had been busy will looked at it. DSA B sate to the incident that on stay in the front commend been told/trained said no. He recalled a the HM when they talk she didn't tell him that stay in the common at time he saw Client #1 probably around the til busy passing medicat certainty.  During a follow-up into p.m. DSA B said he were a communication bool switch by at least one a verbal request to go switch didn't always we never used it.  When interviewed on confirmed she worked home, with DSA A and was a full time staff at there for about five ye #1 had a history of eld agency. At the Maple often open an exit doc Staff were always pre The regular Maple Ave Client #1 very closely, staff person stayed in all times, to monitor the DSA C said Client #1 between 8:30 p.m. 9:00	dec monitor for Client #1, th Client #2 and had not ald he had not been told prior e staff person needed to non area. When asked if he since the incident, DSA B a phone conversation with the dabout the incident, but tone staff person needed to rea. DSA B said the last prior to the elopement was time DSA C left, but he was ion and did not recall with the said there was a of the exit doors to activate to outside. DSA B said the tork properly and Client #1  9/19/17 at 4:35 p.m. DSA C the Maple Ave to DSA B on 9/10/17, She the home and had worked the home and had worked the prior the home, Client #1 would or and try to go outside. sent and followed him/her. the staff knew to monitor the front common area at the area and the exit doors.	W	159			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MEII	TIPI	LE CONSTRUCTION			<u> </u>
	F CORRECTION	IDENTIFICATION NUMBER:	1		LC CONSTRUCTION	[°		E SURVEY PLETED
								С
		16G113	B, WNG			İ		/25/2017
NAME OF F	ROVIDER OR SUPPLIER	***************************************	, , , , ,		STREET ADDRESS, CITY, STATE, ZIP CODE			2012011
MOSAIC-	217 MAPLE AVENUE			2	217 MAPLE AVENUE			
····				1	NEVADA, IA 50201			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECT			(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR			COMPLETION DATE
		and the second s			DEFICIENCY)			
101450								
W 159			W	159	)			
	back up after an hour	or so, but it was not typical	-					<u> </u>
	for Client #1 to get rig	ht back up after going to						
		left the Maple Avenue n. to go pass medication at	İ					
	another house. Client	#1 was sitting at the kitchen						
	table having a snack v	when she left. She returned						
	to the house around 9	:30 p.m. and learned of the			]			
	elopement incident. D	SA C said after Client #1						
	went to bed staff shou	ld check on him/her every 2						
		check the video monitor						
	every hour.							·
	When interviewed on :	9/19/17 at 4:15 p.m. DSA E						
	stated she was a regu	lar full-time staff person at						
		She noted the two staff						
		the incident on 9/10/17						
		th Client #1 as the regular	Ì		The state of the s			
		Client #1 had been more						
		n in seizure medication.	İ		ļ			
		41 would open an exit door bout 2-3 times per shift,						
	Staff closely monitored	the client. The exit door in						
	the bedroom wing was		İ					
		t had gone out that door in						
	the past. The regular s	taff knew that a staff						
	person should stay in I	he front area to monitor,						
		ot aware of any other time					1	l
		eloped from the Maple Ave					ĺ	ĺ
		the client had a history of			J			
		er prior living site. DSAE			-		Ì	ĺ
		went to bed between 7:45	· ·					
		e/She usually stayed in bed, said after Client #1 went to	}					
		k him/her every hour, but		ļ	1			
	should check more offe	en on the video monitor.						
		nt #1 could move quickly.						
		• •	1					
		7 revealed door chimes on						
	the four exit doors of the	ne home, which sounded					i	

CTATEMENT	OF DEFICIENCIES	AVAIL REGISTER OF TENANT			The state of the s		<u>O. 0938-0391</u>
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY
		The state of the s	A, BUILD	ING	TO STATE OF THE ST	LOW	PLETED
]							С
		16G113	B. WING			09	/25/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	217 MAPLE AVENUE		
MOSAIC-	217 MAPLE AVENUE				NEVADA, IA 50201		
244	OUR MARINE OF			L			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	ıv.	PROVIDER'S PLAN OF CORRECTION		(X5)
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<u> </u>					DEFICIENCY)		
					Wal-	-	
W 159	Continued From page	. Q .	100	159			
	, -	vere opened. The door	"	เบฮ			İ
		cal sound of eight notes and					
		me did not continue if the	- [				
		The door chime worked					
		en completely shut and					
		it doors were located at the					
		uth), which opened to the					1
		of the house, off of the					
	dining room and leadi	ng to a patio and backyard					
		f of a sensory room that led					
		t) and a bedroom wing door					
		tio area (northwest). Client					
	#1's bedroom was loc						
	bearoom nailway, nex	t to the bedroom wing exit					
		non area of the house was					
		uded the living room, dining					
	room and kitchen.		İ				1
	During chaografiana a	m 0/40/47 factor					[
	During observations o						
		m. to 4:00 p.m. Client #1					
		time pacing/walking around,					
		toring. The back door that					
		ckyard was wide open. At					
	one point, Client #1 W	ent outside the open door,					
	with statt following. Cli	ient #1 wore a galt belt, but					[
	appeared steady while						
		OSS) said the back patio					<u> </u>
	door was often left ope	en during nice weather.					<b>5</b>
	Mhan interdered	0/40/47 = 4 4/00 = 5 - 41					]
		9/19/17 at 4:00 p.m. the					
	Pitect Support Superv	risor (DSS) reported Client					
	#1 had a history of elo						
		the said she was not aware	İ				
		ent #1 had from the Maple					
		0/17. It was common for					
		of the exit doors and go					j
}		n, but staff always saw the					]
		n/her. The DSS noted Client					
	#1 had been more act	ive since a decrease in					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		SURVEY PLETED
		16G113	B. WING_			C 25/2017
	ROVIDER OR SUPPLIER 217 MAPLE AVENUE			STREET ADDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE NEVADA, IA 50201		20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	8E	(X5) COMPLETION DATE
W 159	sometimes left open, present. The doors stational record revises to the incident staff in the home, but did n said the facility had be Mosaic staff from the said Client #1 typically p.m. Since the eloper reported she trained sperson in the front cor Staff could more easily from the common area to the incident staff has staff in the common area to the incident staff has staff in the common area to the QIDP, Assent to the QIDP, Assent to the QIDP, Assent to the QIDP, Assent to the QIDP, Assent to the QIDP, Assent to the QIDP, Assent to the USP, Assent to the U	the said the patio door was but only if staff were mould all be closed when the DSS reported she present at the time of the med on the clients residing of recall training them. She wen short staffed and used Des Moines area. The DSS went to bed around 8:00 ment incident, the DSS taff there must be one staff mon area at all times. If y monitor all the exit doors at the DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.  The DSS said even prior dibeen told to keep one rea.	W 1	59		

