OK 7/10/18 ✓7/18/18

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

PRINTED: 06/20/2018
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 06/07/2018

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 As the result of the investigation of #76178-I a deficiency was cited at W193.	W 000		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff demonstrated adequate communication and monitoring to provide necessary supervision for a client with a known history of elopement. This affected 1 of 1 clients involved in the investigation of #76178-I (Client #1). Finding Follows: Record review on 6/06/18 revealed a facility General Event Report (GER) and internal facility investigation regarding Client #1's elopement to the facility driveway on the afternoon of 5/23/18. According to the GER and investigation, four Direct Support Associates (DSA) and two maintenance staff were at the facility on the afternoon of 5/23/18 with six clients, including Client #1. According to the staff interviewed, at the time of the incident DSA A had been in the living room area with Client #1 and other clients, but went with another client to the client's bedroom for a grooming task. DSA B was in the medication room. DSA C was in the kitchen with two clients. DSA D cleaned in the basement of the facility. DSA B left the medication room and went to the living room area to check on clients when she noticed the front door was open. She	W 193	W193 STAFF TRAINING PROGRAM Staff will demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. Specifically, staff will be retrained on Behavior Support Plans. This will be monitored through monthly observations in the home. Person(s) Responsible: Program Manager	6/20/18

POC 6/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Carol Mau, Executive Director
Digitally signed by Carol Mau, Executive Director
DN: cn=Carol Mau, Executive Director, o, ou=Mosaic in Central Iowa, email=carol.mau@mosaicinfo.org, c=US
Date: 2018.06.25 09:11:46 -05'00'

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.

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 06/07/2018

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 193	Continued From page 1 went outside and found Client #1 in the driveway, trying to open the agency van door. The staff did not hear the exit door chimes sound at the time of the incident. Two maintenance men had been using a shop vacuum, which was very noisy. Client #1 returned to the facility and had no injuries or ill effects. Staff estimated Client #1 had been gone from the house for less than 3-5 minutes. The incident occurred at approximately 1:15 p.m. Client #1, 26 years old, had diagnoses including: profound intellectual disability, autism, cerebral palsy, unspecified hearing loss, obsessive-compulsive disorder, anxiety disorder, impulse disorder and intermittent explosive disorder. Client #1 ambulated independently and was non-verbal, without functional communication skills. Client #1 had one prior elopement, on 7/17/17. At that time, staff noticed Client #1 outside sitting in a staff person's vehicle. The staff had not been aware the client was missing until seeing him/her out the window, sitting in the vehicle. After that incident, elopement (leaving the house without staff supervision) was added to Client #1's behavior support program (BSP) as a target behavior to be diminished. According to the BSP, Client #1 "has a history of elopement. Staff should be aware of where (Client #1) is at all times. (Client #1's) home has door chimes on all exits. Staff should be sure to lock their vehicles as (Client #1) has a history of getting into unlocked vehicles. (Client #1) is encouraged to push the mac switch button by the door before leaving. Staff should respond immediately if door chimes go off." The home had door chimes on all exit doors, which sounded if the doors were opened.	W 193		

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 06/07/2018

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 193	Continued From page 2 According to the web site Weather Underground, the temperature at the Ames Airport (13 miles from the facility) on 5/23/18 at 12:53 p.m. was 81 degrees Fahrenheit with a heat index of 83.8 degrees. The temperature at 1:53 p.m. was 84 degrees Fahrenheit with a heat index of 87.8 degrees. Observation on 6/07/18 at 8:30 a.m. revealed an agency van in the driveway of the facility. The agency van was approximately 35-40 feet from the front door of the house. A short sidewalk led from the front door to the driveway. The entire area was in view of the living room window. The interior of the ranch style home had a large open area encompassing the living room, dining room and kitchen. The front door and part of the living room could be seen from the kitchen, if facing that direction. All exit doors, including the front door, had a door chime that sounded when the doors were opened. The door chime consisted of 8 musical notes, lasting about 8 seconds. The door chime was similar in sound and volume to a door bell. When interviewed on 6/06/18 at 2:45 p.m. DSA A stated she had been in the living room of the home with Client #1 and a couple other clients just prior to the incident. She noticed one of the other clients needed to shave under his/her nose, so she and the client went back to his/her bedroom. Client #1 was seated in the living room when DSA A left the room. She said she passed by the two maintenance men, DSA B and DSA C, who were near the front door. DSA A said she did not tell the other two staff that she was leaving the room because she thought they saw her. DSA A also stated she should not be required to tell other staff when she was leaving an area.	W 193		

