V 8/9/18 OK 7/25/18

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

PRINTED: 07/24/2018
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
	16G156	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 KELLY'S COURT FOREST CITY, IA 50436

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W 000	INITIAL COMMENTS At the time of investigation 73930-I concerns were noted with nursing services' failure to complete an assessment, which prevented treatment by appropriate medical services. This resulted in a determination of Immediate Jeopardy (IJ). The facility was notified at 2:40 p.m. on 3/26/18. A plan was provided which included development of a change in condition policy, policy revision when nursing staff should provide on-site assessment and staff training regarding the policy changes. The IJ was removed at 3:50 p.m. on 3/27/18. The investigation of 73930-I resulted in following deficiencies: Condition-level deficiencies were cited at W102, W158 and W318. Standard-level deficiencies were cited at W104, W186, W189, W192, W339 and W368.	W 000	See attached POC 8/24/18	
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain minimal compliance with the Condition of Participation (Co) - Governing Body and Management. Based on interviews and record review the governing body failed to provide adequate management and operating direction to ensure implementation of policy and procedure regarding health and safety of clients.	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Ludwig, AD — TITLE — 7/24/18 — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 The governing body also failed to provide operating direction to consistently develop effective measures to ensure safety and supervision of clients, provision of health services and adequate training of staff. Cross reference W104: Based on interviews and record reviews the facility failed to consistently provide adequate management and operating direction to ensure implementation of policy and procedure regarding health and safety of clients. The facility failed to provide adequate management and operating direction to ensure provision of required supports, supervision, care and service delivery in accordance with client needs, ensure the effectiveness of staff training and provision of health services including client assessment. Cross reference W158: Based on interviews and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Facility Staffing. The facility failed to consistently provide adequate staff and oversight, appropriately trained staff to ensure provisions of appropriate health care services to meet identified client needs. Cross reference W339: Based on interviews and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to consistently provide adequate care and oversight to ensure provision of appropriate health care services to meet identified client medical needs.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1)	W 104		

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W 104	Continued From page 2 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to consistently provide adequate management and operating direction to ensure implementation of policy and procedure regarding health and safety of clients. The facility failed to provide adequate management and operating direction to ensure provision of required supports, supervision, care and service delivery in accordance with client needs, ensure the effectiveness of staff training and provision of health services including client assessment. This affected all clients (Clients #1 - #8) residing at 105 Kelly's Court and involved in investigation 73930-I. Findings follow: Record review on 3/19/18 revealed a facility self-report dated 1/23/18. According to the report, Client #1 expired on 1/23/18. Staff reported the client had diarrhea throughout the night and experienced breathing difficulties at approximately 3:06 a.m. and in respiratory distress at approximately 6:16 a.m. Cardiopulmonary resuscitation (CPR) was performed and the client was pronounced dead at the facility. The facility began an immediate investigation into the unexpected death of Client #1. The autopsy, dated 1/25/18, listed the cause of death as complications of ruptured bowel in the setting of Fournier's gangrene. The manner of death was documented as undetermined.	W 104		

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Review of Client #1's ambulance report dated 1/23/18 revealed Emergency Medical Services was contacted at 6:16 a.m. Compressions and mouth-to-mouth were being given at the time of arrival. Client #1's pupils were fixed, dilated and glossy. Eyes and mouth were open, lower extremities mottled and the client was cool to touch. Cardiopulmonary resuscitation (CPR) was stopped. Automated External Defibrillator (AED) was applied without defibrillation.

Further record review on 3/20/18 revealed the following information: Client #1 was a legal minor with a diagnosis of microcephaly, congenital chromosomal abnormality, cerebral palsy, epilepsy, bilateral hip dysplasia, reactive airway disease; unspecified asthma, unspecified cardiac murmur (resolved); ventricular septal defect. The client used a wheelchair for mobility and could crawl to in-house destinations. Client #1 ate ground meat with all other foods cut into small bite size pieces and drank regular liquids. The client required 24 hour supervision in the home and in the community. While Client #1 had the ability to spend time in her bedroom playing with toys, staff were required to check on her every 10 - 15 minutes. During sleeping hours, staff should do visual checks hourly and check/reposition as needed every 2 hours.

1. See W186 for additional information.
a. When interviewed on 3/19/18 at 5:30 p.m. Direct Support Associate (DSA) C stated she worked for the agency about two years, worked in various sites and a variety of shifts but not at 105 Kelly's Court during the past month. On 1/22/18 she worked second shift at another site

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and was asked to work at Kelly's Court for the third shift. DSA C stated she worked at House 102 until approximately 3:00 a.m. when she was contacted by DSA B. The staff asked if DSA C could relieve her at House 105. When DSA C arrived, DSA B reported Client #1 was sick and thought she had some type of flu. DSA B did not inform her of Client #1's diarrhea but said she changed the client's incontinence brief frequently. Staff also did not tell her Client #1's buttock was red and sore. She immediately went to Client #1's bedroom and put her coat down. DSA C observed both Client #1 and her roommate were awake. She talked to Client #1 and said she thought she looked really sick. DSA C observed Client #1 looked uncomfortable while moving around in bed. She continued to talk to the client, touching her hand and tickling her stomach. DSA C stated when she touched her stomach, it felt very hard. After seeing Client #1, she left the bedroom to talk to DSA C but the staff had left the facility. She got the house phone as well as the information book and returned to Client #1's bedroom. She attempted to call the Program Manager (PM) but did not get an answer. DSA C knew the PM worked next door (101 Kelly's Court) and thought she was probably busy. She then contacted the on-call nurse (the Licensed Practical Nurse (LPN) and told her Client #1 did not look good. The LPN responded she already knew. DSA C asked if the client should go to the hospital and the LPN responded she would check Client #1 in the morning. The LPN then asked if there was a vaporizer in the room. DSA C responded yes and the LPN wanted it turned on. Immediately after the phone conversation, Client #1 grabbed at DSA C's hand and moved around, trying to reposition herself.

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W 104	Continued From page 5 DSA C stated due to assisting Client #1 she forgot to turn on the vaporizer. The PM called her back and DSA C relayed her concerns. The PM stated she would call the nurse and discuss the concerns. DSA C stated she did not hear back from the PM or the LPN the remainder of the shift. DSA C stated when she first arrived and observed Client #1; her breathing was fast paced. There were no further bowel movements and Client #1 was alert/ attentive to the DSA C's interactions (verbal and touching her hand). DSA C decided to sit in Client #1's bedroom and watched a school assignment video on her phone. She would touch Client #1 occasionally during the hour she watched her assignment. Client #1's breathing began to slow down after 4:00 a.m. and staff thought she calmed and appeared to fall asleep. DSA C watched television in the bedroom and during this time DSA D called on her personal cell phone to talk. At approximately 5:00 a.m. she noticed her Godmother texted on her personal cell phone. She checked Client #1 and she appeared to be OK. She called her Godmother at approximately 5:57 a.m. and remained in Client #1's bedroom while she talked on her personal cell phone. While she was on her personal cell phone, Client #2 came to Client #1's bedroom door. The client came into the bedroom after DSA C said hi and tried to grab her cell phone. She redirected Client #2 by having him take the facility phone and information book out of the bedroom while she remained on her personal call. After Client #2 left the bedroom, she noticed Client #1's breathing changed. The client slowing inhaled and exhaled with his/her eyes were half open. She decided to end her personal phone call; checked Client #1 and found her unresponsive.	W 104		

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W 104	Continued From page 6 DSA C stated she tried to move him/her around and checked his/her breathing. She yelled at Client #2 to retrieve the information book and phone and she started chest compressions. DSA C called DSA D on her personal cell phone because she felt since he was a recent call; she could just press one button to connect with DSA D. DSA D told her to contact the on-call nurse and gave her the phone number. Client #2 had returned the facility phone to her so DSA C called the LPN. She was instructed by the LPN to continue chest compressions and call 911. When DSA C called 911, she told the dispatcher what went on and was instructed to continue with chest compressions. The Direct Support Supervisor (DSS) and Direct Support Manager (DSM) arrived shortly and took over emergency measures while she was still on the phone with the dispatcher. The PM also came to the house as she walked out of the Client #1's bedroom. DSA C stated she was very upset and waited until the paramedics arrived, answered their questions and directed them to Client #1's bedroom. She was informed by the DSM Client #1 passed away. She stated her personal phone call lasted approximately 15 minutes and she never left Client #1's bedroom at any time, even during the personal phone call. When interviewed on 3/20/18 at 10:20 a.m. DSA G stated staff were not to use their cell phones at work for personal reasons but could be used for work related issues. Record review of the Personal Electronic Devices policy last updated on 2/1/17 documented "Personal cell phones are to be left in an employee's locker or car during his/her work shift	W 104		

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W 104	Continued From page 7 (including at conferences) and should only be used and accessed as authorized or required by his/her supervisor. An employee may use his/her personal cell phone to provide the two-step security sign-in for accessing Mosaic e-mail. Personal Cell phones that are not being used for Mosaic related business are not permitted in individuals home or on the work floor." In addition, the Mosaic Employee Handbook, last updated on February, 2017 documented personal calls and texts during work time were discouraged. When necessary, they should be received and placed during breaks or unpaid meal times. When interviewed on 3/26/18 at 10:55 a.m. the PM confirmed staff should not make personal phone calls during work time. When interviewed on 3/18/18 at 9:30 a.m. the Associate Director (AD) confirmed staff failed to follow the agency's "Use of Personal electronic Devices" policy. She stated staff should not have made a personal phone call during scheduled work time. b. When interviewed on 3/19/18 at 5:30 p.m. DSA C stated she was unable to complete the bed checks on the Clients #2 - #8 after 3:00 a.m. due to the needs of Client #1. She further stated while working in House 102 with another staff prior to 3:00 a.m. she was never asked or notified House 105 could use additional assistance. DSA C stated two direct support staff should have been in the house so one staff could assist Client #1 and bed checks and repositioning could have been completed with the other clients in the home.	W 104		

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W 104	Continued From page 8 When interviewed on 3/26/18 at 3:05 p.m. DSA B stated she worked 2nd shift on January 22, 2018. She started bed checks at approximately 10:30 p.m. and as she approached a client's bedroom, she heard a muffled scream from Client #1. She walked into the room and could smell Client #1 had a bowel movement (BM). She observed the BM was soft as she changed the client's incontinence brief. After she finished changing the client, she could hear the client's stomach gurgling immediately followed by another BM. DSA B stated the BMs started to be watery, diarrhea-like although there was some form to it. She changed Client #1 several times before 11:00 p.m. when DSA D arrived. When the staff walked into Client #1's bedroom, she directed DSA D to contact the on-call nurse due to Client #1's continuous diarrhea. DSA D left the client's bedroom and when he returned, told her the nurse said to give the client water. She gave the Client #1 a bath because the client's body was covered with feces as well as her bed. DSA D left the bedroom because the phone rang and when he returned she could hear him say something like "I don't know, I will ask her" and then handed DSA B the phone. The PM was on the phone and asked DSA B if she could cover third shift at another house. DSA B responded Client #1 was not well and needed someone to check on her. She stated she could possibly cover third shift but would not go anywhere until someone checked Client #1. The PM told DSA B she or the nurse would be over to check the client. DSA B stated Client #1 continued to have non-stop diarrhea but at times there was also formed stool. She stated the PM came to the house around 12:00 a.m. due to covering a shift	W 104		