STREET ADDRESS, CITY, STATE, ZIP CODE  166113  NAME OF PROMOTER OR SUPPLER  MOSAIC-217 MAPLE AVENUE  (M4) D  (		O TOTT MEDIOTALE	MEDIO/ NO OLIVIOLO				OMB M	J. 0938-0391
MANE OF PROMDER OR SUPPLIER  MOSAIC-217 MAPLE AVENUE  SUMMARY STATEMENT OF DEFICIENCIES  (PACH DEPOCIETOR MAST SE PRECEDED BY PULL  PREST  RESULATORY OR LSO EXPIRETING RECORDANDON  TAG  Continued From ps of the facility and was out of staff sight, then a GER should have been written. If staff had Client #1 in either bind, then a GER was not required. The QIDP did not know the details of the incident. When interviewd on 97/22/17 at 11:00 a.m. DSAD said she did not recall the incident. When interviewd on 97/22/17 at 11:00 a.m. DSAD said she did not recall the incident. Dim/n gan interview on 97/22/17 at 11:00 a.m. DSAD said she did not recall the incident. She heard the door alam, looked outside and saw Client #1's shadow (on the patio, just leaving the bedroom wing door) and she immediately went outside, keeping the client in sight before she got to him/hor.  A team meeting consisting of two managers, the facility nurse, the Program Coordinator (at that time) and the QIDP was held on 41/91/17 to discuss concerns regarding Client #1's frequent falls. According to notes written by the QIDP, the team also discussed Client #1 having pane out the bedroom wing door without staff acknowledgement. The notes indicated the team discussed the possibility of "stress" on the exit door, fencing in the backyrad and having staff do a head count every time the door chimse sounded. When interviewed on 02/01/7 at 3:10 p.m. regarding follew thy gustaff on a head count every time the door chimse sounded. When interviewed on 02/01/7 at 3:10 p.m. regarding follew the sun and to a head count whenever they heard a door chime sound. She was unable to find documentation of this training.  Record review revealed Client #1's 30-day Lifestyle Plan meeting held on 4/20/17 and attended by the CUIP. Client if 1's gustafian, the facility nurse, Program Coordinator and other staff. Documentation failed to reveal any							COM	PLETED
MOSAIC-217 MAPLE AVENUE    TYMAPLE AVENUE   STREET ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE ADDRESS, CITY, STATE, 2P CODE   STATE, 2			16G113	B, WING		- And Adding to the Control of the C	1	
INSURAL-Y MAPLE NUMBER   SUMMANY STATEMENT OF DEPTICIPACIES   INSURANCE CONTINUES   SUMMANY STATEMENT OF DEPTICIPACIES   INSURANCE CONTINUES   INSURANCE	NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CONSISTERFERENCED TO THE APPROPRIATE CONSISTER REGULATORY OR LSC IDENTIFYING INFORMATION)  W 159  Continued From page 11  knowledge of anyone responding to it. She said if Client #1 in their slight the entire time, then a GER was not required. The QIDP did not know the details of the Incident. When interviewed on 9/21/17 at 10:30 a.m. DSA b asid she did not recall the incident. During an Interview on 9/21/17 at 10:30 a.m. DSA B asid she did not recall the incident. She heard the door alarm, looked outside and saw Client #1's shadow (on the patho, just leaving the bedroom wing door) and she immediately went outside, keeping the client in sight before she got to him/her.  A team meeting consisting of two managers, the facility nurse, the Program Coordinator (at that time) and the QIDP was held on 4/19/17 to discuss concerns regarding Client #1's frequent falls. According to notes written by the QIDP, the team also discussed Client #1's high gone out the bedroom wing door without staff acknowledgement. The notes indicated the team discussed the possibility of "sirens" on the exit door, fencing in the backyard and having staff do a head count very time the door chimes sounded. When interviewed on 9/20/17 at 3:10 p.m. regarding Client #1's 3:0-day Lifestyle Plan meeting held on 4/20/17 and attended by the QIDP, Client #1's guardian, the facility nurse, Program Coordinator and other staff. Documentation falled to reveal any	MOSAIC-2	217 MAPLE AVENUE						
knowledge of anyone responding to it. She said if Client #1 left the facility and was out of staff sight, then a GER should have been written. If staff had Client #1 in their sight the entire time, then a GER was not required. The QIDP did not know the details of the incident. When interviewed on 9/2/1/17 at 10:30 a.m. DSA D said she did not recall the incident. During an interview on 9/2/2/17 at 11:00 a.m. DSA E said she recalled the incident. During an interview on 9/2/2/17 at 11:00 a.m. DSA E said she recalled the incident. She heard the door alarm, looked outside and saw Client #1's shadow (on the patio, just leaving the bedroom wing door) and she immediately went outside, keeping the client in sight before she got to him/her.  A team meeting consisting of two managers, the facility nurse, the Program Coordinator (at that time) and the QIDP was held on 4/19/17 to discuss concerns regarding Client #1's frequent falls. According to notes written by the QIDP, the team also discussed Client #1 having gone out the bedroom wing door without staff acknowledgement. The notes inclidated the team discussed the possibility of "sirens" on the exit door, fencing in the backyard and having stoff do a head count every time the door chimes sounded. When interviewed on 9/20/17 at 3:10 p.m. regarding follow up on any of these suggestions, the QIDP said she thought staff were told to do a headcount whenever they heard a door chime sound. She was unable to find documentation of this training.  Record review revealed Client #1's 30-day Lifestyle Plan meeting held on 4/20/47 and attended by the QIDP, Client #1's guardian, the facility nurse, Program Coordinator and other staff. Documentation falled to reveal any	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI,		COMPLETION
Indication of discussion regarding Client #1's	W 159	knowledge of anyone Client #1 left the facilithen a GER should he Client #1 in their sight was not required. The details of the Incident. 9/21/17 at 10:30 a.m. recall the incident. Du at 11:00 a.m. DSA E sincident. She heard the outside and saw Clien just leaving the bedroot immediately went outsight before she got to A team meeting consistedility nurse, the Program also discussed to the bedroom wing docacknowledgement. The discussed the possibil door, fencing in the base a head count every tin sounded. When intervolution, regarding follow usuggestions, the QIDF were told to do a head a door chime sound. Second review revealed Lifestyle Plan meeting attended by the QIDP facility nurse, Program staff. Documentation	responding to it. She said if by and was out of staff sight, are been written. If staff had the entire time, then a GER QIDP did not know the When interviewed on DSA D said she did not ring an interview on 9/22/17 aid she recalled the ne door alarm, looked the did, she she did not on wing door) and she side, keeping the client in him/her.  Sting of two managers, the gram Coordinator (at that as held on 4/19/17 to arding Client #1's frequent es written by the QIDP, the Client #1 having gone out or without staff enotes indicated the team in the door chimes when door chimes when door she was unable to find training.  Ad Client #1's 30-day held on 4/20/17 and Client #1's guardian, the a Coordinator and other failed to reveal any		159			

