STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G155	A. BUILDING _____ B. WING _____	12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-101 KELLY'S COURT	101 KELLY'S COURT FOREST CITY, IA 50436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of programs within 30 days of the Individual Service Plan (ISP). This affected 2 of 3 sample clients (Client #2 and Client #7). Findings follow: 1. Record review on 12/11/18 revealed Client #7's ISP dated 8/29/18. The document noted team agreement to the implementation of a program to throw/bounce a ball and a program to mop the floor. Further record review revealed Client #7's ISP Programs to play catch/bounce a ball with staff and to mop the floor. Both documents noted 10/11/18 as the creation date. 2. Record review on 12/12/18 revealed Client #2's ISP dated 8/22/18. Goals to be developed included pushing a switch to play music, washing face and grasping items. Review of the ISP Programs revealed the programs were created on 10/10/18 and 10/11/18. Further record review on 12/12/18 revealed the	W 249	W249 PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, all programs identified during the 30 day and/or annual individual service plan meetings will be written, trained, and implemented within 30 days of the planning meeting. This will be monitored by a quality audit. Responsible person: Program Manager	2/27/19

POC 2/27/19

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

Teresa TeKolste, Interim Associate Director

Digitally signed by Teresa TeKolste, Interim Associate Director
DN: cn=Teresa TeKolste, Interim Associate Director, o=Mosaic in Northern Iowa, ou=Mosaic, email=teresa.tekolste@mosaicinfo.org, c=US
Date: 2019.01.30 22:06:47 -06'00'

(X6) DATE

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

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W 249	Continued From page 1 facility Program Services and Supports policy. According to the policy, the Qualified Intellectual Disability Professional (QIDP) would have all programs written, staff trained and the programs implemented within 30 days of the ISP. When interviewed on 12/11/18 at 9:25 a.m., the QIDP stated she failed to develop programs for Client #7 and Client #2 within 30 days of their ISPs. When interviewed on 12/12/18 at 2:05 p.m., the Interim Associate/Executive Director confirmed the QIDP failed to follow the Program Services and Supports policy.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review the facility Human Rights Committee (HRC) failed to ensure written informed consent by the guardian. This affected 1 of 3 sample clients with restrictive measures (Client #3). Findings follow: Record review on 12/11/18 revealed Client #3's Informed Consent signed by the guardian on 11/17/17. The consent lacked documentation of Human Rights Committee review. Further record review on 12/12/18 revealed the facility Human Rights Committee Policy.	W 263	W 263 PROGRAM MONITORING & CHANGE The committee will insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Due process for a restriction of rights will be completed before implementation of the restriction. Specifically, both guardian and Human Rights Committee will review and consent to a restriction of rights before implementation. At a minimum verbal consent will be obtained by guardian and Human Rights Committee prior to implementing a restriction. All verbal consents will be followed with written consent. Guardian written consent will be reviewed by the Human Rights Committee. This will be monitored by quality audits and monthly Human Rights Committee meetings. Responsible person: Program Manager	2/27/19

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W 263	Continued From page 2 According to the policy, a function of the committee included ensuring written guardian consent for restrictive programs. When interviewed on 12/12/18 at 9:55 a.m., the Qualified Intellectual Disability Professional (QIDP) confirmed she failed to present the consent to the committee for review.	W 263		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure quarterly (every 90 days) fire drills were completed on each shift. This potentially affected all 7 clients living in the home at the time of the survey (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6 and Client #7). Findings follow: Record review on 12/10/18 of facility fire drills conducted between January 2018 and December 2018 revealed a first shift drill conducted on 4/25/18 and 11/28/18. The facility failed to complete a fire drill on the first shift during July, August, September or October 2018. Further record review revealed the facility conducted a third shift drill on 3/14/18 and 8/13/18. The facility failed to conduct a fire drill in April, May, June or July 2018. When interviewed on 12/10/18 at 3:45 p.m., the Qualified Intellectual Disability Professional	W 440	W 440 EVACUATION DRILLS The facility will hold evacuation drill at least quarterly for each shift of personnel. Specifically, a fire drill will be conducted monthly with a quarterly rotation per shift. Documentation of each drill will be completed and tracked by the Safety Committee which meets monthly. Responsible person: Direct Support Manager	2/27/19