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W 104	Continued From page 9 at the facility next door. DSA B stated the PM commented about Client #1's appearance and went to get a thermometer. She took the client's temperature which was 95.4 degrees Fahrenheit. The PM stated she did not know what to do but was going to call the nurse and check the client's medication book. When the PM returned to Client #1's bedroom, she stated she was going to give the client Tylenol. DSA D told DSA B he felt uncomfortable working alone at House 105 due to Client #1 being ill and volunteered to work at another house needing coverage. After the PM attempted to administer the Tylenol, she left to return to the house next door. After both staff left the facility, DSA B stated due to the care Client #1 required, she stayed in the client's bedroom. She observed the client's stomach appeared hard and poked out. The client cried off and on, kicking her legs and moving around in bed. DSA B tried to hold the client and rub her stomach. At one point, she carried Client #1 into the living room and placed her in a recliner. Client #1 calmed down briefly (approximately five minutes) but began moving around again, so she carried her back to her bedroom. Client #1 continued to move around in bed, making noises. She contacted the PM at 1:17 a.m. due to Client #1's raw and bleeding buttocks. She was told to put cream on after every brief change and the DSS should be in around 4:00 a.m. to assist her. The client had more than a dozen episodes of diarrhea between 1:43 a.m. - 2:43 a.m. She contacted the PM at 2:43 a.m. about Client #1's condition and questioned when her replacement would be in. She was told the DSS would come in around 5:00 a.m. but maybe one of the staff from House 102 could cover since there was 2 staff in that house. She called House 102 and	W 104		

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talked to DSA C. DSA B explained Client #1's condition and she needed to leave because she was getting tired. DSA C agreed to come over and arrived shortly before 3:00 a.m. Prior to leaving, DSA B stated Client #1 appeared to be calmer but thought she was probably exhausted. She recalled Client #1 made some noises like he/she would have another BM. She told DSA C Client #1 was not doing well; not to leave her side and the PM was up to date on the client's condition. She stated due to the needs of Client #1, she was unable to complete bed checks or assist other clients in the home. She stated Client #5 required brief changes through the night due to incontinence and other clients required assistance to use the restroom so they were not incontinent. DSA B stated she felt a second staff person should have assigned to assist to meet the client's needs.

When interviewed on 3/26/18 at 10:55 a.m. the PM stated on the evening of 1/22/18 there was a snowstorm resulting in call-ins by third shift staff. In the process of arranging staff coverage, two staff were assigned to 102 Kelly's Court House, one staff to 105 Kelly's Court and she would work at 101 Kelly's Court. Two staff from the previous shift were sleeping at House 101 due to the weather and were not on-duty. When she became aware Client #1 experienced excessive diarrhea, she encouraged staff to stay with Client #1 on third shift. She stated she did not make any further arrangements for the care and supervision of the others clients in the home.

Observations on 3/20/18 at 10:05 a.m. revealed Kelly's Court House 101, House 102 and House 105 were located on the same city block. The

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W 104	Continued From page 11 houses were in a horseshoe and although each house had a separate entrance, they were within a short walking distance of each other. House 105 was located between the other two homes. See W186 for additional information regarding specific needs of clients residing at 105 Kelly's Court. When interviewed on 3/27/18 at 2:00 p.m. the AD stated the agency did not have a specific policy regarding staffing rations at each facility. She stated in the eight-bed home, like 105 Kelly's Court, the expectation was to have three staff on first and second shift and one staff on third shift. At Kelly's Court, where there were three facilities, if a house had one than one staff at night, the additional staff could float from house-to-house as need. She confirmed this did not occur on 1/22-23/18 night shift. On 3/28/18 at 9:30 a.m. the AD confirmed the float staff should have been sent to assist in House 105 as needed. 2. See W189 for interviews and additional information: a. Record review revealed an undated facility protocol document entitled "When to call the nurse "On-Call." According to the document, staff should contact the on-call nurse if a client had difficulty breathing or absence thereof requiring artificial respiration (direct care staff should implement rescue breathing and notify 911 initially.) If respirations were less than 6 per minute (inhalation and exhalation=one respiration) attempt to awaken/startle the individual and then notify the nurse. Anytime an individual was found unresponsive, showing no signs of life, direct care staff should call 911	W 104		

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W 104	Continued From page 12 immediately and begin CPR immediately. When interviewed on 3/28/18 at 3:40 p.m. the PM confirmed staff failed to follow emergency protocols by not immediately contacting 911 when Client #1 was observed not breathing. When interviewed on 3/27/18 at 2:05 p.m. the AD confirmed staff should have called 911 immediately upon observing Client #1 not breathing and staff were currently participating in additional training. b. Record review revealed the Mandatory Orientation and Training Policy last updated on 11/1/17. According to the policy CPR/First Aid/Automated External Defibrillator (AED) recertification was to be completed as recommended by the American Red Cross and currently recertification was required every two years. Record review revealed the CPR certifications had lapsed for the following staff involved in the administration of CPR for Client #1 on 1/23/18: DSA C: no documentation of completion of CPR in the employee's training log. Due date for CPR was listed as 5/31/17. DSS: CPR card listed renewal date as 12/2017. DSM: CPR card listed renewal date as 4/2017. When interviewed on 3/19/18 at 5:30 p.m. DSA C stated her CPR training was previously completed through the National Guard program and not through the agency. When interviewed on 3/19/18 at 2:55 p.m. the DSS stated she was trained in CPR but her certification had lapsed in December, 2017.	W 104		

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W 104	Continued From page 13 When interviewed on 3/20/18 at 9:05 a.m. the DSM stated her CPR certification was expired at the time of the incident. She stated the on-line training was completed but never finished the testing. When interviewed on 3/27/18 at 2:05 p.m. the AD confirmed staff should have completed CPR training according to the American Red Cross recommendations. She stated it would be the expectation Mosaic staff would complete and maintain CPR certification. 3. See W192 for additional information and interviews: a. When interviewed on 3/28/18 at 9:30 a.m. the Associate Director (AD) confirmed staff failed to follow the agency's "Use of Personal Electronic Devices" policy. She stated staff should not have used Snapchat to communicate client concerns. b. Record review on 3/19/18 revealed a General Events Report (GER) dated 1/23/18. According to the GER, staff were instructed to sit with Client #1 due to not feeling well and experiencing diarrhea. The client appeared to be breathing hard and was uncomfortable. The report also documented the contact with emergency personnel and the client's death on 1/23/18. Client #1's record failed to contain any specific documentation of the client's change in condition or completion of the required third shift forms. According to the Employee DSA guidebook staff should complete awake/asleep charts nightly by third shift staff on duty. Staff should record whether the individuals were awake or asleep and when they completed bed checks through	W 104		

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W 104	Continued From page 14 the shift. The form would be collected at the end of the month and filed in case it was needed in the future. When interviewed on 3/26/18 at 10:55 a.m. the PM confirmed Client #1's record lacked any documentation regarding the client's condition change through the night on 1/22/18-1/23/18. She stated staff should have completed a T-log regarding the client's diarrhea as this would have been the best way to get the information to the appropriate people. An additional interview on 3/26/8 at 10:10 a.m. the PM stated she could not locate the 3rd shift documentation sheets for January, 2018 and was unsure if the sheets had been made available for staff's use during the month of January. She confirmed the following documentation sheets should be completed by staff for all clients on a nightly basis: Third Shift Observation Record which included the client's name, month and year. Staff should document the following information: 1) Asleep in room 2) Awake in room 3) In living room 4) Repositioned 5) Seizure 6) Voids on toilet 7) No results on toilet 8) BM 9) Dry 10) Wet 11) Opportunity to be toileted. In addition a 3rd shift Toileting graph included 15-Minute intervals to document if the client voided, was wet, dry or there were no results as well as a cleaning checklist was to be completed night. When interviewed on 3/28/18 at 9:30 a.m. the AD confirmed staff should have completed required documentation on third shift. 4. See W339 for additional information and interviews: Record review revealed the Incident Reporting	W 104		

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W 104	Continued From page 15 Policy last updated on 1/1/15. According to the policy, health services staff should respond to an incident by evaluating the physical/mental condition of the individual and administer or secure medical attention when warranted. When interviewed on 328/18 at 9:30 a.m. the AD confirmed the nurse should have come to the facility to complete an assessment on Client #1 due to a change in his/her condition.	W 104		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Facility Staffing. The facility failed to consistently provide adequate staff and oversight appropriately trained staff to ensure provisions of appropriate health care services to meet identified client needs. Findings follow: Cross reference W186: Based on interviews and record review the facility failed to coordinate and organized available staff to provide appropriate supervision. The facility failed to consistently provide appropriate and adequate supports to ensure appropriate supervision, care and service delivery were provided to clients in accordance with their needs. Staff failed to maintain uninterrupted supervision of clients due to time spent on a personal phone call.	W 158		

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W 158	Continued From page 16 Cross reference W189: Based on interviews and record review, the facility failed to immediately implement emergency protocols. The facility also failed to maintain training certifications on CPR. Cross reference W192: Based on interviews and record review the facility failed to appropriately train staff on the health needs of the clients as evidenced by lack of appropriate communication regarding a client's change in condition. Staff also failed to complete necessary documentation related to a client's condition change.	W 158		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to maintain uninterrupted supervision of a client due to time spent on a personal phone call. The facility also failed to consistently provide adequate supports to ensure appropriate supervision, care and service delivery were provided to all clients in accordance with their needs. This affected all clients residing in House 105 (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6, Client #7 and Client #8) involved in investigation #73930-I. Findings follow:	W 186		

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W 186	Continued From page 17 Record review on 3/19/18 revealed a facility self-report dated 1/23/18. According to the report, Client #1 expired on 1/23/18. Staff reported the client had diarrhea throughout the night and experienced breathing difficulties at approximately 3:06 a.m. and in respiratory distress at approximately 6:16 a.m. Cardiopulmonary resuscitation (CPR) was performed and the client was pronounced dead at the facility. The facility began an immediate investigation into the unexpected death of Client #1. The autopsy dated January 25, 2018 listed the cause of death as complications of ruptured bowel in the setting of Fournier's gangrene. The manner of death was documented as undetermined. Further record review on 3/20/18 revealed the following information: Client #1 was a legal minor with a diagnosis of microcephaly, congenital chromosomal abnormality, cerebral palsy, epilepsy, bilateral hip dysplasia, reactive airway disease; unspecified asthma, unspecified cardiac murmur (resolved); ventricular septal defect. The client used a wheelchair for mobility and could crawl to in-house destinations. Client #1 ate ground meat with all other foods cut into small bite size pieces and drank regular liquids. The client required 24 hour supervision in the home and in the community. While Client #1 had the ability to spend time in his/her bedroom playing with toys, staff were required to check on him/her every 10 - 15 minutes. During sleeping hours, staff should do visual checks hourly and check/reposition as needed every 2 hours. 1. When interviewed on 3/19/18 at 5:30 p.m.	W 186		