PRINTED: 10/12/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ 16G113 B. WING 09/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE MOSAIC-217 MAPLE AVENUE NEVADA, IA 50201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 159 Continued From page 12 W 159 elopement attempts or discussion of a plan to address the maladaptive behavior. The Lifestyle Plan did note the door chimes on the exit doors. The QIDP hand wrote a note on the working copy of the Lifestyle Plan that read, "possible different door alarm on back door," but this was not on the final plan. The QIDP hand wrote a note on the working copy of the Lifestyle Plan under the BSP (Behavior Support Plan) section that read, "Do not need." The facility did not develop a plan to address the elopement attempts or identify it as a need. The facility did identify communication as a priority need and developed a program for Client #1 to communicate his wants/needs by using a communication book with pictures. The program did not specifically address teaching Client #1 to request to go outside. Staff were supposed to ask Client #1 to indicate what he/she wanted to do by using the pictures in the communication book. According to the Lifestyle Plan, Client #1 had a general level of supervision and read, "Staff provide hourly visual observation during overnight hours to ensure I am sleeping well and do not require further supports. I often like to spend time alone in my room throughout the day. Staff will check in with me every 20-30 minutes to ensure that I am engaged in an activity and do not require further supports. In the summer I like to spend much of my time outside. I like to go for walks but need staff assistance outside of the

safely."

home." The Lifestyle Plan also noted, "I am a social person and do not understand the difference between a stranger and a friend. I need assistance to maintain appropriate relationships with others." and "I need physical and verbal assistance to access my community

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	16G113	B. WNG			09.	/25/2017
NAME OF PROVIDER OR SUPPLIER			ธา	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOSAIC-217 MAPLE AVENUE			21	17 MAPLE AVENUE		
			NI	EVADA, IA 50201		
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reported she was a regular Maple Ave home. When communication book, Dike to use it. When ask DSA F said she didn't kn might be at the facility of When interviewed on 9/QIDP reported Client #1 eloped from this facility. history of elopement from Client #1 also had a hist exit doors at this facility accompanying him/her, client and either redirect outside with the client. To leave the house without tracked/documented. The elopement incident on 9/Qeveloping a behavior prelopement, but had not estaff present at the time were not regular staff for The staff were fill-in staff worked at the house for The regular staff person go pass medications at a questioned what Client #1 should have been if he/s 7:45 p.m., the QIDP said overnight shift, the staff Client #1 approximately QIDP noted a video mor that showed Client #1's I	21/17 at 8:55 a.m. DSA F ular full-time staff at the n asked about Client #1's SA F said the client didn't red where it was located, now, but she thought it ffice.  19/17 at 3:00 p.m. the had not previously She said Client #1 had a m his/her prior placement. rory of trying to go out the without staff but staff had seen the red him/her or gone The incidents of attempts red QIDP said since the rogram to address the completed it yet. The two of the incident on 9/10/17 r the Maple Ave home. If from Des Moines and the past month or so, working that shift left to another house. When it's level of supervision she went to bed around d since it was not the should have checked on every 20-30 minutes. The nitor in the living room bed, due to the client's staff could have checked ors had door chimes	W	169			

