STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G072	A. BUILDING _____ B. WING _____	05/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-319 COUNTRY CLUB DRIVE	319 COUNTRY CLUB DRIVE BELMOND, IA 50421

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardian written informed consent for all restrictions used, failed to ensure the Human Rights Committee (HRC) ensured guardian written informed consent was obtained, and failed to develop programming for the client to work toward the reduction and/or elimination of the restriction. This affected 1 of 3 sample clients (Client #5). Finding follows: Record review on 5/15/19 revealed Client #5's Active Medications, signed by the physician on 3/22/19. According to the orders, Client #5 was prescribed Nortriptyline HCL (the generic medication for Pamelor) 25 milligrams two times per day. The purpose of the medication was to treat mental/mood problems such as depression, relieve anxiety and tension, and increase energy levels. Continued record review revealed Client #5's Informed Consent Form. The Human Rights Committee (HRC) approved the consent initially on 4/19/18 for the use of Diazepam prior to dental appointments. On 6/14/18, the Qualified Intellectual Disability Professional (QIDP) e-mailed the HRC requesting approval for Client #5 to start receiving Pamelor due to concerns Client #5 had increased anxiety around cares and showers. The e-mail failed to include any	W 125	W125 Protection of Clients Rights Mosaic will ensure that rights of all clients. therefore, Mosaic will allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the rights to file complaints and the right to due process. Specifically, both guardian and Human Rights Committee will review and consent to the restrictions of the rights prior to implementation of a rights restriction. At a minimum verbal consent will be obtained by guardian and Human Rights Committee prior to implementing a restriction. All verbal consent will be followed with a written consent. Guardians written consent will be reviewed bu the Human Rights Committee in addition to interventions attempted, intended outcome and restoration plan. The QIDP, DSS and DSA will be trained on the policy Rights Protections and Promotions. This will be monitored by the Quality Assurance Manager Through monthly quality audits and monthly Human Rights Committee meetings. Person(s) Responsible: Program Manager and QIDP	7-31-2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Directo — 7/16/19

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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MOSAIC-319 COUNTRY CLUB DRIVE	319 COUNTRY CLUB DRIVE BELMOND, IA 50421

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W 125	Continued From page 1 additional information regarding previous interventions attempted, the intended outcome, side effects of the medication, a plan to reduce the use of the Pamelor, or a program to work with Client #5 to reduce the use of the medication. The HRC approved the use of the medication Pamelor by e-mail on 6/14/18 and 6/18/18. Client #5's guardian signed the Informed Consent Form for the use of Diazepam on 6/29/18 but the consent failed to include the use of Pamelor. The HRC failed to ensure guardian written informed consent was obtained. Additionally, the record lacked programming for Client #5 to work toward reducing the use of Pamelor. Review of facility policy "Behavior Support and Intervention Plans, last revised 3/20/17, instructed the agency prohibited the use of restrictive interventions, which included the use of behavior modifying medications, without prior informed consent. The policy instructed written informed consent would be obtained from the legal guardian and would include the specific issue/treatment/procedure, the attendant risks and benefits, alternative forms of treatment, and the right to refuse the treatment and the consequences of the refusal. The policy noted all medications used for behavior management were to be used only as an integral part of a behavior support plan designed to lead to a less restrictive way of managing the behaviors for which the medication was employed. The policy noted all behavior-modifying medications and their corresponding programs were to be reviewed and approved by the client, their legal guardian, and the HRC prior to use and/or implementation. When interviewed on 5/15/19 at 11:30 a.m., the Associate Director confirmed the HRC had not	W 125		

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W 125	Continued From page 2 ensured guardian written informed consent was obtained for medications used with Client #5. She confirmed the facility failed to develop a program for Client #5 to work toward reducing the use of the medication Pamelor. During a follow-up interview on 5/15/19 at 1:30 p.m., the AD stated she was unsure if Client #5's guardian was informed of the use of Pamelor or provided any information on the medication. She stated she assumed his guardian was aware because Client #5's guardian was very involved in his care and services.	W 125		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure policies regarding potential client abuse and/or mistreatment were followed. This affected #5 of #6 clients (Client #2, Client #3, Client #4, Client #5, and Client #6) who resided in the facility. Findings follow: 1. Record review on 5/14/19 revealed a T-Log, the facility electronic record communication system, dated 5/1/19 for Client #2. According to the T-Log, on 4/30/19 Client #2 began to engage in inappropriate behaviors, which included arguing with staff, throwing herself on the floor, pushing and kicking objects, dragging herself across the floor, and yelling and screaming. The T-Log noted the temporary staff who worked	W 149	W 149 Staff Treatment of Clients Mosaic will develop and implement written polices and procedures that prohibit mistreatment, neglect or abuse of the clients Specifically, Mosaic will ensure staff and temporary staff are trained and follow the following policies: Rights Protections and Promotion, Peer to Peer Aggression, Mandatory Reporting for Dependent Adults and Children, Documentation and Incident Reporting. The Program Manager and QIDP will monitor the both effectiveness and implementation of agency policies. Person(s) Responsible: Program Manager and Direct Support Supervisor	07-31-2019