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Direct Support Associate (DSA) C stated she worked for the agency about two years, worked in various sites and a variety of shifts but not at 105 Kelly's Court during the past month. On 1/22/18 she worked second shift at another site and was asked to work at Kelly's Court for the third shift. DSA C stated she worked at House 102 until approximately 3:00 a.m. when she was contacted by DSA B. The staff asked if DSA C could relieve her at House 105. When DSA C arrived, DSA B reported Client #1 was sick and thought she had some type of flu. DSA B did not inform her of Client #1's diarrhea but said she changed the client's incontinence brief frequently. Staff also did not tell her Client #1's buttock was red and sore. She immediately went to Client #1's bedroom and put her coat down. DSA C observed both Client #1 and her roommate were awake. She talked to Client #1 and said she thought she looked really sick. DSA C observed Client #1 looked uncomfortable while moving around in bed. She continued to talk to the client, touching her hand and tickling her stomach. DSA C stated when she touched her stomach, it felt very hard. After seeing Client #1, she left the bedroom to talk to DSA C but the staff had left the facility. She got the house phone as well as the information book and returned to Client #1's bedroom. She attempted to call the Program Manager (PM) but did not get an answer. DSA C knew the PM worked next door (101 Kelly's Court) and thought she was probably busy. She then contacted the on-call nurse (the Licensed Practical Nurse (LPN) and told her Client #1 did not look good. The LPN responded she already knew. DSA C asked if the client should go to the hospital and the LPN responded she would check Client #1 in the morning. The

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LPN then asked if there was a vaporizer in the room. DSA C responded yes and the LPN wanted it turned on. Immediately after the phone conversation, Client #1 grabbed at DSA C's hand and moved around, trying to reposition herself. DSA C stated due to assisting Client #1 she forgot to turn on the vaporizer. The PM called her back and DSA C relayed her concerns. The PM stated she would call the nurse and discuss the concerns. DSA C stated she did not hear back from the PM or the LPN the remainder of the shift. DSA C stated when she first arrived and observed Client #1; her breathing was fast paced. There were no further bowel movements and Client #1 was alert/ attentive to the DSA C's interactions (verbal and touching her hand). DSA C decided to sit in Client #1's bedroom and watched a school assignment video on her phone. She would touch Client #1 occasionally during the hour she watched her assignment. Client #1's breathing began to slow down after 4:00 a.m. and staff thought she calmed and appeared to fall asleep. DSA C watched television in the bedroom and during this time DSA D called on her personal cell phone to talk. At approximately 5:00 a.m. she noticed her Godmother texted on her personal cell phone. She checked Client #1 and she appeared to be OK. She called her Godmother at approximately 5:57 a.m. and remained in Client #1's bedroom while she talked on her personal cell phone. While she was on her personal cell phone, Client #2 came to Client #1's bedroom door. The client came into the bedroom after DSA C said hi and tried to grab her cell phone. She redirected Client #2 by having him take the facility phone and information book out of the bedroom while she remained on her personal call. After Client #2

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W 186	Continued From page 20 left the bedroom, she noticed Client #1's breathing changed. The client slowing inhaled and exhaled with his/her eyes were half open. She decided to end her personal phone call; checked Client #1 and found her unresponsive. DSA C stated she tried to move him/her around and checked his/her breathing. She yelled at Client #2 to retrieve the information book and phone and she started chest compressions. DSA C called DSA D on her personal cell phone because she felt since he was a recent call; she could just press one button to connect with DSA D. DSA D told her to contact the on-call nurse and gave her the phone number. Client #2 had returned the facility phone to her so DSA C called the LPN. She was instructed by the LPN to continue chest compressions and call 911. When DSA C called 911, she told the dispatcher what went on and was instructed to continue with chest compressions. The Direct Support Supervisor (DSS) and Direct Support Manager (DSM) arrived shortly and took over emergency measures while she was still on the phone with the dispatcher. The PM also came to the house as she walked out of the Client #1's bedroom. DSA C stated she was very upset and waited until the paramedics arrived, answered their questions and directed them to Client #1's bedroom. She was informed by the DSM Client #1 passed away. She stated her personal phone call lasted approximately 15 minutes and she never left Client #1's bedroom at any time, even during the personal phone call. When interviewed on 3/20/18 at 10:20 a.m. DSA G stated staff were not to use their cell phones at work for personal reasons but could be used for work related issues.	W 186		

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W 186	Continued From page 21 Record review of the Personal Electronic Devices policy last updated on 2/1/17 documented "Personal cell phones are to be left in an employee's locker or car during his/her work shift (including at conferences) and should only be used and accessed as authorized or required by his/her supervisor. An employee may use his/her personal cell phone to provide the two-step security sign-in for accessing Mosaic e-mail. Personal Cell phones that are not being used for Mosaic related business are not permitted in individuals home or on the work floor." In addition, the Mosaic Employee Handbook, last updated on February, 2017 documented personal calls and texts during work time were discouraged. When necessary, they should be received and placed during breaks or unpaid meal times. When interviewed on 3/26/18 at 10:55 a.m. the PM confirmed staff should not make personal phone calls during work time. When interviewed on 3/18/18 at 9:30 a.m. the Associate Director (AD) confirmed staff failed to follow the agency's "Use of Personal electronic Devices" policy. She stated staff should not have made a personal phone call during scheduled work time. 2. When interviewed on 3/26/18 at 3:05 p.m. former DSA B stated she worked 2nd shift on January 22, 2018. She started bed checks at approximately 10:30 p.m. and as she approached a client's bedroom, she heard a muffled scream from Client #1. She walked into the room and could smell Client #1 had a bowel	W 186		

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movement (BM). She observed the BM was soft as she changed the client's incontinence brief. After she finished changing the client, she could hear the client's stomach gurgling immediately followed by another BM. DSA B stated the BMs started to be watery, diarrhea-like although there was some form to it. She changed Client #1 several times before 11:00 p.m. when DSA D arrived. When the staff walked into Client #1's bedroom, she directed DSA D to contact the on-call nurse due to Client #1's continuous diarrhea. DSA D left the client's bedroom and when he returned, told her the nurse said to give the client water. She gave the Client #1 a bath because the client's body was covered with feces as well as her bed. DSA D left the bedroom because the phone rang and when he returned she could hear him say something like "I don't know, I will ask her" and then handed DSA B the phone. The PM was on the phone and asked DSA B if she could cover third shift at another house. DSA B responded Client #1 was not well and needed someone to check on her. She stated she could possibly cover third shift but would not go anywhere until someone checked Client #1. The PM told DSA B she or the nurse would be over to check the client. DSA B stated Client #1 continued to have non-stop diarrhea but at times there was also formed stool. She stated the PM came to the house around 12:00 a.m. due to covering a shift at the facility next door. DSA B stated the PM commented about Client #1's appearance and went to get a thermometer. She took the client's temperature which was 95.4 degrees Fahrenheit. The PM stated she did not know what to do but was going to call the nurse and check the client's medication book. When the PM returned to Client #1's bedroom, she

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stated she was going to give the client Tylenol. DSA D told DSA B he felt uncomfortable working alone at House 105 due to Client #1 being ill and volunteered to work at another house needing coverage. After the PM attempted to administer the Tylenol, she left to return to the house next door. After both staff left the facility, DSA B stated due to the care Client #1 required, she stayed in the client's bedroom. She observed the client's stomach appeared hard and poked out. The client cried off and on, kicking her legs and moving around in bed. DSA B tried to hold the client and rub her stomach. At one point, she carried Client #1 into the living room and placed her in a recliner. Client #1 calmed down briefly (approximately five minutes) but began moving around again, so she carried her back to her bedroom. Client #1 continued to move around in bed, making noises. She contacted the PM at 1:17 a.m. due to Client #1's raw and bleeding buttocks. She was told to put cream on after every brief change and the DSS should be in around 4:00 a.m. to assist her. The client had more than a dozen episodes of diarrhea between 1:43 a.m. - 2:43 a.m. She contacted the PM at 2:43 a.m. about Client #1's condition and questioned when her replacement would be in. She was told the DSS would come in around 5:00 a.m. but maybe one of the staff from House 102 could cover since there was 2 staff in that house. She called House 102 and talked to DSA C. DSA B explained Client #1's condition and she needed to leave because she was getting tired. DSA C agreed to come over and arrived shortly before 3:00 a.m. Prior to leaving, DSA B stated Client #1 appeared to be calmer but thought she was probably exhausted. She recalled Client #1 made some noises like he/she

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would have another BM. She told DSA C Client #1 was not doing well; not to leave her side and the PM was up to date on the client's condition. She stated due to the needs of Client #1, she was unable to complete bed checks or assist other clients in the home. She stated Client #5 required brief changes through the night due to incontinence and other clients required assistance to use the restroom so they were not incontinent. DSA B stated she felt a second staff person should have assigned to assist to meet the client's needs.

When interviewed on 3/19/18 at 5:30 p.m. DSA C stated she was unable to complete the bed checks on the Clients #2 - #8 after 3:00 a.m. due to the needs of Client #1. She further stated while working in House 102 with another staff prior to 3:00 a.m. she was never asked or notified House 105 could use additional assistance. DSA C stated two direct support staff should have been in the house so one staff could assist Client #1 and bed checks and repositioning could have been completed with the other clients in the home.

When interviewed on 3/26/18 at 10:55 a.m. the PM stated on the evening of 1/22/18 there was a snowstorm resulting in call-ins by third shift staff. In the process of arranging staff coverage, two staff were assigned to 102 Kelly's Court House, one staff to 105 Kelly's Court and she would work at 101 Kelly's Court. Two staff from the previous shift were sleeping at House 101 due to the weather and were not on-duty. When she became aware Client #1 experienced excessive diarrhea, she encouraged staff to stay with Client #1 on third shift. She stated she did not make

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W 186	Continued From page 25 any further arrangements for the care and supervision of the others clients in the home. Observations on 3/20/18 at 10:05 a.m. revealed Kelly's Court House 101, House 102 and House 105 were located on the same city block. The houses were in a horseshoe and although each house had a separate entrance, they were within a short walking distance of each other. House 105 was located between the other two homes. Record review on 3/29/18 revealed the following information regarding clients residing at Kelly's Court: Client #2's Individual Data Sheet (IDS) last updated on 8/11/17 defined supervision level as: 24 hour supervision at home and in the community. The client was incontinent and required disposable briefs. Client #2 informal programming included use of the bathroom every two hours while awake. During sleeping hours, staff should check the client every two hours and change if wet. Client #2 Behavior Support Plans (BSPs) last updated on 3/23/18 addressed aggressive behaviors defined as hitting and kicking with intent to cause injury, self-injurious behaviors defined as hitting or kicking the walls/doors/windows hard enough to cause injury to self and decrease spitting behavior. Client #3's IDS last updated on 11/8/16 defined supervision level as: 24 hour supervision at home and in the community. The client could spend time in her bedroom unsupervised with staff checks every 15 minutes. The client was incontinent and required incontinence briefs. Client #3's BSP last updated on 1/30/18	W 186		

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addressed aggressive behavior defined as hitting, throwing items, pushing, kicking and biting and self-injurious behavior defined as biting self, hitting self and head banging against walls and objects. The client's program addressing toileting last updated on 1/30/18 included a step in the procedure to awaken Client #3 one time per night to have her use the restroom. The client also received Trazadone as a sleep aide due to difficulty sleeping.