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		MEDICAID SEKVICES			- Andrews	OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		16G113	B, WING	·			C 9/25/2017
NAME OF F	PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	91.251.201.7
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MOSAIC	217 MAPLE AVENUE				NEVADA, IA 50201		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	OI	1,,,,,,,,,,			
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W 159	Continued From page	14	l w	159	91		
	the QIDP said the ma	nagement team held a			,		
	meeting on 9/18/17 to	discuss the incident and					
	possible solutions. Si	ne said staff were being					
	reminded/retrained to	have one staff stay in the					
	front common area of	the home at all times,					
	which ensured better	monitoring of the exit doors.					1
	The QIDP was unable	to produce documentation	ļ			_	1 .
	of the starr training at t	the time of the interview.					1
	On 9/20/19 around 9:0	00 a.m., the QIDP produced					
	an email from the HM	stated she trained DSAA			·		
		on 9/11/17 to ensure client					ĺ
i	safety and make sure	to have one staff person					
	monitoring the front ar	ea. In the email the HM					
	said she also trained E	DSA C and DSA D by phone					
	on 9/1/17. The QIDP a	ilso provided a training					
	sheet written by the D	3S with dates ranging from	Ì				
	9/12/17 to 9/19/17 doc	umenting training of					
	various staff to remind						
	fimes. The AIDD provi	ntral common area at all ded the minutes from the					]
1	management meeting	held on 9/18/17 to discuss					
	the elopement. The te	am determined a Wander					
1	Guard type of system v	would be the best option.					1
ļ	No timeline for implem	entation was noted. The					
	HM also sent an email	to the QIDP on Friday,					
ł	9/15/17 at 7:32 p.m. th	at read, "All staff are going					ĺ
	to have to be trained re	egarding (Client #1's)					
	elopement. Respondin	g to door chimes, knowing					
	client whereabouts, an	d ensuring there is one					
	person up tront." vvne	n interviewed on 9/20/17 at		ĺ			
	9/15/17 email from the	d she had not seen the HM until Monday morning,					
	9/18/17.	тим ининиониаў тотпілд,		ļ			
	During a follow up inter	view on 9/20/17 at 3:10					
1	p.m. the QIDP confirms	ed she was aware Client					
	#1 had a history of elop	pement at his/her prior					
		e. She was also aware		ĺ			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	l · ·		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		16G113	B. WING.		<u> </u>	09/	25/2017
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
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IVIOSAIC-2	217 MAPLE AVENUE			ľ	NEVADA, IA 50201		
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W 159	Client #1's CFA Indication concern. She attender 4/20/17, which was he falls, but also included going out the exit doos the notes at that mee	ated elopement was a d the team meeting on eld to discuss Client #1's d discussion of the client r. The QIDP said she wrote ting, including the	W	159			
	suggestions on how to behavior. Regarding a suggestions, the QIDI been told to do a head door chimes sound. The QIDP also confirm from DSA D dated 4/2 regarding Client #1 go other staff were busy, she did not respond to why the elopement at	o manage the elopement					·
	the QIDP said they we client's falls. Client # time, She acknowledge indicating no BSP was she realized now this she thought BSPs we took behavior modifyl of the interview on 9%. Client #1 did not yet the elopement because the writing it. Since the elopement because they a neighbor, the fact BSP for elopement, he supervision for the clistarted training staff the general area and also acknowledged thin Client #1's 30-day	ere more focused on the I had fallen a lot around that ged she wrote a note s needed. The QIDP said was an error. At the time ere only needed if the client ing medication. At the time 20/17, the QIDP confirmed have a BSP in place for the QIDP struggled with					

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		16G113	B. WING		C 09/25/2017	
	ROVIDER OR SUPPLIER 217 MAPLE AVENUE		STREET ADDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE NEVADA, IA 50201		09/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES I' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
W 159	10:30 a.m. regarding if for DSA A and DSA B, should have document ISP and program plant were also supposed to familiarize them with it but that type of training documented until very not know if DSA A or E training. The QIDP was documentation that DS acknowledging Client was no documentation #1's ISP. DSA A ackn #1's communication pafter the incident. DS Client #1's communication pafter the incident. DS Client #1's communication pafter the incident. DS Client #1's program of Client #1's program of Client #1's program plans for eac responsible.  This STANDARD is no Based on observation review, the facility failed.	svernight shift.  9/21/17 at approximately initial training on Client #1 the QIDP stated they ited they read Client #1's is. The QIDP said staff or receive "site training" to the home and the clients, ighad not been not irrecently, so the QIDP did DSA B had received the site is able to locate SAA had signed off on #1's ISP on 8/10/17. There is for DSA B regarding Client owledged reading Client owledged reading Client rogram on 9/11/17, the day A B acknowledged reading atton program on 7/18/17. The program on 7/18/17, the information in the ISP or irrams regarding elopement. TRAINING PROGRAM  Itemonstrate the skills and to implement the individual in client for whom they are not met as evidenced by: is, interviews and record at to provide adequate staff is competency with correct tentation of individual infected 1 of 1 client	W 18		skills nent h . The sining ect y, ams. hiy	

CENTERS FOR MEDICARE & MEDICAID SERVICES			·			OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		16G113	B. WING	<u></u>		i	C  25/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MOSAIC-2	17 MAPLE AVENUE				217 MAPLE AVENUE NEVADA, IA 50201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DULD BE COMPLETION	
W 194	Continued From page	17	w	194	4		
	See W 159 for additional information regarding the incident.						
·	revealed Client #1 left knowledge on the ever to realize Client #1 was woman came to the dithem know she had for blocks from the facility (DSA) A estimated ship between 7:30 p.m. and checked on the client returned to the facility interviews and record had knowledge of Clie elopements from a princepeated attempts to the current facility, but to address the behavior to realize the current facility, but to address the behavior woman to the current facility, but to address the behavior woman to the current facility, but to address the behavior woman to the current facility to the current facility, but to address the behavior woman to the current facility.	with staff. Additional reviews revealed the facility ent #1's history of for facility and of Client #1's go outside without staff at t had developed no program or. There were two staff ents at the Maple Avenue					
	written by DSAA on 9 #1 to bed and had god DSAB was also assis Client #1 left the hous A neighbor came to the	eral Event Report (GER) /10/17, she had put Client ne to assist other clients. ting another client. She said the without staff knowledge, the facility and told them she clients. A facility nurse the next morning and found					
	including Severe Intel Lennox-Gausaut Synd Spina Bifida. Client #	s old with a diagnosis lectual Disability, drome/Seizure Disorder and 1 was non-verbal without tion. He/She ambulated					

