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 04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 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 000	INITIAL COMMENTS The investigation of #82354-I and #82355-I was completed 4/8/19-4/10/19. As a result of the investigation 82355-I, deficiencies were cited at W249 and Iowa Administrative Code Chapter 50.7(4) (See State Form). The investigation of 82354-I resulted in no deficiencies.	W 000	POC 5/13/19	
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 review, the facility failed to ensure staff consistently provided supports and services as identified in the individual program plan. Specifically, staff failed to provide supervision according to identified needs. This affected 1 of 1 client (Client #8) identified as a result of facility self-reported incident #82355-I. Findings follow: Record review on 4/8/19 revealed a facility	W 249	W249 PROGRAM IMPLEMENTATION 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. Specifically, staff at 105 Kellys Court will be retrained on the Bracelet Procedure, Professional Conduct/ Workplace Rules and Tobacco-free Environment Policy. The PM/QIDP will run Therap acknowledgment reports to ensure staff are trained on the ISPs and program plans. The implementation of policies, procedures and individual active treatment programs will be monitored by the Direct Support Supervisor completing weekly observation checklists. Person(s) Responsible: Direct Support Manager	5/13/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Schlake	AD Interim	5/29/2019

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 Incident Report, dated 4/1/19, documented on 3/28/19 at 5:40 p.m. staff saw Client #8 walking toward 101 Kelly's Court without a staff. Direct Support Associate A (DSA A) stayed with Client #8 until DSA B came out and walked Client #8 back to 105 Kelly's Court. When interviewed on 4/4/19 at 11:30 a.m. DSA B reported he held responsibility of Client #8 on 3/28/19. Around 5:30 p.m., DSA B went outside for a break. He thought he told someone he was going to take a break. DSA B stated he failed to wear a bracelet on 3/28/19 to indicate accountability of Client #8. DSA B stated he was outside for about ten minutes and during that time, Client #8 left the home. DSA B did not see Client #8 when he returned to the home. Someone called from another house to report Client #8 was outside and he went to get him. Client #8 was in front of the home with another staff. He returned without injury. DSA B confirmed he did not wear a bracelet to indicate accountability for Client #8 that day. DSA B confirmed he failed to provide the proper level of supervision for Client #8. Continued record review revealed Client #8's Baseline ISP Program approved on 3/15/19. The program noted Client #8 had a long history of wandering and directed staff to record the number of times Client #8 exited or attempted to exit the home. The program further directed: "...In order to keep Client #8 safe it is important that staff are monitoring Client #8 closely and know where he is..." Client #8's Comprehensive Functional Assessment dated 3/18/19-4/2/19 identified Client #8 "leaves without notifying others/elopes".	W 249		

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W 249	Continued From page 2 Additional record review revealed the Therap behavior support plan and individual support plan acknowledgement reports of staff training completed. The report indicated DSA B received training and acknowledged this on 3/25/19 at 10:34 p.m. Further record review revealed a Bracelet Supervision Procedure, last revised 8/14/18. According to the policy, 105 Kelly's Court would utilize colored bracelets or lanyards for people supported that exit the building unsupervised. Staff should wear a colored bracelet on their wrist or break away lanyard to indicate which individual he/she was assigned to during each shift. The procedure was to ensure the safety of each person supported that may exit the building unsupervised. The procedure further stated: "There will be times during the shift when you need to ask a co-worker to wear one of your individuals bracelets. Examples of this include but aren't limited to: Break, Assisting another individual with a behavioral issue or personal care, using the restroom. During these times you should verbally ask a co-worker to take your bracelet." When interviewed on 4/9/19 at 3 p.m. The Qualified Intellectual Disability Professional (QIDP) confirmed DSA B failed to follow the baseline program for supervision and failed to follow the facility procedure on supervision.	W 249		