Client #4's IDS last updated on 11/8/16 defined supervision level as: 24 hour supervision. Staff should be aware of the client's location and what he was doing. The client was independent in toileting. Client #4's BSP last updated on 11/24/17 addressed aggression defined as hitting, kicking, slapping and biting; stealing defined as taking others property; disruptive behaviors defined as spitting, calling people names, touching others, property destruction defined as breaking objects, putting holes in walls, breaking windows; leaving without permission defined as leaving the premises of the home with staff supervision and not returning when prompted. Restrictive measures included the use of Plexiglas on bedroom window, shutters on the outside of the window and an alarm on bedroom door to be turned on during sleeping hours.

Client #5's IDS last updated on 2/20/18 defined supervision level as: 24 hours supervision. During waking hours the client could be alone in her bedroom with 15 minute checks. The client was incontinent and dependent on staff for toileting needs. Client #5's toileting program last updated on 3/28/18 addressed teaching the client

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W 186	Continued From page 27 to use a communication switch to indicate the need to use the toilet and would not be implemented during sleep hours. Client #5 would be checked and changed during sleep hours. Client #6's IDS last updated 8/14/17 defined supervision level as: 24 hour supervision in the hoe and in the community. The client could spend time in his bedroom unsupervised with staff checks every half hour. During sleeping hours, staff should do visual checks hourly. The client required prompting and monitoring during toileting Client #6's BSP last updated on 3/28/18 addressed aggression defined as throwing or tipping objects, slamming doors, breaking objects, hitting/pushing, kicking, spitting, biting self or others, grabbing at others and scratching. Inappropriate verbal behaviors were defined as swearing, calling others derogatory names and making threats to others. Task refusal was defined as refusing to work on task, refusing to go to scheduled area, leaving assigned area, inappropriate verbal telling untruths, inappropriate conversations and exiting due to history of leaving the building (at previous residence) but not leaving the area. Client #7's IDS last updated on 2/20/18 defined supervision level as: 24 hour supervision at home and in the community. The client could spend time alone in his bedroom with half-hour checks by staff. During sleeping hours, staff should do visual checks hourly. The client used the restroom independently. Client #7 BSP last updated on 8/31/17 addressed aggressions defined as kicking, hitting, spitting and biting. Disruptive behaviors were defined as pounding on objects, yelling/screaming, ringing buzzers,	W 186		

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W 186	Continued From page 28 using profanity, running through the home area, disturbing others while they sleep (turning lights on/off and pulling covers off), exiting behavior (leaving home without telling staff) and throwing/using items as weapons. The client received Trazadone to assist in sleep behavior and the program directed staff to complete the observation sheet of when the client slept and when awake. Client #8's IDS last updated on 9/29/16 defined supervision level as 24 hour supervision at home and in the community. With staff present in the home, the client could be alone in her bedroom for one hour at night and 30 minutes during the day. The client wore a pull-up at night in case of incontinence. The client's BSP last updated on 3/28/18 addressed decreasing incidents of self-harm defined as: scratching arm with fingernails, rubbing pencil eraser against arm to cause a burn, tying or wrapping items around neck, cutting skin with sharp objects, including fingernails, ingesting personal care products and putting objects in ear canals and decreasing incidents of elopement (exiting the building with the intention of evading staff). Restrictive measure included bedroom windows open only two inches. When interviewed on 3/27/18 at 2:00 p.m. the AD stated the agency did not have a specific policy regarding staffing rations at each facility. She stated in the eight-bed home, like 105 Kelly's Court, the expectation was to have three staff on first and second shift and one staff on third shift. At Kelly's Court, where there were three facilities, if a house had one than one staff at night, the additional staff could float from house-to-house	W 186		

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W 186	Continued From page 29 as need. She confirmed this did not occur on 1/22-23/18 night shift. On 3/28/18 at 9:30 a.m. the AD confirmed the float staff should have been sent to assist in House 105 as needed.	W 186		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to immediately implement emergency protocols. Facility staff also failed to maintain training certification on Cardiopulmonary Resuscitation (CPR). This affected 1 of 1 client (Client #1) involved in investigation #73930-I. Findings follow: See W186 for additional information. When interviewed on 3/19/18 at 5:30 p.m. Direct Support Associate (DSA) C stated she worked for the agency about two years, worked in various sites and a variety of shifts but not at 105 Kelly's Court during the past month. On 1/22/18 she worked second shift at another site and was asked to work at Kelly's Court for the third shift. DSA C stated she worked at House 102 until approximately 3:00 a.m. when she was contacted by DSA B. The staff asked if DSA C could relieve her at House 105. When DSA C arrived, DSA B reported Client #1 was sick and thought she had some type of flu. DSA B did not inform her of Client #1's diarrhea but said she changed the	W 189		

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client's incontinence brief frequently. Staff also did not tell her Client #1's buttock was red and sore. She immediately went to Client #1's bedroom and put her coat down. DSA C observed both Client #1 and her roommate were awake. She talked to Client #1 and said she thought she looked really sick. DSA C observed Client #1 looked uncomfortable while moving around in bed. She continued to talk to the client, touching her hand and tickling her stomach. DSA C stated when she touched her stomach, it felt very hard. After seeing Client #1, she left the bedroom to talk to DSA C but the staff had left the facility. She got the house phone as well as the information book and returned to Client #1's bedroom. She attempted to call the Program Manager (PM) but did not get an answer. DSA C knew the PM worked next door (101 Kelly's Court) and thought she was probably busy. She then contacted the on-call nurse (the Licensed Practical Nurse (LPN) and told her Client #1 did not look good. The LPN responded she already knew. DSA C asked if the client should go to the hospital and the LPN responded she would check Client #1 in the morning. The LPN then asked if there was a vaporizer in the room. DSA C responded yes and the LPN wanted it turned on. Immediately after the phone conversation, Client #1 grabbed at DSA C's hand and moved around, trying to reposition herself. DSA C stated due to assisting Client #1 she forgot to turn on the vaporizer. The PM called her back and DSA C relayed her concerns. The PM stated she would call the nurse and discuss the concerns. DSA C stated she did not hear back from the PM or the LPN the remainder of the shift. DSA C stated when she first arrived and observed Client #1; her breathing was fast

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paced. There were no further bowel movements and Client #1 was alert/ attentive to the DSA C's interactions (verbal and touching her hand). DSA C decided to sit in Client #1's bedroom and watched a school assignment video on her phone. She would touch Client #1 occasionally during the hour she watched her assignment. Client #1's breathing began to slow down after 4:00 a.m. and staff thought she calmed and appeared to fall asleep. DSA C watched television in the bedroom and during this time DSA D called on her personal cell phone to talk. At approximately 5:00 a.m. she noticed her Godmother texted on her personal cell phone. She checked Client #1 and she appeared to be OK. She called her Godmother at approximately 5:57 a.m. and remained in Client #1's bedroom while she talked on her personal cell phone. While she was on her personal cell phone, Client #2 came to Client #1's bedroom door. The client came into the bedroom after DSA C said hi and tried to grab her cell phone. She redirected Client #2 by having him take the facility phone and information book out of the bedroom while she remained on her personal call. After Client #2 left the bedroom, she noticed Client #1's breathing changed. The client slowing inhaled and exhaled with his/her eyes were half open. She decided to end her personal phone call; checked Client #1 and found her unresponsive. DSA C stated she tried to move him/her around and checked his/her breathing. She yelled at Client #2 to retrieve the information book and phone and she started chest compressions. DSA C called DSA D on her personal cell phone because she felt since he was a recent call; she could just press one button to connect with DSA D. DSA D told her to contact the on-call nurse

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and gave her the phone number. Client #2 had returned the facility phone to her so DSA C called the LPN. She was instructed by the LPN to continue chest compressions and call 911. When DSA C called 911, she told the dispatcher what went on and was instructed to continue with chest compressions. The Direct Support Supervisor (DSS) and Direct Support Manager (DSM) arrived shortly and took over emergency measures while she was still on the phone with the dispatcher. The PM also came to the house as she walked out of the Client #1's bedroom. DSA C stated she was very upset and waited until the paramedics arrived, answered their questions and directed them to Client #1's bedroom. She was informed by the DSM Client #1 passed away. When asked why she called DSA D instead of 911 immediately, DSA C stated she felt overwhelmed, did not feel prepared and called for DSA D for support. Since she did not have the house phone available and thought 911 should be called from the house phone, she waited until Client #2 brought her the house phone. DSA C stated she was trained but being in the situation felt very different.

When interviewed on 3/19/18 at 7:05 p.m. DSA F stated staff were trained to contact the on-call nurse or on-call supervisor if a client was in distress and they would assess. DSA F stated because he was CPR trained he would contact 911 if needed.

When interviewed on 3/20/18 at 10:20 a.m. DSA G stated staff had been trained to contact the on-call nursing first before calling 911 and was glad staff was being retrained to contact 911 immediately.