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETEO
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MANG OF P	ROVIDER OR SUPPLIER				IT MAPLE AVENUE		
MOSAIC-2	217 MAPLE AVENUE				EVADA, IA 50201		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
\\\\ 19 <i>\</i>	Continued From page	. 10	10/	104			
VV 10-5			W	194			
		ore a posey belt due to ess and a history of falls.		-			
		d to the facility on 3/23/17,		Ì			
		Due to an uncontrolled	ĺ				
		nt #1 had a visual monitor					
		f the client's bed to a small			•		
	monitor in the living ro monitor Client #1 whe						
l :	monitor Olient#1 whe	m in bed.					
	Observation on 9/19/1	17 revealed door chimes on					
	the four exit doors of t	he home, which sounded					
		ere opened. The door					
		al sound of eight notes and	]				
		me did not continue if the The door chime worked					
Î		een completely shut and					
	_	it doors were located at the	i		·		
		uth), which opened to the		- {			
		of the house, off of the					
		ng to a patio and backyard					
		f of a sensory room that led t) and a bedroom wing door					
•		tio area (northwest). Client				i	
	#1's bedroom was loc	•					
' <u>"</u>		t to the bedroom wing exit					
		non area of the house was		}			
	an open area that inci	uded the living room, dining		ĺ			
	TOOM SHE KILEREN.		}				
	During observations of	on 9/19/17 from					
		m, to 4:00 p.m, Cllent #1					
		time pacing/walking around,					
		itoring. The back door that				!	
		ackyard was wide open, so a at one point, with staff					
		ore a gait belt, but appeared					
	steady while walking.						
		d the back patio door was	'				
	often left open during						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		SURVEY PLETED
		16G113	B. WING			l	C /25/2017
	PROVIDER OR SUPPLIER 217 MAPLE AVENUE		1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 17 MAPLE AVENUE IEVADA, IA 50201	<u> </u>	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 194	Continued From page	19	w	194			
	Comprehensive Functioned at 4/14/17. A sect behavior Issues. Und without notifying other "Total" was checked. Checked for uses side uses traffic lights, and When asked on 9/20/the meaning of "Total, Disability Professional would need total staff. The client would try to assistance. She said total staff assistance to crosswalks and traffic with strangers.  A team meeting consistacility nurse, the Progitime) and the QIDP with strangers.  A team meeting to not team also discussed the bedroom wing doc acknowledgement. The discussed the possibil door, fencing in the bear a head count every tir sounded. When interpum, regarding follow suggestions, the QIDF were told to do a head a door chime sound, documentation of this	The box for "Total" was also walks, uses crosswalks, lautious with strangers, 17 at 1:20 p.m. to explain "the Qualified Intellectual (QIDP) said Client #1 assistance not to elope. The elope if not for total staff Client #1 would also need to use sidewalks, lights and to be cautious sting of two managers, the gram Coordinator (at that as held on 4/19/17 to arding Client #1's frequent tes written by the QIDP, the Client #1 having gone out to without staff the notes indicated the team lity of "sirens" on the exit ackyard and having staff do no the door chimes viewed on 9/20/17 at 3:10 up on any of these P said she thought staff do training.					

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY APLETED
		16G113	B. WNG		0:	C 9/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MOSAIC-	217 MAPLE AVENUE			217 MAPLE AVENUE NEVADA, IA 50201		:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
W 194	and other staff. The L chimes on the exit doc communication as a p a program for Client # wants/needs by using pictures. The program address teaching Clie outside. Staff were su indicate what he/she v pictures in the commu- to the Lifestyle Plan, C level of supervision ar hourly visual observat to ensure I am sleepin further supports. I ofte in my room throughou with me every 20-30 m engaged in an activity supports. In the summ my time outside. I like staff assistance outsid Lifestyle Plan also not and do not understand stranger and a friend. maintain appropriate r and "I need physical a access my community Client #1 had a Person 03/2017. According to typically went to bed a should provide hourly 6:00 a.m. When interviewed on the	urse, Program Coordinator ifestyle Plan noted door ors. The facility did identify riority need and developed 1 to communicate his a communication book with n did not specifically ont #1 to request to go pposed to ask Client #1 to vanted to do by using the nication book. According client #1 required general d directed, "Staff provide on during overnight hours g well and do not require in like to spend time alone the day. Staff will check in ninutes to ensure that I am and do not require further er I like to spend much of to go for walks but need e of the home." The ed, "I am a social person I the difference between a I need assistance to clationships with others." and verbal assistance to safely."  and Schedule dated the schedule, Client #1 round 10:00 p.m. and staff checks from 10:00 p.m. to  0/19/17 at 4:00 p.m. the isor (DSS) reported Client	W 18	94		