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W 149	Continued From page 3 brought Client #2's shoes to her bedroom and Client #2 hit the staff on the arm. The temporary staff than began to "mirror or copy (Client #2's) behaviors while in her room and began to smack the walls and even moved (Client #2's) bed away from the wall (Client #2) then escalated more and smacked the (temporary staff) on the right arm and on right cheek and then pushed the (temporary staff). (Temporary staff) asked (Client #2) why don't you want me to hit your walls and move your bed if you can damage things in the living room? (Client #2) replied I don't want my stuff to break." The temporary staff then went into the dining room to assist another client; Client #2's behavior continued to escalate. Record review revealed Client #2 was 16 years old. Record review of facility policies on 5/14/19 revealed the policy "Mandatory Reporter: Abuse and/or Neglect of a Child", last revised 9/1/17. According to the policy, the agency prohibited abuse, neglect, exploitation, mistreatment, and degradation of individuals. The policy instructed all suspected abuse and/or neglect concerns were to be reported to the Iowa Department of Human Services within 24 hours of the incident and to the Iowa Department of Inspections and Appeals within 24 hours of the incident occurring or the next business day. The policy further instructed staff were to complete a General Events Report (GER), contact Health Services to evaluate the individual, and to notify the Associate Director. The policy noted the Agency was to initiate an investigation within 24 hours of the report on all reports and/or suspected concerns of abuse and/or neglect.	W 149		

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W 149	Continued From page 4 When interviewed on 5/14/19 at 1:00 p.m., the Qualified Intellectual Disability Professional (QIDP) stated the facility had several discussions regarding the incident. She stated they discussed the staff's actions could be considered degradation, as identified in the facility policy. She stated the temporary staff had not worked back at the facility since the incident. When interviewed on 5/14/19 at 1:15 p.m., the Associate Director (AD) stated the facility had a very long conversation about the incident. She said the facility had not completed a formal written inquiry into the incident but considered the T-Log as the written statement but confirmed the agency had not spoken to the temporary staff or Client #2 about the incident. She stated the facility decided the temporary staff was no longer able to work at the facility following the incident. She explained they had discussed the temporary staff's actions could be considered degradation. The AD confirmed the facility failed to report the incident to the Department of Human Services or the Department of Inspections and Appeals, failed to complete a formal inquiry into the incident, and failed to ensure the staff had completed a GER, per facility policy. 2. Record review on 5/14/19 of facility General Events Reports (GERs), dated 2/15/19 - 5/14/19, revealed the following: a. On 2/22/19, Client #3 after staff observed she had a thin scratch from her hip to her thigh. On 2/26/19, Licensed Practical Nurse (LPN) A noted she would assess the area when the weather permitted. The record lacked a completed nursing assessment of the injury.	W 149		

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W 149	Continued From page 5 b. On 4/2/19, Client #2 slammed her hand in a cupboard door during a behavioral incident. According to the GER, Client #2 scraped her left thumb and was assisted to wash the area with soap and a Band-Aid was applied. On 4/3/19, LPN A assessed Client #2's injury and noted there was an abrasion on the left thumb between the first and second knuckle with a small amount of serous drainage. The GER lacked a nursing assessment the day the injury occurred. c. On 3/16/19, Client #4 tipped her wheelchair over and staff noted Client #4 may have hit her head and noted she had a bruise on the middle of her forehead and two scratches on her right leg. LPN A noted on 3/18/19 Client #4 had a bruise above her nose on the low forehead which was purple with yellow around it and measured 1.5 inches by 0.25 inches. LPN A noted Client #4 stated it hurt when lightly touched. Nursing staff failed to complete an assessment on Client #4 until two days after the incident occurred. d. On 4/4/19 Client #6 was using a hot glue gun when he dropped some of the glue onto his pants and attempted to get it off. As a result, Client #6 burned his finger causing it to blister which popped. The GER lacked any documentation a nurse had assessed the injury. e. On 4/28/19, Client #3 had a scratch on her left hip. The GER lacked any documentation a nurse had assessed the injury. f. On 4/28/19, staff observed Client #5 had an abrasion to his abdomen. Staff documented triple antibiotic ointment was applied to the abrasion. The record lacked any documentation a nurse had assessed the injury.	W 149		