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W 189	Continued From page 33 When interviewed on 3/28/18 at 10:30 a.m. the LPN stated staff had been instructed to contact 911 if a client was having trouble breathing. She stated staff were never told to contact on-call nursing first for emergency situations. Record review revealed an undated facility protocol document entitled "When to call the nurse "On-Call." According to the document, staff should contact the on-call nurse if a client had difficulty breathing or absence thereof requiring artificial respiration (direct care staff should implement rescue breathing and notify 911 initially.) If respirations were less than 6 per minute (inhalation and exhalation=one respiration) attempt to awaken/startle the individual and then notify the nurse. Anytime an individual was found unresponsive, showing no signs of life, direct care staff should call 911 immediately and begin CPR immediately. When interviewed on 3/28/18 at 3:40 p.m. the PM confirmed staff failed to follow emergency protocols by not immediately contacting 911 when Client #1 was observed not breathing. When interviewed on 3/27/18 at 2:05 p.m. the Associate Director (AD) confirmed staff should have called 911 immediately upon observing Client #1 not breathing and staff were currently participating in additional training. 2. Record review revealed the Mandatory Orientation and Training Policy last updated on 11/1/17. According to the policy CPR/First Aid/Automated External Defibrillator (AED) recertification was to be completed as	W 189		

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W 189	Continued From page 34 recommended by the American Red Cross and currently recertification was required every two years. Record review revealed the CPR certifications had lapsed for the following staff involved in the administration of CPR for Client #1 on 1/23/18: DSA C: no documentation of completion of CPR in the employee's training log. Due date for CPR was listed as 5/31/17. Direct Support Supervisor (DSS): CPR card listed renewal date as 12/2017. Direct Support Manager (DSM): CPR card listed renewal date as 4/2017. When interviewed on 3/19/18 at 5:30 p.m. DSA C stated her CPR training was previously completed through the National Guard program and not through the agency. When interviewed on 3/19/18 at 2:55 p.m. the DSS stated she was trained in CPR but her certification had lapsed in December, 2017. When interviewed on 3/20/18 at 9:05 a.m. the DSM stated her CPR certification was expired at the time of the incident. She stated the on-line training was completed but never finished the testing. When interviewed on 3/27/18 at 2:05 p.m. the AD confirmed staff should have completed CPR training according to the American Red Cross recommendations. She stated it would be the expectation Mosaic staff would complete and maintain CPR certification.	W 189		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2)	W 192		

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W 192	Continued From page 35 For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to appropriately train staff on the health needs of the clients due to inappropriate communication of a client's change in condition as well as failure to complete necessary documentation related to the condition change of the client. This affected one of one client involved in investigation #73930-I (Client #1). Findings follow: 1. When interviewed on 3/19/18 at 4:55 p.m. the Direct Support Associate (DSA) A stated she gave Client #1 her evening medications on 1/22/18 with some difficulty. The client would frequently give the medication passer a difficult time so this was not unusual behavior. She worked until 9:15 p.m. on 1/22/18 and no concerns were observed with Client #1. DSA A received a Snapchat (mobile application that allows users to capture videos and pictures, send messages which self-destruct after a few seconds) on her personal cell phone after 11:00 p.m. from DSA D indicating he was concerned about Client #1. He communicated something wasn't right, the client was having excessive bowel movements. She instructed DSA D to contact the on-call nurse and used Snapchat to relay the number to him. DSA A assumed he contacted her on his personal phone because DSA D was in the client's bedroom and did not have the facility phone immediately available. DSA D then communicated to her using	W 192		

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W 192	Continued From page 36 Snapchat he was not happy with the answer he got from the nurse. DSA A instructed him to contact the Administrator On-Call (AOC) because he seemed upset and provided him with the number via Snapchat. She did contact the AOC around 11:18 p.m. and was told she (the AOC) would contact the staff. When DSA A communicated with DSA D, he responded via Snapchat he had tried to call, did not get an answer but the AOC never called him. She then communicated via Snapchat DSA D should contact the executive on-call and relayed the phone number. She was aware the executive on-call (the Program Manager (PM) had talked to DSA D and she did not hear back from facility staff the remainder of the night. When interviewed on 3/26/18 at 4:15 p.m. DSA D stated he worked at 105 Kelly's Court on second shift until approximately 8:45 p.m. and then returned around 10:50 p.m. to work the third shift. When he arrived back at the facility at 10:50 p.m. no clients were in the central area of the house. DSA D stated he walked back toward the bedrooms and saw DSA B assisting Client #1 as she had a bowel movement (BM). DSA D stated he brought more briefs and wipes into the bedroom. He observed Client #1 appeared to be in pain, moved around in bed and moaned and had continuous BMs, every one to two minutes. While the BMs were diarrhea consistency, DSA D stated she also had one large, firm BM. DSA D stated he left the room briefly to check if any clients were outside their bedrooms. When he returned to Client #1's bedroom, she had an "explosion" which he explained as extreme diarrhea and feces all over his/her body and bed. Client #1 required a bath and bedding change as	W 192		

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W 192	Continued From page 37 well. After getting the client cleaned up, he contacted the on-call nurse (the LPN) and explained Client #1 was in pain, having continuous bowel movements and did not look normal. The LPN stated staff should give the client some water, tuck her in bed and she would check her in the morning. DSA D said he was upset by the LPN's response and wanted to know what more could be done. DSA D stated he felt the nurse should have come to the facility to assess Client #1 after he called and reported the changes in his/her condition. He got a cup of water and attempted to give Client #1 some water but she refused. DSA D stated this was unusual because Client #1 usually liked to eat and drink. DSA D decided to contact DSA A since she was a lead staff and she could possibly give him more information. DSA D stated he could not locate DSA A's phone number so used Snapchat to communicate with her. He told her Client #1 (used a shortened version of the client's name) was not feeling good and he was not happy with what the nurse told him. DSA A instructed him via Snapchat to contact the AOC. He stated he tried to call the number but no one answered. DSA D stated he was going to contact the Executive on-call (the PM) just as she walked into the facility. They walked back to Client #1's bedroom and the PM tried to calm the client by talking with her and rubbing her arms. The PM talked to DSA B about going to another facility to provide coverage. DSA D felt since DSA B provided the cares for Client #1, it would be better if he assisted with the coverage at another facility and left 105 Kelly's Court around 11:30 p.m. Record review of the Personal Electronic Devices	W 192		

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W 192	Continued From page 38 policy last updated on 2/1/17 documented "Personal cell phones are to be left in an employee's locker or car during his/her work shift (including at conferences) and should only be used and accessed as authorized or required by his/her supervisor. An employee may use his/her personal cell phone to provide the two-step security sign-in for accessing Mosaic e-mail. Personal Cell phones that are not being used for Mosaic related business are not permitted in individuals home or on the work floor." In addition, the Mosaic Employee Handbook, last updated on February, 2017 documented personal calls and texts during work time were discouraged. When necessary, they should be received and placed during breaks or unpaid meal times. When interviewed on 3/28/18 at 9:30 a.m. the Associate Director (AD) confirmed staff failed to follow the agency's "Use of Personal Electronic Devices" policy. She stated staff should not have used Snapchat to communicate client concerns. 3. Record review on 3/19/18 revealed a General Events Report (GER) dated 1/23/18. According to the GER, staff were instructed to sit with Client #1 due to not feeling well and experiencing diarrhea. The client appeared to be breathing hard and was uncomfortable. The report also documented the contact with emergency personnel and the client's death on 1/23/18. Client #1's record failed to contain any specific documentation of the client's change in condition or completion of the required third shift forms. According to the Employee DSA guidebook staff should complete awake/asleep charts nightly by	W 192		

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W 192	Continued From page 39 third shift staff on duty. Staff should record whether the individuals were awake or asleep and when they completed bed checks through the shift. The form would be collected at the end of the month and filed in case it was needed in the future. When interviewed on 3/26/18 at 10:55 a.m. the PM confirmed Client #1's record lacked any documentation regarding the client's condition change through the night on 1/22/18-1/23/18. She stated staff should have completed a T-log regarding the client's diarrhea as this would have been the best way to get the information to the appropriate people. An additional interview on 3/26/8 at 10:10 a.m. the PM stated she could not locate the 3rd shift documentation sheets for January, 2018 and was unsure if the sheets had been made available for staff's use during the month of January. She confirmed the following documentation sheets should be completed by staff for all clients on a nightly basis: third Shift Observation Record which included the client's name, month and year. Staff should document the following information: 1) Asleep in room 2) Awake in room 3) In living room 4) Repositioned 5) Seizure 6) Voids on toilet 7) No results on toilet 8) BM 9) Dry 10) Wet 11) Opportunity to be toileted. In addition a 3rd shift Toileting graph included 15-Minute intervals to document if the client voided, was wet, dry or there were no results as well as a cleaning checklist was to be completed night. When interviewed on 3/28/18 at 9:30 a.m. the AD confirmed staff should have completed required documentation on third shift.	W 192		
W 318	HEALTH CARE SERVICES	W 318		

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W 318	Continued From page 40 CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to consistently provide adequate care and oversight to ensure provision of appropriate health care services to meet identified client medical needs. Cross reference W339: Based on interviews and record review, the facility failed to provide adequate nursing services by not completing an assessment in accordance with a client change of condition. In addition, facility staff failed to document the results of a PRN (as needed) medication.	W 318		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to provide adequate nursing services by not completing an assessment in accordance with a client change of condition. In addition, facility staff failed to document the results of a PRN (as needed) medication. This	W 339		

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W 339	Continued From page 41 affected 1 of 1 client (Client #1) involved in investigation #73930-I. Findings follow: Record review on 3/19/18 revealed a facility self-report dated 1/23/18. According to the report, Client #1 expired on 1/23/18. Staff reported the client had diarrhea throughout the night and experienced breathing difficulties at approximately 3:06 a.m. and in respiratory distress at approximately 6:16 a.m. Cardiopulmonary resuscitation (CPR) was performed and the client was pronounced dead at the facility. The facility began an immediate investigation into the unexpected death of Client #1. The autopsy dated January 25, 2018 listed the cause of death as complications of ruptured bowel in the setting of Fournier's gangrene. The manner of death was documented as undetermined. Record review on 3/20/18 revealed the following information: Client #1 was a legal minor with a diagnosis of microcephaly, congenital chromosomal abnormality, cerebral palsy, epilepsy, bilateral hip dysplasia, reactive airway disease; unspecified asthma, unspecified cardiac murmur (resolved); ventricular septal defect. The client used a wheelchair for mobility and could crawl to in-house destinations. Client #1 ate ground meat with all other foods cut into small bite size pieces and drank regular liquids. The client required 24 hour supervision in the home and in the community. While Client #1 had the ability to spend time in his/her bedroom playing with toys, staff were required to check on him/her every 10 - 15 minutes. During sleeping hours, staff should do visual checks hourly and check/reposition as needed every 2 hours.	W 339		

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Review of Client #1's ambulance report dated 1/23/18 revealed Emergency Medical Services was contacted at 6:16 a.m. Compressions and mouth-to-mouth were being given at the time of arrival. Client #1's pupils were fixed, dilated and glossy. Eyes and mouth were open, lower extremities mottled and the client was cool to touch. CPR was stopped. Automated External Defibrillator (AED) was applied without defibrillation.

When interviewed on 3/19/18 at 5:30 p.m. DSA C stated she worked for the agency about two years, worked in various sites and a variety of shifts but not at 105 Kelly's Court during the past month. On 1/22/18 she worked second shift at another site and was asked to work at Kelly's Court for the third shift. DSA C stated she worked at House 102 until approximately 3:00 a.m. when she was contacted by DSA B. The staff asked if DSA C could relieve her at House 105. When DSA C arrived, DSA B reported Client #1 was sick and thought she had some type of flu. DSA B did not inform her of Client #1's diarrhea but said she changed the client's incontinence brief frequently. Staff also did not tell her Client #1's buttock was red and sore. She immediately went to Client #1's bedroom and put her coat down. DSA C observed both Client #1 and her roommate were awake. She talked to Client #1 and said she thought she looked really sick. DSA C observed Client #1 looked uncomfortable while moving around in bed. She continued to talk to the client, touching her hand and tickling her stomach. DSA C stated when she touched her stomach, it felt very hard. After seeing Client #1, she left the bedroom to

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talk to DSA C but the staff had left the facility. She got the house phone as well as the information book and returned to Client #1's bedroom. She attempted to call the Program Manager (PM) but did not get an answer. DSA C knew the PM worked next door (101 Kelly's Court) and thought she was probably busy. She then contacted the on-call nurse (the Licensed Practical Nurse (LPN) and told her Client #1 did not look good. The LPN responded she already knew. DSA C asked if the client should go to the hospital and the LPN responded she would check Client #1 in the morning. The LPN then asked if there was a vaporizer in the room. DSA C responded yes and the LPN wanted it turned on. Immediately after the phone conversation, Client #1 grabbed at DSA C's hand and moved around, trying to reposition herself. DSA C stated due to assisting Client #1 she forgot to turn on the vaporizer. The PM called her back and DSA C relayed her concerns. The PM stated she would call the nurse and discuss the concerns. DSA C stated she did not hear back from the PM or the LPN the remainder of the shift. DSA C stated when she first arrived and observed Client #1; her breathing was fast paced. There were no further bowel movements and Client #1 was alert/ attentive to the DSA C's interactions (verbal and touching her hand). DSA C decided to sit in Client #1's bedroom and watched a school assignment video on her phone. She would touch Client #1 occasionally during the hour she watched her assignment. Client #1's breathing began to slow down after 4:00 a.m. and staff thought she calmed and appeared to fall asleep. DSA C watched television in the bedroom and during this time DSA D called on her personal cell phone to talk.