previous placement. She said the patio door was

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DAT	E SURVEY (PLETED
		16G113	B. WNG		n,	C 9/25/2017
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE		372372V17
MOSAIC-	217 MAPLE AVENUE			217 MAPLE AVENUE NEVADA, IA 50201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(XS) COMPLETION DATE
W 194	should all be closed we The DSS said she thou the time of the incider Maple Ave clients, but them. She said the far and had been using Moines area. The DSS went to bed around 8 elopement incident, si there must be one star common area at all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor all the easily monitor area.  When interviewed on reported she worked it about one year, in the filled in at the Maple Amonth approximately DSAA said she prior the entitled one staff usual When asked if she had the incident to make so the front area of the hot. She recalled a phabilitation Manager the incident to discussion to be in the front area of the hot. She recalled a phabilitation Manager the incident to discussion to be in the front area of the hot. She recalled a phabilitation Manager the incident to discussion to be in the front area of the hot. She recalled a phabilitation Manager the incident to discussion to be in the front area of the hot. She recalled a phabilitation Manager the incident to discussion to be in the front area of the hot. She recalled a phabilitation for the hot.	If staff were present, but when clients went to bed, bught the two staff present at at had been trained on the at she did not recall training cility had been short staffed dosaic staff from the Des as aid Client #1 typically 100 p.m. She said since the he had been training staff of person in the front mes. Staff could more exit doors from the common even prior to the incident keep one staff in the 19/20/17 at 9:55 a.m. DSAA for the Mosaic agency for 10 Des Moines area. She we home for about one 3-4 times as of 9/10/17, to the incident she had not one staff person needed to be the house, but she ally stayed in the front area. If the does not conversation with the (HM) within a day or two of a the elopement incident, ot tell her a staff person ont area. DSAA said she	W 15			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE	SURVEY PLETED
		16 <b>G</b> 113	B. WING				C
	PROVIDER OR SUPPLIER 217 MAPLE AVENUE		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI 217 MAPLE AVENUE NEVADA, IA 50201	DE	<u> </u>	25/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
W 194	estimated maybe aroustimated between 7: questioned by the factincident). When asked have checked on Cliebed, DSA A said shest client about every 2 himonitor in the living rollooked at it prior to the to the door.  During a follow up interport of the puring a communication there was any way for heving a communication there was any way for heving a communication there was any way for heving a communication there was any way for heving a communication there was any way for heving a communication there was any way for heving a communication there was any way for heving a communication to the person was assigned shared responsibility from the filled in at the Mapi and estimated he worked with DSA A and DSA of person was assigned shared responsibility from the filled in at the Mapi and estimated he worked with DSA and DSA of person was assigned shared responsibility from the filled in at the Mapi and estimated he worked with the ward of the video monitor for t	and 7:30 p.m. (she had 40 p.m. to 8:00 p.m. when ility within a day of the if how often she should int #1 after he/she went to should have checked the ours. She knew of the video bom, but said she had not is neighbor woman coming erview on 4/20/17 at 1:50 didn't know of Client #1 on book. When asked if if Client #1 to communicate butside, DSAA said she ig.  9/20/17 at 10:45 a.m. DSA PM shift on 9/10/17, along C. DSAB said no staff to Client #1, the staff or the clients. DSAB said the Ave home since late July ked there 10-15 times. DSA v Client #1 had a history of a sware the client would try staff. DSAB said he thought at the time of the incident. If was in bed, staff should try 1-2 hours. DSAB knew or Client #1, but had been and had not looked at it. DSA on told prior to the incident needed to stay in the front	W	194			

NAME OF PROVIDER OR SUPPLIER  MOSAIC-217 MAPLE AVENUE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 194  Continued From page 23 him that one staff person needed to stay in the common area. DSA B said the last time he saw Client #1 prior to the elopement was probably around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B said the switch didn't always work properly and		of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		OATE SURVEY OMPLETED	
MOSAIC-217 MAPLE AVENUE    MOSAIC-217 MAPLE AVENUE   STREET ADDRESS, CITY, STATE, ZIP CODE			16G113	B, WING			ŀ		
MOSAIC-217 MAPLE AVENUE  (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 194  Continued From page 23 him that one staff person needed to stay in the common area. DSA B said the last time he saw Client #1 prior to the elopement was probably around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B	NAME OF P	ROVIDER OR SUPPLIER		· · · · · ·	Π	STREET ADDRESS, CITY, STATE, ZIP CODE		09/25/2017	
MOSAIC-217 MAPLE AVENUE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 194  Continued From page 23 him that one staff person needed to stay in the common area. DSA B said the last time he saw Client #1 prior to the elopement was probably around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B						, , , ,			
(X4) ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 194  Continued From page 23  him that one staff person needed to stay in the common area. DSA B said the last time he saw Client #1 prior to the elopement was probably around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B	MOSAIC-2	217 MAPLE AVENUE							
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 194  Continued From page 23  him that one staff person needed to stay in the common area. DSA B said the last time he saw Client #1 prior to the elopement was probably around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B	U(V)	SUMMARY STA	ATEMENT OF DEFICIENCIES	T in	L			060	
him that one staff person needed to stay in the common area. DSAB said the last time he saw Client #1 prior to the elopement was probably around the time DSAC left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSAB said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSAB	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	PREFIX (EACH CORRECTIVE ACTION SHOULD & TAG CROSS-REFERENCED TO THE APPROPRI		DBE	COMPLETION	1
common area. DSAB said the last time he saw Client #1 prior to the elopement was probably around the time DSAC left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSAB said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSAB	W 194	Continued From page	23	/ w	19	14			
Client #1 prior to the elopement was probably around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B		him that one staff per	son needed to stay in the	İ		·			
around the time DSA C left, but he was busy passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B									
passing medication and did not recall with certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B									
Certainty.  During a follow-up interview on 4/20/17 at 2:00 p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B									
p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B			na dia nocrecali with						
p.m. DSA B said he was not aware of Client #1 having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSA B	İ	During a fallery up int	ianiau an 4/00/47 -4 0:00			ļ			
having a communication book. He said there was a switch by at least one of the exit doors to activate a verbal request to go outside. DSAB									
a switch by at least one of the exit doors to activate a verbal request to go outside. DSAB									
activate a verbal request to go outside. DSAB						,			
		•							
Client #1 never used it.		Client #1 never used i	t.						
When interviewed on 9/19/17 at 4:35 p.m. DSA C		When interviewed on	9/19/17 at 4:35 p.m. DSA C			İ			
confirmed she worked PM shift at the Maple Ave									
home, with DSA A and DSA B on 9/10/17. She		-							
was a full time staff at the home and worked									
there for about five years. She was aware Client				ŀ					
#1 had a history of eloping at his/her prior agency. At the Maple Ave home, Client #1 would				•					
often open an exit door and try to go outside.				[					
Staff were always present and followed him/her.				[					
The regular Maple Ave staff knew to monitor									
Client #1 very closely. They also made sure one									,
staff person stayed in the front common area at									
all times, to monitor the area and the exit doors.		all times, to monitor th	ie area and the exit doors.						
DSA C said Client #1 typically went to bed									
between 8:30 p.m. 9:00 p.m. Once in bed, Client									
#1 usually stayed in bed. Sometimes he/she got									
back up after an hour or so, but it was not typical									
for Client #1 to get right back up after going to bed. DSA C said she left the Maple Avenue				İ					
home around 7:30 p.m. to go pass medication at									
another house. Client #1 was sitting at the kitchen									
table having a snack when she left. She returned									
to the house around 9:30 p.m. and learned of the				1					ļ
elopement incident. DSA C said after Client #1									