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W 149	Continued From page 6 g. On 5/1/19, Client #2 drug herself across the floor during a behavioral incident. Client #2 sustained a blister to her foot that popped open. On 5/2/19, Registered Nurse (RN) A noted she assessed the area to the top of the foot on 5/2/19. The GER lacked a nursing assessment of the area the day the injury occurred. h. On 5/7/19, staff documented Client #5 had scratches on his face after assisting him to get dressed. On 5/8/19, LPN A noted she would assess Client #5 on 5/8/19. The GER lacked a documented nursing assessment of the injury. Review of facility policies revealed "Incident Reporting", last revised 1/1/15. The policy instructed all incidents were to be documented in a GER. The policy noted a GER would be completed for "an incident that results in and/or may result in an injury and/or health concerns for an individual of known or unknown causes including scratches, bruises, and/or swollen and reddened areas..." and "...any incidents of behavior that result in or cause any risk of injury, and/or health and medical concerns to the individual and/or others." The policy instructed Health Services would be notified of any injury and/or health concern regarding a client. Health Services staff were to respond by evaluating the physical/mental condition of the client and to administer or secure medical attention when warranted. When interviewed on 5/20/19 at 10:00 a.m., the Associate Director confirmed nursing staff was to complete an assessment of the client immediately following each incident and/or injury and were to document their assessment findings.	W 149		

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W 149	Continued From page 7 She stated the nurse was to complete the assessment right away and were not to wait until the following day to assess the client, per the Incident Reporting policy.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of abuse, neglect, and/or mistreatment to the appropriate state agency in a timely manner. This affected 1 client added to the sample (Client #2). Finding follows: Record review on 5/14/19 revealed a T-Log, the facility electronic record communication system, dated 5/1/19 for Client #2. According to the T-Log, on 4/30/19 Client #2 began to engage in inappropriate behaviors, which included arguing with staff, throwing herself on the floor, pushing and kicking objects, dragging herself across the floor, and yelling and screaming. The T-Log noted the temporary staff who worked brought Client #2's shoes to her bedroom and Client #2 hit the staff on the arm. The temporary staff than began to "mirror or copy (Client #2's) behaviors while in her room and began to smack the walls and even moved (Client #2's) bed away from the wall (Client #2) then escalated more and smacked the (temporary staff) on the right arm and on right	W 153	W 153 Staff Treatment of Clients The facility must ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown source are reported immediately to the administrator or to officials accordance with state law. Specially, Mosaic will ensure staff are trained on Mandatory Reporter for Dependent Adults and Children, and the Abuse and Neglect Reporting procedures and Incident Reports. The Program Manger and QIDP will monitor documentation and incident reports on a daily basis. Person(s) Responsible: Program Manager and QIDP	7-9-2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G072	A. BUILDING _____ B. WING _____	05/20/2019

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W 153	Continued From page 8	W 153		

cheek and then pushed the (temporary staff). (Temporary staff) asked (Client #2) why don't you want me to hit your walls and move your bed if you can damage things in the living room? (Client #2) replied I don't want my stuff to break." The temporary staff then went into the dining room to assist another client; Client #2's behavior continued to escalate.

Record review revealed Client #2 was 16 years old.

Record review of facility policies on 5/14/19 revealed the policy "Mandatory Reporter: Abuse and/or Neglect of a Child", last revised 9/1/17. According to the policy, the agency prohibited abuse, neglect, exploitation, mistreatment, and degradation of individuals. The policy instructed all suspected abuse and/or neglect concerns were to be reported to the Iowa Department of Human Services within 24 hours of the incident and to the Iowa Department of Inspections and Appeals within 24 hours of the incident occurring or the next business day.

When interviewed on 5/14/19 at 1:00 p.m., the Qualified Intellectual Disability Professional (QIDP) stated the facility had several discussions regarding the incident. She stated they discussed the staff's actions could be considered degradation, as identified in the facility policy. She stated the temporary staff had not worked back at the facility since the incident.