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W 440	Continued From page 3 (QIDP) confirmed staff failed to complete quarterly fire drills on first and third shifts.	W 440		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, interviews and record review the facility failed to encourage clients to wash or sanitize their hands to enhance their health and wellness. This affected 2 of 3 sample clients (Client #3 and Client #7) and potentially affected all the clients in the home (Client #1, Client #2, Client #4, Client #5 and Client #6). Findings follow: 1. Observations on 12/10/18 revealed the following: 4:20 p.m., Client #3 ate trail mix at the table. Staff failed to wash or sanitize her hands before or after she ate. 4:40 p.m., Client #3 sat with her index finger in her nose. At 5:17 p.m., Direct Support Associate (DSA) B assisted her to serve food onto her plate. He failed to prompt her to wash her hands. 4:40 p.m. - 4:55 P.m. Client #7 helped with meal preparation tasks (placed pitchers on a cart, gathered dishes and pushed a cart) in the kitchen when prompted by staff. Staff failed to prompt him to wash his hands. At 5:10 p.m. Client #7 served food onto his plate and began to eat his	W 455	W455 INFECTION CONTROL There will be an active program for the prevention, control, and investigation of infection and communicable disease. Specifically, each client will have a personal active treatment schedule. The active treatment schedule will include hand washing at routine times. Additionally, the staff working at 101 Kelly's Court home will be re-trained on the Mosaic Health and Wellness policy. The active treatment schedule and frequent hand washing will be followed by direct support staff daily. Responsible person: Direct Support Supervisor	2/27/19

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W 455	Continued From page 4 meal. Bottles of hand sanitizer sat on the table. Staff failed to encourage clients to sanitize their hands. 2. Observation on 12/11/18 at 8:05 a.m. revealed Client #7 prepared pancakes in the microwave without washing his hands. At 8:15 a.m., the Qualified Intellectual Disability Professional (QIDP) sanitized her hands and assisted him to cut pancakes on his plate. She failed to encourage Client #7 to sanitize his hands. At 8:35 a.m., Client #7 sat on the floor in the living room and rubbed his fingers along an air vent. At 8:55 a.m., Client #7 poured cereal in a bowl and followed prompts from staff to get a spoon and milk. No staff encouraged him to wash or sanitize his hands. Client #7 ate bites of cereal and intermittently went to the living room and rubbed his hands on the floor and on the bottom of his feet. He returned to the table and ate more cereal. Staff failed to encourage him to sanitize his hands. 3. Observation on 12/11/18 at 8:20 a.m. revealed DSA C accompanied Client #3 to the table and assisted her to pour cereal and milk in a bowl. She failed to sanitize Client #3's hands. At 8:30 a.m. DSA D accompanied Client #3 to the kitchen to make toast. She failed to encourage her to wash her hands at the sink before making toast. When interviewed on 12/11/18 at 9:05 a.m., the QIDP said staff should encourage clients to wash or sanitize their hands to keep them well. When interviewed on 12/11/18 at 9:10 a.m., DSA D confirmed she failed to assist clients to wash or sanitize their hands prior to breakfast.	W 455		

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W 455	Continued From page 5 Record review on 12/12/18 revealed the facility Health and Wellness policy. According to the policy, "People who receive services will be encouraged as part of everyday services to practice good hygiene. This includes proper hand washing throughout the day, frequently throughout the day. Antibacterial gels may be use if handwashing is not possible". When interviewed on 12/12/18 at 2:00 p.m., the Nurse Manager confirmed staff should encourage clients to wash their hands throughout the day.	W 455		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	960155	A. BUILDING: _____ B. WING _____	12/12/2018

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C 209	01-50.9(4) Background Checks 481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks. 50.9(4) Validity of background check results. The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the facility. This REQUIREMENT is not met as evidenced by: Based on interview and personnel record review, the facility failed to comply with state regulations (Iowa Administrative Code 481-50.9(4) regarding pre-employment screenings. The facility failed to consistently obtain employee background checks within 30 days of hire for new employees. Findings follow: Record review on 12/10/18 revealed the facility completed a background check for Direct Support Associate (DSA) A on 2/22/18. The facility listed DSA A's hire date as 4/9/18. The date of hire occurred greater than 30 days after the background check. When interviewed on 12/11/18 at 2:45 p.m. the Human Relations Business Partner confirmed the facility failed to hire DSA A within 30 days of the background check.	C 209	W209 BACKGROUND CHECKS Criminal, dependent adult abuse, and child abuse record checks. Validity of background check results. The results of a background check conducted pursuant to this rule will be valid for a period of 30 calendar days from the date the results of the background check are received by the facility. Specifically, each employee hired will have an Iowa SiNG criminal and child /adult abuse check completed prior to hire. The date of the SING will not exceed 30 days prior to hire. This will be monitored by review of SING date prior to hire date by Human Resources Department. Responsible person: Human Resources Business Partner	2/1/19