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED  $\mathbf{c}$ 166113 B. WING 09/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE MOSAIC-217 MAPLE AVENUE NEVADA, IA 50201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 194 Continued From page 24 W 194 went to bed staff should check on him/her every 2 hours and staff should check the video monitor every hour. When interviewed on 9/19/17 at 4:15 p.m. DSAE stated she was a regular full-time staff person at the Maple Ave home. She noted the two staff present at the time of the incident on 9/10/17 were not as familiar with Client #1 as the regular staff. DSA E said Client #1 had been more active since a reduction in seizure medication. She estimated Client #1 would open an exit door and try to go outside about 2-3 times per shift. Staff closely monitored the client. The exit door in the bedroom wing was next to Client #1's bedroom and the client had gone out that door in the past. The regular staff knew that a staff person should stay in the front area to monitor. DSA E sald she was not aware of any other time Client #1 had actually eloped from the Maple Ave home, but she aware the client had a history of elopements from his/her prior living site. DSA E said Client #1 usually went to bed between 7:45 p.m. and 9:00 p.m. He/She usually stayed in bed, but not always. DSA E said after Client #1 went to bed, staff should check him/her every hour, but should check more often on the video monitor, DSA E noted that Client #1 could move quickly. When interviewed on 9/21/17 at 8:55 a.m. DSA F said she was a regular full-time staff at the Maple Ave home. When asked about Client #1's communication book, DSA F said the client didn't like to use it. When asked where it was located. DSA F said she didn't know, but she thought it might be at the facility office. When interviewed on 9/19/17 at 3;00 p,m, the QIDP said Client #1 had not previously eloped

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT€ COMP	SURVEY LETED
						(	5
		16G113	B, WING		<u> </u>	09/3	25/2017
NAME OF PI	ROVIDER OR SUPPLIER	A CONTROL OF THE CONT	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	17 MAPLE AVENUE		
MOSAIC-2	217 MAPLE AVENUE			N	IEVADA, IA 50201		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
W 194	Continued From page	25	w·	194			
	from this facility. She	said Client #1 had a history					
	of elopement from his/her prior placement. Client						
	#1 also had a history of trying to go out the exit						
		ithout staff accompanying					
		seen the client and either					
	redirected him/her or	gone outside with the client.	-				
	The incidents of atten	npts to leave the house					
	without staff were not	being tracked/documented.					
i		the elopement incident on					
		ting on a behavior program					
		nent, but had not completed		•		ļ	•
		resent at the time of the	Ì				
		ere not regular staff for the	İ				
		e staff were fill-in staff from					
		worked at the house for the					
	past month or so. The		}		Vander of the state of the stat	ĺ	
	_	left to go pass medications nen questioned what Client					
		on should have been if					
		ound 7:45 p.m., the QIDP					
		he overnight shift, the staff					
	should have been che						
		20-30 minutes. The QIDP				į	
		eo monitor in the living room					
		's bed, due to the client's					
		ne staff could have checked					
		doors had door chimes	ŀ				
		should have alerted the					
	staff. Since the elope	ment incident on 9/10/17,					
	the QIDP said the ma	nagement team had held a					
		discuss the incident and					1
	possible solutions. S	he sald staff were being					
		have one staff stay in the					
		the home at all times,					
	<b>{</b>	monitoring of the exit doors.					
		to produce documentation					
	of the staff training at	the time of the interview.					
	On 9/20/19 around 9:	00 a.m., the QIDP produced					