When interviewed on 5/14/19 at 1:15 p.m., the Associate Director (AD) stated the facility had a very long conversation about the incident. The AD confirmed the facility failed to report the incident to the Department of Human Services or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 9 Department of Inspections and Appeals.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: 1. Record review on 5/14/19 revealed a T-Log, the facility electronic record communication system, dated 5/1/19 for Client #2. According to the T-Log, on 4/30/19 Client #2 began to engage in inappropriate behaviors, which included arguing with staff, throwing herself on the floor, pushing and kicking objects, dragging herself across the floor, and yelling and screaming. The T-Log noted the temporary staff who worked brought Client #2's shoes to her bedroom and Client #2 hit the staff on the arm. The temporary staff than began to "mirror or copy (Client #2's) behaviors while in her room and began to smack the walls and even moved (Client #2's) bed away from the wall (Client #2) then escalated more and smacked the (temporary staff) on the right arm and on right cheek and then pushed the (temporary staff). (Temporary staff) asked (Client #2) why don't you want me to hit your walls and move your bed if you can damage things in the living room? (Client #2) replied I don't want my stuff to break." The temporary staff then went into the dining room to assist another client; Client #2's behavior continued to escalate. Record review revealed Client #2 was 16 years old. Record review of facility policies on 5/14/19	W 154	W 154 Staff treatment of Clients The facility must ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown source are reported immediately to the administrator or to officials accordance with state law. Specially, Mosaic will ensure staff are trained on Mandatory Reporter for Dependent Adults and Children, and the Abuse and Neglect Reporting procedures and incident reports. The Program Manger and QIDP will monitor documentation and incident reports on a routine basis. Person(s) Responsible: Program Manager and QIDP	7-31-2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 154	Continued From page 10 revealed the policy "Mandatory Reporter: Abuse and/or Neglect of a Child", last revised 9/1/17. According to the policy, the Agency was to initiate an investigation within 24 hours of the report on all reports and/or suspected concerns of abuse and/or neglect. When interviewed on 5/14/19 at 1:00 p.m., the Qualified Intellectual Disability Professional (QIDP) stated the facility had several discussions regarding the incident. She stated they discussed the staff's actions could be considered degradation, as identified in the facility policy. She stated the temporary staff had not worked back at the facility since the incident. When interviewed on 5/14/19 at 1:15 p.m., the Associate Director (AD) stated the facility had a very long conversation about the incident. She said the facility had not completed a formal written inquiry into the incident but considered the T-Log as the written statement but confirmed the agency had not spoken to the temporary staff or Client #2 about the incident. She stated the facility decided the temporary staff was no longer able to work at the facility following the incident. She explained they had discussed the temporary staff's actions could be considered degradation. The AD confirmed the facility failed to complete a formal inquiry into the incident.	W 154		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W 227	W227 Individual Program Plan The individual program plan states the specific objectives necessary to meet the clients needs as identified by the comprehensive assessment required. Specifically, Mosaic will ensure that all individuals will be assessed the first 30 days	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 227	Continued From page 11 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure client programming objectives were based on needs identified from the Comprehensive Functional Assessment (CFA). This affected 1 of 3 sample clients (Client #6). Findings follow: Record review on 5/14/19 and 5/15/19 revealed Client #6's Individual Program Plans (IPPs) and CFA. The CFA, signed by the Qualified Intellectual Disability Professional on 1/23/19, instructed a skill was identified as a "strength" if the client was able to do the task with no assistance or reminders; "need" was to be identified if the client needed reminders or any other type of assistance to do the task. Review of Client #6's Individual Program Plans (IPPs) revealed the objectives were not consistently developed based on Client #6's assessed needs as follows: a. The program "Med Administration," created 12/26/18, noted the long-term objective was to teach and encourage Client #6 to do every step of his medication administration process independently. The current goal was for Client #6 to go to the medication room when it was time for his medications with one verbal prompt. According to Client #6's CFA, all areas of the medication administration skills was a strength. b. The program "Calming Techniques", created 12/26/18, noted the long-term objective was for Client #6 to learn and implement calming and coping skills to regulate his emotions and feelings in a health, productive manner. The goal being	W 227	continue from page 11 and annually thereafter. QIDP will be retrained on the Individual Lifestyle Plan Policy and reviewing of the assessment to ensure all objective correlate with the assessment based on the clients interest, needs and desires. The Individuals Lifestyle Plans will be audited the month following their admission (at least 30 days) and at the annual meeting to ensure all needs from the Comprehensive Functional Assessment are captured in the objectives by the monthly case file review that is monitored by the Quality Assurance Manager. Person(s) Responsible: Program Manager and QIDP	07-31-2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G072	A. BUILDING _____ B. WING _____	05/20/2019