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At approximately 5:00 a.m. she noticed her Godmother texted on her personal cell phone. She checked Client #1 and she appeared to be OK. She called her Godmother at approximately 5:57 a.m. and remained in Client #1's bedroom while she talked on her personal cell phone. While she was on her personal cell phone, Client #2 came to Client #1's bedroom door. The client came into the bedroom after DSA C said hi and tried to grab her cell phone. She redirected Client #2 by having him take the facility phone and information book out of the bedroom while she remained on her personal call. After Client #2 left the bedroom, she noticed Client #1's breathing changed. The client slowing inhaled and exhaled with his/her eyes were half open. She decided to end her personal phone call; checked Client #1 and found her unresponsive. DSA C stated she tried to move him/her around and checked his/her breathing. She yelled at Client #2 to retrieve the information book and phone and she started chest compressions. DSA C called DSA D on her personal cell phone because she felt since he was a recent call; she could just press one button to connect with DSA D. DSA D told her to contact the on-call nurse and gave her the phone number. Client #2 had returned the facility phone to her so DSA C called the LPN. She was instructed by the LPN to continue chest compressions and call 911. When DSA C called 911, she told the dispatcher what went on and was instructed to continue with chest compressions. The Direct Support Supervisor (DSS) and Direct Support Manager (DSM) arrived shortly and took over emergency measures while she was still on the phone with the dispatcher. The PM also came to the house as she walked out of the Client #1's bedroom.

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DSA C stated she was very upset and waited until the paramedics arrived, answered their questions and directed them to Client #1's bedroom. She was informed by the DSM Client #1 passed away. DSC stated the nurse should have come to check Client #1 or sent her to the hospital when she called about her condition.

When interviewed on 3/26/18 at 3:05 p.m. Direct Support Associate (DSA) B stated she worked 2nd shift on January 22, 2018. She started bed checks at approximately 10:30 p.m. and as she approached a client's bedroom, she heard a muffled scream from Client #1. She walked into the room and could smell Client #1 had a bowel movement (BM). She observed the BM was soft as she changed the client's incontinence brief. After she finished changing the client, she could hear the client's stomach gurgling immediately followed by another BM. DSA B stated the BMs started to be watery, diarrhea-like although there was some form to it. She changed Client #1 several times before 11:00 p.m. when DSA D arrived. When the staff walked into Client #1's bedroom, she directed DSA D to contact the on-call nurse due to Client #1's continuous diarrhea. DSA D left the client's bedroom and when he returned, told her the nurse said to give the client water. She gave the Client #1 a bath because the client's body was covered with feces as well as her bed. DSA D left the bedroom because the phone rang and when he returned she could hear him say something like "I don't know, I will ask her" and then handed DSA B the phone. The PM was on the phone and asked DSA B if she could cover third shift at another house. DSA B responded Client #1 was not well and needed someone to check on her. She

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stated she could possibly cover third shift but would not go anywhere until someone checked Client #1. The PM told DSA B she or the nurse would be over to check the client. DSA B stated Client #1 continued to have non-stop diarrhea but at times there was also formed stool. She stated the PM came to the house around 12:00 a.m. due to covering a shift at the facility next door. DSA B stated the PM commented about Client #1's appearance and went to get a thermometer. She took the client's temperature which was 95.4 degrees Fahrenheit. The PM stated she did not know what to do but was going to call the nurse and check the client's medication book. When the PM returned to Client #1's bedroom, she stated she was going to give the client Tylenol. DSA D told DSA B he felt uncomfortable working alone at House 105 due to Client #1 being ill and volunteered to work at another house needing coverage. After the PM attempted to administer the Tylenol, she left to return to the house next door. After both staff left the facility, DSA B stated due to the care Client #1 required, she stayed in the client's bedroom. She observed the client's stomach appeared hard and poked out. The client cried off and on, kicking her legs and moving around in bed. DSA B tried to hold the client and rub her stomach. At one point, she carried Client #1 into the living room and placed her in a recliner. Client #1 calmed down briefly (approximately five minutes) but began moving around again, so she carried her back to her bedroom. Client #1 continued to move around in bed, making noises. She contacted the PM at 1:17 a.m. due to Client #1's raw and bleeding buttocks. She was told to put cream on after every brief change and the DSS should be in around 4:00 a.m. to assist her. The client had

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W 339	Continued From page 47 more than a dozen episodes of diarrhea between 1:43 a.m. - 2:43 a.m. She contacted the PM at 2:43 a.m. about Client #1's condition and questioned when her replacement would be in. She was told the DSS would come in around 5:00 a.m. but maybe one of the staff from House 102 could cover since there was 2 staff in that house. She called House 102 and talked to DSA C. DSA B explained Client #1's condition and she needed to leave because she was getting tired. DSA C agreed to come over and arrived shortly before 3:00 a.m. Prior to leaving, DSA B stated Client #1 appeared to be calmer but thought she was probably exhausted. She recalled Client #1 made some noises like he/she would have another BM. She told DSA C Client #1 was not doing well; not to leave her side and the PM was up to date on the client's condition. She stated due to the needs of Client #1, she was unable to complete bed checks or assist other clients in the home. She stated Client #5 required brief changes through the night due to incontinence and other clients required assistance to use the restroom so they were not incontinent. DSA B stated she felt a second staff person should have assigned to assist to meet the client's needs. She felt the concerns about the client's condition were appropriately communicated and even though she did not talk directly to the on-call nurse, nursing personnel should have come to the facility to complete an assessment. When interviewed on 3/26/18 at 4:15 p.m. DSA D stated he worked at 105 Kelly's Court on second shift until approximately 8:45 p.m. and then returned around 10:50 p.m. to work the third shift. When he arrived back at the facility at 10:50 p.m.	W 339		

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no clients were in the central area of the house. DSA D stated he walked back toward the bedrooms and saw DSA B assisting Client #1 as she had a bowel movement (BM). DSA D stated he brought more briefs and wipes into the bedroom. He observed Client #1 appeared to be in pain, moved around in bed and moaned and had continuous BMs, every one to two minutes. While the BMs were diarrhea consistency, DSA D stated she also had one large, firm BM. DSA D stated he left the room briefly to check if any clients were outside their bedrooms. When he returned to Client #1's bedroom, she had an "explosion" which he explained as extreme diarrhea and feces all over his/her body and bed. Client #1 required a bath and bedding change as well. After getting the client cleaned up, he contacted the on-call nurse (the LPN) and explained Client #1 was in pain, having continuous bowel movements and did not look normal. The LPN stated staff should give the client some water, tuck her in bed and she would check her in the morning. DSA D said he was upset by the LPN's response and wanted to know what more could be done. DSA D stated he felt the nurse should have come to the facility to assess Client #1 after he called and reported the changes in his/her condition. He got a cup of water and attempted to give Client #1 some water but she refused. DSA D stated this was unusual because Client #1 usually liked to eat and drink. DSA D decided to contact DSA A since she was a lead staff and she could possibly give him more information. DSA D stated he could not locate DSA A's phone number so used Snapchat to communicate with her. He told her Client #1 (used a shortened version of the client's name) was not feeling good and he was not

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happy with what the nurse told him. DSA A instructed him via Snapchat to contact the AOC. He stated he tried to call the number but no one answered. DSA D stated he was going to contact the Executive on-call (the PM) just as she walked into the facility. They walked back to Client #1's bedroom and the PM tried to calm the client by talking with her and rubbing her arms. The PM talked to DSA B about going to another facility to provide coverage. DSA D felt since DSA B provided the cares for Client #1, it would be better if he assisted with the coverage at another facility and left 105 Kelly's Court around 11:30 p.m.

When interviewed on 3/19/18 at 2:55 p.m. the DSS stated she was the Administrator on-call (AOC) on 1/22-23/18. At 11:25 p.m. she received a phone call from the DSA A. She was unsure why the staff person called because DSA A was not on the schedule. The DSS also did not know how the staff got the information but thought DSA D called her. DSA A stated DSA D was concerned about Client #1 and felt the client was not "right". The DSS stated she was aware the Executive on-call (the PM) was working at Kelly's Court and she contacted her by phone. She informed the PM about the information regarding Client #1 and staff's concerns. The PM responded she would check to see what was going on. The DSS stated she did not specifically tell the PM, DSA A had called. They also discussed the staffing situation as there were many call-ins due to bad weather conditions. She stated since the PM was already at the facility, she knew the PM would make the decision on how to use the staff resources. The

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DSS was to go in early the next morning to relieve the PM but overslept. She checked her phone and there were no other phone calls through the night. The DSS stated she received a phone call after 5:00 a.m. but thought it was related to her oversleeping. Upon arrival at Kelly's Court she went to House 101. She was talking to the Direct Support Manager (DSM) when a phone call came into the house. The DSM stated they needed to go to House 105 quickly and would probably need to do CPR. They ran to the house and into Client #1's bedroom where DSA C was on the bed giving Client #1 chest compressions. The DSM moved the client to the floor and gave Client #1 some breaths. The DSS stated she began to give chest compressions. There was no response from Client #1 but the client felt warm. She stated the paramedics arrived quickly. After their arrival the DSS thought they would have her immediately pull back but they wanted her to continue to do chest compressions while they placed the AEDS pads on. The DSS recalled they said something about the client's skin color and eyes being dilated. She was instructed to stop compressions because the client was "gone". She also recalled the comment was made Client #1 had been gone for a while. The DSS stated her priority became the other clients in the home and left the area to assist.

When interviewed on 3/19/18 at 4:55 p.m. the DSA A stated staff were trained to contact the on-call staff when there were problems. She experienced at times, nursing was called but did not always come in to do assessments. She stated Certified Medication Aides (CMAs) could do vitals and some staff might not have known

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how to follow the on-call policy. There was a vague description of when to contact the on-call nurse and they were recently trained on a new Change of Condition policy. DSA A stated staff should also try to contact the on-call person a second time if they did not answer because they might have been temporarily engaged. Staff should also follow the on-call chain (i.e.: on-call administrator, on-call executive) if they had continued concerns.