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 06/07/2018

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 193	Continued From page 3 DSA A said she had worked at the agency for almost 10 years, but had only been at the Shagbark facility since around March of this year. DSA A worked at the Shagbark facility one day per week. DSA A said she had minimal training in the home and had not been trained on Client #1's programs. She said she was not aware Client #1 had a history of elopement. DSA A said she had not been told that a staff person needed to stay in the living room area/common area of the home to supervise clients. The facility provided documentation that DSA A had acknowledged reading Client #1's BSP on 3/30/18. The acknowledgment indicated DSA A had read and understood the program. When asked about this documentation on the afternoon of 6/06/18, DSA A said she did not recall reading the program or knowing anything about Client #1 having a history of elopement. When interviewed on 6/06/18 at 4:20 p.m. DSA B stated she had seen Client #1 sitting in the living room within five minutes of going to the medication room. DSA A also sat in the living room. DSA C was in the kitchen, cleaning up. Two maintenance men were in the kitchen using a shop vacuum, so it was noisy. DSA B said DSA A was newer to the home and only worked there one day per week. DSA B stated she told DSA A many times that a staff person needed to stay in the common area/living room area to supervise clients, and had just reminded DSA A again that morning. DSA B said she frequently reminded DSA A of this because she often didn't do it. DSA B left the medication room after less than five minutes to check on clients. She saw the front door was open and headed toward it. She saw Client #1 reaching out to touch the door of the	W 193		

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 06/07/2018

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 193	Continued From page 4 van in the driveway as she got to the front door. DSA B directed Client #1 back inside. The client was not injured. He/she wore only a pair of shorts, with nothing on his/her feet. DSA B said she did not know DSA A left the living room area. DSA B said she did not recall a time when she, DSA C and the two maintenance men were all standing near the front door. At the time of the incident, the maintenance men were in the kitchen, running the shop vacuum. When interviewed on 6/06/18 at 4:05 p.m. DSA C stated she saw Client #1 sitting in the living room a few minutes before she went to the kitchen to do dishes and cleaning. DSA A was also in the living room. DSA C said she cleaned and loaded the dishwasher, so she was not facing the living room area. DSA C said the two maintenance men were in the kitchen running the shop vacuum, which was very noisy. DSA C said DSA A was a newer staff to the Shagbark home and only worked there one day per week. Staff had told DSA A that a staff person needed to stay in the living room/common area of the home to supervise clients. Staff also told DSA A that staff should communicate with each other when leaving an area. DSA C heard DSA B say something about Client #1 being outside. DSA C went to the living room area and saw Client #1 through the window, standing by the van. She said she did not recall a time when she, DSA B and the two maintenance men were all standing around the front door. The facility had interviewed the two maintenance men regarding the incident. They said they were not aware of the elopement and staff had not mentioned it to them. When interviewed on 6/07/18 at 9:30 a.m. Maintenance Specialist A	W 193		

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 06/07/2018

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 193	Continued From page 5 said he did not recall the specific date, but confirmed he and a co-worker had been at Shagbark in the past 2-3 weeks and used the shop vacuum to clean under and around the refrigerator. When interviewed on 6/06/18 at 4:35 p.m. the Qualified Intellectual Disability Professional (QIDP) stated staff were typically trained on client programs by reading the programs on the computer. Staff clicked on the acknowledgement icon to indicate they had read and understood the program. The QIDP confirmed the staff were supposed to know Client #1's whereabouts at all times. Staff had been trained to always have a staff person in the common area of the home, supervising clients. Staff were trained to communicate with other staff if they had been supervising the common area and needed to leave the area. The door chimes on the exit doors were in place due to Client #1's history of elopement. Since the elopement incident on 5/23/18, the facility retrained staff regarding supervising the common area of the home and communicating with co-workers. They also revised Client #1's BSP to note that if the door chimes were not working or could not be heard, staff needed to keep Client #1 in sight.	W 193		