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MOSAIC-319 COUNTRY CLUB DRIVE	319 COUNTRY CLUB DRIVE BELMOND, IA 50421

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W 227	Continued From page 12 worked on was for Client #6 to practice a calming technique with one or less verbal cues. According to his CFA, using coping skills to assist with mental health needs was identified as a strength. c. The program "Menu Planning," created on 12/26/18, identified the long-term objective was for Client #6 to use the basic food groups to plan a menu. The current goal was for Client #6 to create a menu using the basic food groups with three or less verbal cues. The CFA noted Client #6 was able to choose a balanced diet as a strength. d. The "BSP (Behavior Support Plan)," created 12/26/18, noted the long-term objective was for Client #6 to learn calming and coping skills to regulate his emotions and feelings; along with, learning desirable behavior to replace his undesirable behavior to meet his needs. Goals being worked on included for Client #6 to display ten or fewer episodes of property destruction (throwing/tearing, kicking walls, breaking thigns), ten or fewer episodes of using profanity, ten or fewer episodes of verbal threats to harm others, and five or fewer episodes of physical aggression (defined as choking, kicking, punching, slamming others against a wall). Client #6's CFA Maladaptive Behaviors section noted the only needs he had was for throwing objects at others, lies to others, and uses inappropriate language (swearing, demeaning, etc). The CFA noted all other areas of maladaptive behaviors, which included hitting others, kicking others, and threatening others were identified as "NA (not applicable)". The CFA lacked any information regarding the maladaptive behaviors of property destruction (throwing/tearing, kicking walls, breaking things), choking others, or slamming	W 227		

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W 227	Continued From page 13 others against a wall, all that were addressed within Client #6's BSP. e. The program "Groceries," created 12/26/18, had a long-term objective to live independently in the future. The goal Client #6 was working on was to add the cost of groceries when shown picture and the prices with two or less verbal cues. The program noted Client #6 was able to use a calculator to add the cost of the groceries. According to the arithmetic skills section of the CFA, all areas were noted as a strength, which included but was not limited to identifying numbers, counting over 100, performing simple and multiple digit addition and subtraction, and using a calculator. f. The program "Chores," created 12/26/18, had a long-term objective to live in his own place, and he needed to learn how to maintain his home and keep a clean environment. The goal Client #6 was working on was to complete five household tasks with two or less verbal prompts. The CFA identified all areas of the Home Living section, which included general cleaning skills, cooking/food preparation skills, kitchen cleaning skills, and laundry skills, were a strength except for ironing and mending clothing. When interviewed on 5/16/19 at 11:30 a.m., the Associate Director confirmed Client #6's programming objectives were not based on the needs identified within his CFA.	W 227		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan	W 252	W 252 Program Documentation Data relative to accomplishment of the criteria specified in clients individual program plan objectives will be documented in measurable terms.	

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	16G072	A. BUILDING _____ B. WING _____	05/20/2019

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W 252	Continued From page 14 objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff recorded data on client programs, as directed in the individual programs. This affected 3 of 3 sample clients (Client #1, #5, and #6). Findings follow: Record review on 5/14/19 - 5/15/19 revealed monthly program data reviews. The reports identified each client's formal programming, the total score toward each identified objective, and the total number of times program documentation was completed each month. The reports noted the following: 1. Client #1's monthly program data from January 2019 - April 2019 revealed the following programs and frequency of documentation: a. "Leisure: Reading" program was to be documented daily on second shift. Staff documented on the program 21 times in January, 13 times in February, three times in March, and six times in April. b. "Hygiene" program had four objectives to be documented on daily on the first shift. Objective for showering was documented nine times in January, seven times in February, three times in March and eleven times in April. Objective for tooth brushing was documented eleven times in January, nine times in February, eight times in March, and fourteen times in April. Objective for taking out the trash with soiled attends from her	W 252	Continue from page 14 Specifically, each client's individual support plan program will be incorporated into personal active treatment schedules that will be followed and programs documented in accordance to the program by direct support staff. This will be monitored by weekly programmatic reports from Therap. The QIDP will continue to do monthly QIDP notes for each client. DSS and DSSp will be retrained on how to audit program documentation. Person(s) Responsible: Program Manger and QIDP	07-31-2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G072	A. BUILDING _____ B. WING _____	05/20/2019