When interviewed on 3/20/18 at 10:10 a.m. DSA E stated she assisted Client #1 on 1/22/18 in the morning and with no identified issues. She attempted to give the client her morning medications but Client #1 continued to spit them out. DSA E said this was not unusual behavior for the client so DSA G assisted. DSA E said she helped the client with her bath until DSA G relieved her due other clients requiring assistance. Again, she stated, there was nothing unusual about the client's behavior. She observed Client #1 later in the day positioned on a mat, playing with toys. DSA E was aware of the client's bowel issues and in the past had either BMs or smears without assistance of medication. Prior to the client's death, she required enemas every third day without a BM. The client's BMs were formed even with the use of an enema which she thought was strange. Staff had also noticed a recent foul smell during toileting and a urine analysis was obtained. There was no infection noted but because the smell continued the doctor did prescribe medication. DSA E stated these were the only noted recent changes she recalled with Client #1.

When interviewed on 3/20/18 at 10:20 a.m. DSA

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G stated she worked with Client #1 during the day on 1/22/18 due to being home from school. The client appeared happy and normal. DSA G had noticed a cold sore on his/her lip but Client #1 ate and drank a regular breakfast and lunch. The client played on a mat and rolled around. She was aware the client experienced some changes in her BMs because they changed from having smears in her incontinence brief to having no BMs. DSA G stated an enema was administered every third day without a BM to try and resolve the constipation issue. She stated staff were trained to contact the on-call nursing first before calling 911 and was glad staff were being retrained to contact 911 immediately. She stated when a client's condition changed staff continued to advocate until there was resolution. She felt nurses needed to listen to staff's concerns since they knew the clients so well.

When interviewed on 3/20/18 at 9:05 a.m. the DSM stated she came into work between 5:30-6:00 a.m. on 1/23/18 to determine staffing needs. She was present in House 101 where the PM worked the overnight shift and the DSS was also present. Two staff were also in the facility due to spending the night because of extreme weather conditions. After 6:00 a.m. the DSM received a phone call from the LPN. She wanted someone to quickly go to House 105 because Client #1 was not breathing. The DSM told the DSS they were to go to House 105 and probably needed to do CPR. As they entered Client #1's bedroom the DSM observed DSA C administering chest compressions to the client. The staff quickly left the room and the DSM lifted Client #1 out of bed and onto the floor. The DSM checked to see if the client was breathing by listening and placing

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her face close to Client #1's mouth. When the DSS was positioned, she started chest compressions and when she stopped the compressions, the DSM administered breaths. She could not recall at what point she administered breaths but anytime the DSS stopped compressions she would do a breath. She stated the first couple of breaths seemed to be ineffective but during the third breath she heard a pop and the client gurgled. She felt after that, the breaths were more effective. The DSM stated at one point, she felt they were being successful with the resuscitation. Client #1's eyes were open but noted the client always slept with his/her eyes open and he/she felt warm. She thought they completed CPR for approximately six to ten minutes until the paramedics arrived. They continued CPR per the instructions of the paramedics until their equipment was set up. She backed off when instructed and AED pads were applied while DSS continued chest compressions. When the AED was hooked up, it read no movement and no shock. There was no CPR administered after that and the paramedics commented Client #1 had been gone a little while. She left the area and observed DSA C was quite distraught. The DSM physically assisted her out of the house as not to upset the other clients. She was aware a doctor came to the facility and the client's father also arrived.

When interviewed on 3/19/18 at 3:40 p.m. the PM stated she was the executive on-call on 1/22-23/18. Due to a snow storm she worked third shift to provide coverage at Kelly's Court. During a phone conversation with the AOC (the DSS) regarding staffing they also discussed

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concerns about Client #1's condition. She told the DSS she would check on the client as she made arrangements for staff coverage. Because staff failed to show for work at another facility, she asked DSA B (staff from second shift working in House 105) to stay in order to provide coverage. DSA B agreed to stay and also told the PM she did not want to go to another facility until someone had looked at Client #1 due to being ill. The PM was also aware someone had contacted the on-call nurse. She went to 105 Kelly's Court and took Client #1's axillary temperature (95.4) but no other vitals. The PM stated she knew the client had diarrhea but not been vomiting. Staff told her Client #1 diarrhea was continuous for 45-60 minutes and he/she was uncomfortable in his/her movements. The PM stated she called the LPN with the information regarding her observations. The LPN told her she instructed staff to give the Client #1 small sips of water and since the client was uncomfortable, Tylenol should be given. The PM stated she tried several times to administer the Tylenol but Client #1 refused most of it. At the time of her assessment, two staff (DSA B and DSA D) were in the facility. She stated, due to needing coverage elsewhere, DSA D agreed to transfer to another facility. DSA B agreed to remain at 105 Kelly's Court until between 4-5 a.m. when the DSS would be in. The PM stated she heard from DSA B sometime between 1:15 a.m.-1:45 a.m. concerned Client #1's buttock was red and rough due to diarrhea. She reassured the staff to stay with the client to monitor him/her. She did not have the impression there was anything life threatening about Client #1's condition. At approximately 2:50 a.m., the PM received a call from DSA B about wanting a

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replacement because she was having a hard time staying awake. She told the staff to contact the facility next door as there were two staff present and maybe one could replace her. Shortly after 3:00 a.m. due to assisting a client in the house she was working in, the PM missed a call from DSA C. She called her back and DSA C told her she talked to the on-call nurse and was told Client #1 might have the flu. She questioned if the client should be at the facility and needed to be seen. The PM then contacted the on-call nurse (the LPN) because staff remained concerned about Client #1's breathing, her toes were discolored and his/her stomach was hard. The LPN responded she talked to DSA C and was not told about Client #1's toes. The LPN gave no instructions for staff, only reassuring the PM she would be check Client #1 in the morning. After her phone call with the LPN, she became busy with the other clients in House 101 without following up with DSA C. She received a phone call from the DSS stating she overslept and would be in but no other communication from DSA C. At approximately 5:45 a.m., the DSM came to the facility and the PM let her know Client #1 was not feeling well. She assisted a client with a shower and after completion, heard from staff the DSM left the house quickly. The PM then observed the paramedic unit at the House 105. She went to House 105 and several clients were in the living area, obviously upset. She observed CPR being performed on Client #1 briefly before they stopped. She heard the paramedics say they could not resuscitate Client #1. The PM stated she tried to comfort staff and the clients in the house. She contacted the client's father who came to the facility immediately as well as the Medical Examiner.

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W 339	Continued From page 56 The PM stated, in retrospect, she should have checked back with DSA C and followed up with her. She felt staff was probably waiting to hear from her and provide direction. The PM also stated she should have insisted the nurse come in to complete an assessment as she only did the client's temperature and no other vitals. She could not recall questioning about the specifics of the client's diarrhea but was aware a change in the client's condition occurred. The PM stated the client bowel issues changed from having small bowel movements (smears) regularly in his/her incontinence brief to constipation and then loose stools. She felt at the time of the continuous diarrhea, she and nursing staff should have questioned this more. She stated as a supervisor, she should have listened more intently to staff's concerns. The PM stated, in addition, she should have asked for more support due to working in another house and involved with other responsibilities. When interviewed on 3/19/18 at 2:25 p.m. the LPN stated on 1/22/18 at approximately 11:30 p.m. she was contacted via phone by DSA A with DSA B also providing input. She was informed Client #1 had loose stools but was alert, responsive and not running an elevated temperature. The LPN stated staff described the loose stools as a "pretty good amount" and "blowout" but did not provide any other specifics. Staff also expressed concern the client's buttock was sore and she wanted them to continue to use the prescribed cream. She instructed the staff to give Client #1 sips of water, watch his/her temperature and let her know of any changes. The LPN stated she did not talk to DSA D but only DSA A. She stated the PM contacted her	W 339		

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W 339	Continued From page 57 after midnight about a PRN (as needed) medication for a client in another home. They discussed staff's concerns regarding Client #1, and she informed the PM about her instructions to staff. The PM stated she would contact the LPN if anything changed. The LPN stated she did not give permission to administer Client #1 Tylenol nor did the PM request a PRN medication. Also, she did not instruct the PM to check Client #1's medication book for the availability of PRNs but stated the PM would know to do this prior to requesting a PRN. The PM informed the nurse about Client #1's toes being discolored and thought the information came during the first phone call with the PM. The LPN stated the second phone call came around 3:00 a.m. from DSA C. Staff informed her Client #1 was having trouble breathing but no further incidents of diarrhea. The LPN stated she asked DSA C several questions about the client's breathing status and staff affirmed the client was congested. She instructed staff to move the client closer to the vaporizer for about 15-20 minutes and let her know if there were further problems. The LPN stated an additional discussion about Client #1 occurred during a 3:12 a.m. phone call with the PM. The LPN stated she informed the PM about what DSA C said to her in the previous phone call. DSA C called her again after 6:00 a.m. to report Client #1 was not breathing. The LPN asked the staff what she was doing and DSA C replied she was calling her. She instructed DSA C to start cardiopulmonary resuscitation (CPR) and call 911. The LPN stated she left her home shortly thereafter and met the ambulance with no lights on coming from the facility. The LPN stated she did not have direct communication with the	W 339		

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paramedics but talked to the Medical Examiner who came to the house. She heard that when the paramedics put the defibrillator on Client #1, it recommended no shock. The LPN stated Client #1's most prevalent issues were constipation and reddened buttock. She stated some clients in the agency experienced some Influenza A and strep throat recently as well as some illnesses with staff. She stated she saw Client #1 approximately a week before, as she sat at the dining room table and ate a brownie. The LPN stated with the information she was given regarding Client #1's condition, she did not feel she needed to complete an assessment but planned on checking Client #1 at the start of her shift on 1/23/18.

When interviewed on 6/14/18 at 4:00 p.m. the Associate State Medical Examiner stated she had concerns if Client #1 received her standard of care but could not say definitively.

Record review revealed the Incident Reporting Policy last updated on 1/1/15. According to the policy, health services staff should respond to an incident by evaluating the physical/mental condition of the individual and administer or secure medical attention when warranted.

Record review revealed an undated facility protocol document entitled "When to call the nurse "On-Call." According to the document, staff should contact the on-call nurse if a client had difficulty breathing or absence thereof requiring artificial respiration (direct care staff should implement rescue breathing and notify 911 initially.) If respirations were less than 6 per minute (inhalation and exhalation=one

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respiration) attempt to awaken/startle the individual and then notify the nurse. Anytime an individual was found unresponsive, showing no signs of life, direct care staff should call 911 immediately and begin CPR immediately.

When interviewed on 328/18 at 9:30 a.m. the Associate Director (AD) confirmed the nurse should have come to the facility to complete an assessment on Client #1 due to a change in his/her condition.

