

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

Citation Number: <b>6924</b>		Date: <b>February 27, 2019</b>		
Facility Name: <b>Mosaic 102 Kelly's Court</b>		Survey Dates: <b>February 5-7 2019</b>		
Facility Address/City/State/Zip  <b>105 Kelly's Court Forest City, IA 50436</b>		<b>MW</b>		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<b>64.60</b>	<p><b>481—64.60(135C) Federal regulations adopted—conditions of participation.</b> Regulations in 42 CFR Part 483, Subpart D, Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.</p> <p>Classification of violations is I, II, and III, determined by the division using the provisions in 481—Chapter 56, "Fining and Citations," to enforce a fine to cite a facility.</p> <p>This rule is intended to implement Iowa Code section 135C.2(3).</p>	<b>I</b>	<b>\$3000</b>	<b>UPON RECEIPT</b>
<b>W193</b>	<p><b>W193</b>-Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p><b>DESCRIPTION:</b></p> <p>Based on interviews and record review, the facility failed to ensure staff training regarding client behavior support programs (BSP), specifically providing an appropriate level of</p>			

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	<p>supervision for a client with a known history of elopement. This affected 1 of 1 client involved in the investigation of #80765-I (Client #1). Finding follows:</p> <p>Review of the facility investigation on 2/05/19 revealed Client #1 left his home at 102 Kelly's Court (KC) on the morning of 12/28/18 and went to a group home next door (105 Kelly's Court), a distance of approximately a half of a city block. The three staff at 102 KC were not aware Client #1 left the facility. A staff person at 105 KC noticed Client #1 outside near that home around 7:45 a.m. She had Client #1 come inside and she notified staff at 102 KC. Staff at 102 KC brought Client #1 back to that facility. Client #1 had no known injuries or adverse effects as the result of the elopement.</p> <p>According to the state climatologist, there was no record of the weather conditions in Forest City, Iowa around 7:45 a.m. on 12/28/18. The closest reading was in Mason City, Iowa, a distance of approximately 30 miles. The temperature in Mason City on 12/28/18 at 7:53 a.m. was 28 degrees Fahrenheit, with a wind chill factor of 8 degrees Fahrenheit. There was no precipitation at that time.</p> <p>Client #1 was 29 years old with a diagnoses</p>			
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	<p>including Moderate Intellectual Disability, Impulse Control Disorder, Major Depressive Disorder, Autistic Disorder, Attention Deficit/Hyperactivity Disorder, Seizure Disorder and Obesity. Client #1 was independently ambulatory and verbal, with function communication skills. According to Client #1's Individual Support Plan (ISP) dated 5/28/18, staff were with Client #1 in the community at all times to keep him safe. Client #1 did not know his personal information. Client #1 had a BSP with target behaviors of verbal aggression, physical aggression, property destruction and exiting the home (without notifying staff). According to the BSP, Client #1 had a history of leaving the home without telling staff and "A staff person should keep their eyes on the exit doors and know where (Client #1) is at all times." Client #1 had previously lived at 105 KC. He moved to 102 KC in October, 2018.</p> <p>When interviewed on 2/05/19 at 4:15 p.m. Direct Support Associate (DSA) A stated she worked at 105 KC on the morning of 12/28/18. At approximately 7:45 a.m. she noticed Client #1 walking around outside of the home. DSA A went out to talk with Client #1. Client #1 told DSA A that he had come over to talk to her about his video game system. He admitted the staff at 102 KC did not know that he had left. It was very cold outside and Client #1 shivered. He wore tennis</p>			
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	<p>shoes, a hooded sweatshirt and jeans. DSA A had Client #1 come inside 105 KC and she then called staff at 102 KC, who did not know Client #1 was gone. A staff person from 102 KC came over and to accompany Client #1 back to his home. DSA A said she did not see any injuries to Client #1.</p> <p>When interviewed on 2/05/19 at 4:50 p.m. DSA B stated she worked at 102 KC on the morning of 12/18/18. She arrived at work around 7:00 a.m. Her two co-workers were DSA C and DSA D, who she barely knew. All three staff were from the same temp agency. There were no facility staff there, other than the Certified Medication Aide (CMA), who was in and out of the home. DSA B said she had not worked much at 102 KC at that time and she had not been assigned to Client #1 prior to 12/28/18. DSA B said the three staff talked about client assignments. DSA B offered to be responsible for Client #2, not realizing this meant she was also be assigned to Client #1. She was aware that Client #1 had a history of trying to leave the house without staff knowledge, but said she didn't know a staff person was supposed to monitor/watch the main exit doors. DSA B said she had not been trained on Client #1's BSP. She said she had not been well trained at 102 KC and didn't know Client #1's assigned staff person wore a bracelet to signify their</p>			