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W 252	Continued From page 15 bedroom was documented eleven times in January, three times in February, four times in March, and nine times in April. Objective for changing soiled sheets was documented nine times in January, three times in February, three times in March, and eight times in April. c. "Behavior Support Program" had four objectives to be documented on by all three shifts daily. All objectives were documented 58 times in January, 43 times in February, 33 times in March, and 44 times in April. d. "Learning Medications" had two objectives which were to be documented daily on first and second shift. Both objectives were documented on 26 times in January, 16 times in February, nine times in March, and 18 times in April. 2. Client #5's monthly program data from January 2019 - April 2019 revealed the following programs and frequency of documentation: a. "Learning Cause and Effect" was to be documented daily on first and second shift. Staff documented 22 times in January, 11 times in February, two times in March, and 14 times in April. b. "Sensory and Grasping" was to be documented daily on first and second shift. Staff documented 34 times in January, 25 times in February, eight times in March, and 21 times in April. c. "Teach Choice-Making" was to be documented daily on all three shifts. The program was documented 20 times in January, five times in February, three times in March, and 13 times in	W 252		

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W 252	Continued From page 16 April. d. "Sensory and Leisure" had five tasks to document daily on first and second shift. Task one was documented 30 times in January, 21 times in February, seven times in March, and 15 times in April. Task two was documented 32 times in January, 21 times in February, seven times in March, and 15 times in April. Task three was documented 28 times in January, 18 times in February, seven times in March, and 15 times in April. Task four was documented 26 times in January, 19 times in February, seven times in March, and 14 times in April. Task five was documented 23 times in January, 18 times in February, six times in March, and 14 times in April. 3. Client #6's monthly program data from January 2019 - April 2019 revealed the following programs and frequency of documentation: a. "Calming Techniques" was to be documented Monday, Wednesday, and Friday's on the second shift. The program was documented on one time in March and six times in April. b. "Behavior Support Plan" was to be documented daily on all three shifts. Staff documented 68 times in January, 52 times in February, 36 times in March, and 53 times in April. c. "Menu Planning" was to be documented Tuesday and Thursday's on the second shift. Staff failed to document the program in March and documented five times in April. d. "Groceries" was to be documented Monday,	W 252		

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	16G072	A. BUILDING _____ B. WING _____	05/20/2019

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W 252	Continued From page 17 Wednesday, and Friday's on the second shift. Staff completed documentation of the program five times in January, four times in February, none in March, and five times in April. e. "Chores" was to be documented on Monday, Wednesday, and Friday's on the second shift. The program lacked any documentation for March and was documented six times in April. f. "Exercise" was to be documented on Monday, Wednesday, and Friday on the second shift. Staff documented the program eight times in January, none in March, and four times in April. g. "Med Administration" was to be documented daily by first and second shift. Staff documented 25 times in January, 11 times in February, four times in March, and 15 times in April. When interviewed on 5/14/19 at 3:15 p.m., the Qualified Intellectual Disability Professional (QIDP) confirmed staff had not been documenting as instructed in each program. When interviewed on 5/15/19 at 1:10 p.m., the Associate Director stated documentation had been an issue and confirmed staff had not been documenting on client programs as instructed.	W 252		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by:	W 322	W322 Physician Services Mosaic must provide or obtain preventative and general medical care to all individuals. Specifically, nursing staff will utilize the Medical Tracker spreadsheet to ensure such screenings are being completed timely. Additionally, an annual health report will	

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	16G072	A. BUILDING _____ B. WING _____	05/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-319 COUNTRY CLUB DRIVE	319 COUNTRY CLUB DRIVE BELMOND, IA 50421