2. Record review on 3/21/18 revealed Client #1's Medication Administration Record (MAR). According to the MAR, Client #1 received Acetaminophen 7.5 milliliters at 12:10 a.m. per the PM/Certified Medication Aide (PM/CMA). The client's record failed to record the results of the PRN medication. In addition, the LPN failed to sign the approval of the medication.

The Medication Supports policy last updated on 1/1/15 documented only approved PRN (as needed) medications could be administered. PRN medications must be documented on the back of the client's medication sheet: exact time and date, medication given, the name and strength of medication, route of administration, date and time medication given, reason for giving medication-specific symptoms, results obtained from medication/client response, signature of person charting results, signature and title of person administering the PRN medication and name and title of person who gave permission for administration of the PRN medication. If person administering PRN medication would not be available when follow-up documentation would be required, a PRN medication sheet must be

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completed.

Further record review revealed the Documenting Health Supports Policy, last revised on 1/1/15. According to the policy, if a CMA gave a PRN medication, the nurse must be notified and the nurse must co-sign. The policy also documented a non-CMA could chart the PRN results in the MAR.

When interviewed on 3/26/18 at 10:55 a.m. the PM confirmed she failed to document the effectiveness of the PRN medication administration for Client in the client's record. She stated she should have checked back with staff on the Client #1's condition and documented in the client's record.

When interviewed on 3/28/18 at 10:30 a.m. the LPN stated she was unaware nurses should co-sign on PRN medication and would not know how to complete the process in their current computer program (Therap). She stated, at times, staff would document in their notes the nurse was contacted and approved the use of the PRN medication. The LPN stated nurses were currently keeping logs of contacts by staff and the use of PRN medication.

When interviewed on 3/27/18 at 1:35 p.m. the DSM stated nurses had the capability to co-sign PRN medications in the computer program (Therap). She also stated staff should document the results of PRN medication one hour after administration.

When interviewed on 3/27/18 at 1:25 p.m. the AD confirmed results of PRN medication

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W 339	Continued From page 61 administration should be documented in the client's record. She further confirmed there was capability for the nurse to co-sign PRN administration in the current computer program (Therap.)	W 339		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure Physician's Order (PO) was followed as written. This affected 1 of 1 client (Client #1) involved in investigation 73930-I. Finding follows: Record review on 3/20/18 revealed Client #1's PO dated 12/28/17. According to the order, the client should use a Continuous Positive Airway Pressure (CPAP) machine when sleeping at night. The PO dated 10/1/17 also included the order for the use of the CPAP. The Medication Administration Record did not include any documentation for the CPAP machine. When interviewed on 3/26/18 at 10:55 a.m. the Program Manager (PM) confirmed Client #1's CPAP had not been used since transfer to 105 Kelly's Court from another facility within the agency. She recalled staff attempted to use the machine with the client in the fall, 2017 but Client #1 would not tolerate wearing the mask. Staff tried various ways to increase Client #1's tolerance to the mask, including placing the mask	W 368		

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W 368	Continued From page 62 on the pillow of the client's bed. She recalled, at one time, the mask had several broken pieces and was given to the client's assigned nurse to complete the needed repairs. The PM stated after the nurse left employment no one followed-up on the use of the CPAP machine. Staff also failed to complete any documentation attempts to increase the client's tolerance to wearing the mask, when the mask was sent for repair, when the repairs were completed and if the client should continue to use the machine She stated staff probably felt the CPAP machine was discontinued because the client would not tolerate its use. When interviewed on 3/28/18 at 10:30 a.m. the Licensed Practical Nurse (LPN) stated she did not question staff about the use of Client #1's CPAP machine when they contacted her on 1/23/18 about his/her breathing difficulties. She stated she was aware the client refused to wear the mask at one time, broke the mask and the previous nurse pursued repairs to the CPAP. The LPN stated she was unaware there was a current PO for Client #1's use of the CPAP.	W 368		

8/9/18 OK 7/25/18

MOSAIC Forest City
105 Kelly's Court
Forest City, IA 50436
PLAN OF CORRECTION
Investigation #73930-I

Investigation Date: 3/7/18 – 6/27/18

W 102 483.410 GOVERNING BODY AND MANAGEMENT:

1. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency.
2. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
3. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency.
4. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.
5. Completion Date: 8/24/18

W 104 483.410(a)(1) GOVERNING BODY:

1. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency.
2. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
3. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency.
4. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.
5. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures.
6. The QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.
7. Completion Date: 8/24/18

W 158 483.430 FACILITY STAFFING:

1. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
2. The QIDPs will retrain staff in each home on the Cell Phone Policy.
3. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures.

4. The QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.
5. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency.
6. Any staff past due in CPR/1st Aid is removed from the schedule until the training is completed. This is tracked by the Staff Training Specialist and DSSs.
7. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.
8. Completion Date: 8/24/18

W 186 483.430(d)(1-2) DIRECT CARE STAFF:

1. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
2. The QIDPs will retrain staff in each home on the Cell Phone Policy.
3. The QIDPs will develop and implement a third shift floater schedule so the staff that is the floater knows their responsibilities and expectations.
4. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures.
5. The QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.
6. Completion Date: 8/24/18

W 189 483.430(e)(1) STAFF TRAINING PROGRAM:

1. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency.
2. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
3. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency.
4. Any staff past due in CPR/1st Aid is removed from the schedule until the training is completed. This is tracked weekly by the Staff Training Specialist and DSSs.
5. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.
6. Completion Date: 8/24/18

W 192 483.430(e)(2) STAFF TRAINING PROGRAM:

1. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
2. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures.
3. The QIDP will retrain staff in each home on the Cell Phone Policy (Electronic Devices).

4. The QIDP will retrain staff in each home on documentation requirements and expectations in regards to programming, daily intervention notes, shift documentation, GERs, and T-Logs.
5. The QIDP will monitor compliance with ISPs, health/medical procedures, and documentation through monthly programming review and observations to prevent recurrence of this deficiency.
6. Completion Date: 8/24/18

W 318 483.460 HEALTH CARE SERVICES:

1. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
2. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency.
3. The RN Manager will retrain the LPNs and CMAs on documenting the result of a PRN Medication (Medication Supports Policy). The RN Manager will review PRN result documentation a minimum of monthly, to prevent recurrence of this deficiency.
4. Completion Date: 8/24/18

W 339 483.460(c)(4) NURSING SERVICES:

1. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency.
2. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency.
3. The RN Manager will retrain the LPNs and CMAs on documenting the result of a PRN Medication (Medication Supports Policy). The RN Manager will review PRN result documentation a minimum of monthly, to prevent recurrence of this deficiency.
4. Completion Date: 8/24/18

W 368 483.460(k)(1) DRUG ADMINISTRATION:

1. The RN Manager and LPNs will review each person's Physicians order and MAR to ensure that everything is correct and will review the Physician's orders every 90 days to prevent recurrence of this deficiency.
2. The NORIA Program Services team complete quarterly file reviews to prevent recurrence of this deficiency.
3. The AD, QIDPs, and Nurses in FC complete monthly medical file reviews to prevent recurrence of this deficiency.
4. Completion Date: 8/24/18

Tasha Ludwig, AD 7/24/18

07
7/25/18

Citation
Mosaic in Northern Iowa
IA. Dept. of Inspections and Appeals
Health Facilities Division
Citation Number: 6829

Mosaic 105 Kelly's Court
Forest City, IA 50436

Survey Date: 3/7/18 – 6/27/18

Deficiency	Plan of Correction	Date of Completion
W 102 483.410 GOVERNING BODY AND MANAGEMENT	The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.	Upon Receipt

W 104 483.410(a)(1) GOVERNING BODY:	The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures by 8/24/18. The QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and	Upon Receipt

	observations to prevent recurrence of this deficiency.	
W 158 483.430 FACILITY STAFFING	All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The QIDPs will retrain staff in each home on the Cell Phone Policy by 8/24/18. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures by 8/24/18. The QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency. Any staff past due in CPR/1st Aid is removed from the schedule until the training is completed. This is tracked by the Staff Training Specialist and DSSs.	Upon Receipt

	All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.	
W 186 483.430(d)(1-2) DIRECT CARE STAFF	All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The QIDPs will retrain staff in each home on the Cell Phone Policy by 8/24/18. The QIDPs will develop and implement a third shift floater schedule so the staff that is the floater knows their responsibilities and expectations by 8/24/18. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures by 8/24/18. The QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.	Upon Receipt

W 189 483.430(e)(1) STAFF TRAINING PROGRAM	The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency. All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The Staff Training Specialist schedules monthly CPR/1st Aid training for new employees as well as current staff that are due, to prevent recurrence of this deficiency. Any staff past due in CPR/1st Aid is removed from the schedule until the training is completed. This is tracked weekly by the Staff Training Specialist and DSSs. All staff training and new staff onboarding is monitored and tracked weekly by the Staff Training Specialist to prevent recurrence of this deficiency.	Upon Receipt

W 192 483.430(e)(2) STAFF TRAINING PROGRAM	All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The QIDPs and Nurses will retrain staff in each home on each person's ISP and health/medical procedures by 8/24/18. The QIDP will retrain staff in each home on the Cell Phone Policy (Electronic Devices) by 8/24/18. The QIDP will retrain staff in each home on documentation requirements and expectations in regards to programming, daily intervention notes, shift documentation, GERs, and T-Logs by 8/24/18. The QIDP will monitor compliance with ISPs, health/medical procedures, and documentation through monthly programming review and observations to prevent recurrence of this deficiency.	Upon Receipt
W 318 483.460 HEALTH CARE SERVICES	All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment,	Upon Receipt

	to prevent recurrence of this deficiency. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency. The RN Manager will retrain the LPNs and CMAs on documenting the result of a PRN Medication (Medication Supports Policy). The RN Manager will review PRN result documentation a minimum of monthly, to prevent recurrence of this deficiency.	
W 339 483.460(c)(4) NURSING SERVICES	All staff have been trained on the Change of Condition Policy that was implemented 3/15/18. All staff will have this training a minimum of annually and within the first 30 days of their employment, to prevent recurrence of this deficiency. The Associate Director implemented a policy for Nursing "On-Call" Responsibilities. The nurses in Forest City have been trained on this policy and will be trained a minimum of annually by the RN Manager to prevent recurrence of this deficiency.	Upon Receipt

	The RN Manager will retrain the LPNs and CMAs on documenting the result of a PRN Medication (Medication Supports Policy) by 8/24/18. The RN Manager will review PRN result documentation a minimum of monthly, to prevent recurrence of this deficiency.	
W 368 483.460(k)(1) DRUG ADMINISTRATION	The NORIA Program Services team complete quarterly file reviews to prevent recurrence of this deficiency. The AD, QIDPs, and Nurses in FC complete monthly medical file reviews to prevent recurrence of this deficiency. The RN Manager and LPNs will review each person's Physicians order and MAR to ensure that everything is correct and will review the Physician's orders every 90 days to prevent recurrence of this deficiency by 8/24/18.	Upon Receipt

Mona Ludwig AD 7/24/18

Administrator/Designee Signature Title Date