INME OF PROMIDER OR SUPPLER  MOSAIC-217 MAPLE AVENUE  MOSAIC-217 MAPLE AVENUE  STREET AUDRESS, CITY, STATE, ZIP CODE 217 MAPLE AVENUE  NEVADA, IA 50201  W 194  Continued From page 28 an amail from the HM that stated shot trained DSA A and DSA B by phone on 9/11/17 to onsure client safety and make sure to have one staff person monitoring the front area. In the email the HM said she also frained DSA C and DSA D by phone on 9/12/17 to 9/19/17 documenting training of various staff to remind start that at one staff needed to be in the central common area at all times. The CIDP sho had the minutes from the management meeting held on 9/18/17 to discuss the olopement. The team determined a Wander Guard type of system would be the best option. No timeline for implementation was noted. The HM also sent an email to the QIDP on Friday, 9/15/17 at 7.32 pm. that read, "All staff are going to have to be trained regarding Cliont #1%] elopement. Responding to door cinimes, knowing client whereabouts, and ensuring there is one person up front." When interviewed on 9/21/17 at approximately 10.30 a.m. regarding initial training on Client #1 for DSA and DSA A, the CIDP said staff were also supposed to receive "site training" to familiarize them with the home and the clients; but that type of training had not been not documentation DSA A signed off on acknowledging Client #1% IS Pon 8/10/17. These		OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
MOSAIC-217 MAPLE AVENUE  MOSAIC-217 MAPLE AVENUE  SUMMAY STATEMENT OF DEFICIENCES (REQUALORY OR LAS DESTIFFING INFORMATION)  W 194  Continued From page 26 an email from the HM that stated she trained DSA A and DSA B by phone on 91/11/7 to ensure citient siefly and make sure to have one staff person monitoring the front area. In the email the HM seid she also trained DSA C and DSA by phone on 91/11/7 to ensure citient siefly and make sure to have one staff person monitoring the front area. In the email the HM seid she also trained DSA C and DSA by phone on 91/11/7 to 9/19/17 documenting training of various staff to romind staff that at one staff needed to be in the central common area at all times. The QIDP also had the minutes from the management meeting held on 91/14/17 to discuss the elopement. The team determined a Wander Guard type of system would be the best option. No timeline for implementation was noted. The HM also sent an email to the QIDP on Friday, 9/15/17 at 7:32 p.m. that read, "All staff are going to have to be trained regarding (Client #15) elopement. Responding to door chinces, knowing client whereabouts, and ensuring there is one person up front." When interviewed on 9/20/17 at 9:00 a.m. the QIDP said she had not seen the 9/15/17 or mail from the HM until Monday morning, 9/18/17.  When interviewed on 9/21/17 at approximately 10:30 a.m. regarding initial training on Client #1 for DSA A and DSA B, the QIDP stated they should have documented litely had read Client #1 for DSA A and DSA B, the QIDP stated they should have documented they had read Client #1 for DSA A and DSA A and DSA A or DSA B had received the sile training. Tice QIDP was able to locate documentation DSA A signed off on			16G113	B, WING			i .	
PREFIX TAG  REGULATORY OR LSG IDENTIFYING IMPORMATION)  W194  Continued From page 26 an email from the HM that stated she trained DSA A and DSA B by phone on 9/11/17 to onsure client safety and make sure to have one staff person monitoring the front area. In the email the HM said she also trained DSA C and DSA D by phone on 9/12/17. The QIDP also provided a training sheet written by the DSS with dates ranging from 9/12/17 to 9/18/17 documenting training of various staff to remind staff that at one staff needed to be in the central common area at all times. The QIDP also had fine minutes from the management meeting held on 9/18/17 to discuss the elopement. The team determined a Wander Guard type of system would be the best option. No timeline for implementation was noted. The HM also sent an email to the QIDP on Friday, 9/15/17 at 7:32 p.m. that read, "All staff are going to have to be trained regarding (Client #1's) elopement. Responding to door chimes, knowing client whereabouts, and ensuring there is one person up front." When interviewed on 9/20/17 at 9:00 a.m. the QIDP said she had not seen the 9/15/17 email from the HM untill Monday morning, 9/18/17.  When interviewed on 9/21/17 at approximately 10:30 a.m. regarding initial training on Client #1 for DSA A and DSA B, the QIDP stated they should have documented they had read Client #1's ISP and program plans. The QIDP said staff were also supposed to receive "site training" to familiarize them with the home and the clients; but that type of training had not been not documented until very recently, so the QIDP did not know if DSA A or DSA B land received the site training. The QIDP was able to locate documentation DSA A signed off on					217 MAPLE AVENUE	DE	1 007	AU BU F
an email from the HM that stated she trained DSA A and DSAB by phone on 9/11/17 to ensure client safety and make sure to have one staff person monitoring the front area. In the email the HM said she also trained DSAC and DSAD by phone on 9/1/17. The Ol/91 DP also provided a training sheet written by the DSS with dates ranging from 9/12/17 to 9/19/17 documenting training of various staff to remind staff that at one staff needed to be in the central common area at all times; The QIDP also had the minutes from the management meeting held on 9/18/17 to discuss the elopement. The team determined a Wander Guard type of system would be the best option. No timeline for implomentation was noted. The HM also sent an email to the QIDP on Friday, 9/15/17 at 7:32 p.m. that read, "All staff are going to have to be trained regarding (Client #1's) elopement. Responding to door chimes, knowing client whereabouts, and ensuring there is one person up front. When interviewed on 9/20/17 at 9:00 a.m. the QIDP said she had not seen the 9/15/17 are mail from the HM until Monday morning, 9/18/17.  When interviewed on 9/21/17 at approximately 10:30 a.m. regarding initial training on Client #1 for DSAA and DSAB, the QIDP stated they should have documented they had read Client #1's ISP and program plans. The QIDP said staff wore also supposed to receive "site training" to familiarize them with the home and the clients; but that type of training had not been not documented utility, so the QIDP did not know if DSAA or DSAB had received the site training. The QIDP was able to locate documental and the processors.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
was no documentation for DSA B regarding Client	W 194	an email from the HM A and DSA B by phon safety and make sure monitoring the front at said she also trained on 9/1/17. The QIDP sheet written by the D 9/12/17 to 9/19/17 do various staff to remind needed to be in the cetimes. The QIDP also management meeting the elopement. The training the elopement. The training the elopement of implement to have to be trained relopement. Respondiction whereabouts, at person up front." Who 9:00 a.m. the QIDP se 9/16/17 email from the 9/18/17.  When interviewed on 10:30 a.m. regarding to DSA A and DSA B, should have document were also supposed to familiarize them with the but that type of trainin documented until very not know if DSA A or I training. The QIDP we documentation DSA A acknowledging Client.	I that stated she trained DSA te on 9/11/17 to ensure client to have one staff person rea. In the email the HM DSA C and DSA D by phone also provided a training DSS with dates ranging from cumenting training of d staff that at one staff entral common area at all had the minutes from the g held on 9/18/17 to discuss eam determined a Wander would be the best option. Inentation was noted. The fill to the QIDP on Friday, hat read, "All staff are going regarding (Client #1's) ing to door chimes, knowing and ensuring there is one en interviewed on 9/20/17 at aid she had not seen the en HM until Monday morning,  9/21/17 at approximately initial training on Client #1 I, the QIDP stated they hated they had read Client I plans. The QIDP said staff or receive "site training" to the home and the clients; ig had not been not I/ recently, so the QIDP did DSA B had received the site as able to locate A signed off on #1's ISP on 8/10/17. There	W	194			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUH	TIPLE	CONSTRUCTION	(X3) DATE 5	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	3			COMPL	ETED
						c	: [
		16G113	B, WING	-		09/2	5/2017
NAME OF P	ROVIDER OR SUPPLIER			l	TREET ADDRESS, CITY, STATE, ZIP CODE		
MORAIC-	217 MAPLE AVENUE		217 MAPLE AVENUE				
moonto-2	SICHIMI EE AVEIVOE			N	EVADA, IA 50201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
W 194	#1's ISP. DSAA acki #1's communication p after the incident. DS Client #1's communic However, there was i	e 27 nowledged reading Client program on 9/11/17, the day SA B acknowledged reading cation program on 7/18/17. no information in the ISP or grams regarding elopement.	W	194			
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