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W 322	Continued From page 18 Based on interview and record review, the facility failed to ensure all clients received general healthcare services as evidenced by failure to ensure annual physicals were completed. This affected 1 of 3 (Client #5) sample clients. Finding follows: Record review on 5/15/19 revealed Client #5's record lacked documentation of completion of an annual physical. Review of the facility policy "Health and Wellness," last revised 12/1/15, instructed physicals were to be completed annually. When interviewed on 5/15/19 at 11:30 a.m., the Associate Director confirmed the facility was unable to locate any documentation Client #5 had received a physical.	W 322	continued from page 18 be completed prior to a persons Individual Support planning meeting. The nursing staff are responsible for the screening tracking form. The completion of preventative screens and yearly health reports will be monitored by the Quality Assurance Manger through monthly quarterly audits. Person(s) Responsible: RN, Program Manager and QIDP	07-31-2019
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing assessments were completed following a client injury and/or incident, per facility policy. This affected 5 of 6 clients (Client #2, Client #3, Client #4, Client #5, and Client #6) who resided in the facility. Findings follow: Record review on 5/14/19 of facility General Events Reports (GERs), dated 2/15/19 - 5/14/19, revealed the following:	W 331	W331 Nursing Services Mosaic will provide clients with nursing services in accordance with their needs. Specifically, all nursing staff will be trained and follow Incident Reporting policy and procedures of Documenting Health Supports policy. This will be monitored by the QIDP and Program Manger through daily reviews of GER's Person(s) Responsible: Program Manager and QIDP	07-31-2019

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	16G072	A. BUILDING _____ B. WING _____	05/20/2019

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W 331	Continued From page 19 1. On 2/22/19, Client #3 after staff observed she had a thin scratch from her hip to her thigh. On 2/26/19, Licensed Practical Nurse (LPN) A noted she would assess the area when the weather permitted. The record lacked a completed nursing assessment of the injury. 2. On 4/2/19, Client #2 slammed her hand in a cupboard door during a behavioral incident. According to the GER, Client #2 scraped her left thumb and was assisted to wash the area with soap and a Band-Aid was applied. On 4/3/19, LPN A assessed Client #2's injury and noted there was an abrasion on the left thumb between the first and second knuckle with a small amount of serous drainage. The GER lacked a nursing assessment the day the injury occurred. 3. On 3/16/19, Client #4 tipped her wheelchair over and staff noted Client #4 may have hit her head and noted she had a bruise on the middle of her forehead and two scratches on her right leg. LPN A noted on 3/18/19 Client #4 had a bruise above her nose on the low forehead which was purple with yellow around it and measured 1.5 inches by 0.25 inches. LPN A noted Client #4 stated it hurt when lightly touched. Nursing staff failed to complete an assessment on Client #4 until two days after the incident occurred. 4. On 4/4/19 Client #6 was using a hot glue gun when he dropped some of the glue onto his pants and attempted to get it off. As a result, Client #6 burned his finger causing it to blister which popped. The GER lacked any documentation a nurse had assessed the injury. 5. On 4/28/19, Client #3 had a scratch on her left	W 331		

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W 331	Continued From page 20 hip. The GER lacked any documentation a nurse had assessed the injury. 6. On 4/28/19, staff observed Client #5 had an abrasion to his abdomen. Staff documented triple antibiotic ointment was applied to the abrasion. The record lacked any documentation a nurse had assessed the injury. 7. On 5/1/19, Client #2 drug herself across the floor during a behavioral incident. Client #2 sustained a blister to her foot that popped open. On 5/2/19, Registered Nurse (RN) A noted she assessed the area to the top of the foot on 5/2/19. The GER lacked a nursing assessment of the area the day the injury occurred. 8. On 5/7/19, staff documented Client #5 had scratches on his face after assisting him to get dressed. On 5/8/19, LPN A noted she would assess Client #5 on 5/8/19. The GER lacked a documented nursing assessment of the injury. Review of facility policies revealed "Incident Reporting", last revised 1/1/15. The policy instructed all incidents were to be documented in a GER. The policy noted a GER would be completed for "an incident that results in and/or may result in an injury and/or health concerns for an individual of known or unknown causes including scratches, bruises, and/or swollen and reddened areas ..." and " ...any incidents of behavior that result in or cause any risk of injury, and/or health and medical concerns to the individual and/or others." The policy instructed Health Services would be notified of any injury and/or health concern regarding a client. Health Services staff were to respond by evaluating the physical/mental condition of the client and to	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 21 administer or secure medical attention when warranted. When interviewed on 5/20/19 at 10:00 a.m., the Associate Director confirmed nursing staff was to complete an assessment of the client immediately following each incident and/or injury and were to document their assessment findings. She stated the nurse was to complete the assessment right away and were not to wait until the following day to assess the client, per the Incident Reporting policy.	W 331		