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	<p>responsibility for Client #1. DSA B said she and Client #1 were in the main area of the home when DSA C and DSA D went to the bedroom wing to get their clients up for the day. A short time later, DSA B went to the bedroom wing to get Client #2 up and ready, leaving no staff in the main area of the home with Client #1. DSA B said she had no idea Client #1 left until the staff person from 105 KC called. DSA B estimated maybe 20 minutes had passed from when she last saw Client #1 in the main area of the home until the staff person from 105 KC called to say Client #1 was there. Since the incident, DSA B said she had been trained regarding Client #1's BSP and supervision level.</p> <p>When interviewed on 2/05/19 at 1:20 p.m. DSA C stated she worked at the Mosaic homes off and on a few times since approximately November 2018. DSA C was employed by a temp agency that provided staff to the facility. DSA C worked at 102 KC on morning of 12/28/18. Her two co-workers were DSA B and DSA D, who she didn't really know. It was her first time working with DSA D and she worked with DSA B one other time. DSA C worked at 102 KC previously and was familiar with Client #1. Usually a Mosaic staff was present and the Mosaic staff worked with Client #1, but that day the three staff were all from the temp agency. The med passer was Mosaic</p>			
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	<p>staff, but she wasn't there the entire time. DSA C had been told that Client #1 had a history of leaving the house without staff knowledge. She knew a staff person needed to be in the main area to monitor the exit doors. The staff person assigned to Client #1 should wear a bracelet. Client #1 was the only client in the house whose staff wore a bracelet. DSA B was assigned to Client #1 and his roommate, Client #2, on the morning of 12/28/18. DSA C didn't recall if DSA B wore the bracelet. DSA C got to the house shortly before 7:00 a.m. She saw Client #1 around 7:15 a.m. when she went back to get her clients up. Client #1 was in the dining area when she saw him, which was the main area of the house. DSA B was also in the dining area. DSA C and DSA D went to get their clients up. DSA B was also the staff for Client #1's roommate, Client #2, who was not up yet. Possibly DSA B went back to get Client #2 up and that's when Client #1 left, but DSA C didn't know for sure. Staff at 105 KC called later to say Client #1 was there. DSA C had no idea he was gone.</p> <p>When interviewed on 2/05/19 at 2: 45 p.m. DSA D stated she worked at the Mosaic homes off and on several times by the end of December. She was an employee of a temp agency that provided staff to the facility. DSA D worked at 102 KC on morning of 12/28/18, with DSA B and DSA C,</p>			
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	<p>who she didn't know. It was her first time working with either of them. DSA D said it might have been her second time working the morning shift at 102 KC. DSA D was somewhat familiar with Client #1, from when she worked overnights at the facility. DSA D got to the house shortly before 7:00 a.m. on 12/28/18. She saw Client #1 shortly after she first arrived. He was in the dining area or living room when she saw him, which was the main area of the house. DSA B was also in the main area. The three staff discussed the assignments and DSA D agreed to take Client #1 and Client #2. DSA D got the impression that DSA A had worked with those two clients before. DSA D had been told that Client #1 had a history of leaving the house without staff knowledge. She knew that a staff person needed to be in the main area to monitor the exit doors. The staff person assigned to Client #1 should wear a bracelet. DSA D did not recall that DSA B wore the bracelet. DSA B was in the main area with Client #1 when DSA C and DSA D went to the bedroom wing to get their clients up. DSA D estimated she last saw Client #1 in the main area of the house around 7:15 a.m. when she headed back to get her clients up. A staff person at 105 KC called later to say Client #1 was there. DSA D had no idea he was gone. Client #1 seemed fine when he returned to 102 KC, without any injuries.</p>			
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	<p>When interviewed on 2/05/19 at 3:40 p.m. the CMA confirmed she passed morning medications at 102 KC on 12/28/18. She said Client #1 tended to be an early riser and was usually up by 6:00 a.m. She was usually finished administering his morning medications by 7:15 a.m. On the morning of 12/28/18, the CMA had to go to another agency facility across town to pass medications, so she estimated she left 102 KC around 7:30 a.m. She did not recall if she saw Client #1 when she left. She returned to 102 KC later that morning and no one told her of Client #1's elopement to 105 KC. She first heard of it the next day when a temp agency staff (not one of the four staff involved in the incident) asked her if it had been reported. The CMA called the Program Manager (PM) to report it.</p> <p>When interviewed on 2/05/19 at 2:10 p.m. the PM stated she first learned of the incident late afternoon to early evening on 12/29/18, when she was notified by the CMA. The three staff at 102 KC at the time of the incident were all temp agency staff. A staff person should have been assigned to Client #1 and wearing a bracelet to signify that person was responsible for him. That staff person was also responsible to watch the doors. Client #1 had a history of leaving or attempting to leave without staff knowledge; it</p>			
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	<p>was part of his behavior program. All staff were retrained on Client #1's BSP after the incident. The facility also put stop signs on the exit doors and reviewed with Client #1 that he needed to stop and ask to go outside.</p> <p>When interviewed on 2/06/19 at 10:00 a.m. the PM stated she could not find documentation that DSA B had been trained on Client #1's BSP prior to the agency retraining in January 2019. She had a staff training sheet from November 2018, but DSA B's name was not on the training sheet. The PM confirmed DSA D's name was also not on the training sheet and she said there was no documentation DSA D had been trained on Client #1's BSP either.</p> <p>During a follow-up interview on 2/07/19 at 10:40 a.m., the PM said Client #1 had moved from 105 KC to 102 KC at the end of October, 2018. He had an elopement at 105 Kelly's Court on 10/19/18.</p> <p><b>FACILITY RESPONSE:</b></p>			
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