STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G016	A. BUILDING _____ B. WING _____	C 06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-102 KELLY'S COURT	102 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 A deficiency was cited at W249 as the result of the investigation of #83899-I. No deficiencies were cited as the result of the investigation of #83900-I.	W 000		
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 provided the appropriate level of supervision for a client with a known history of wandering/elopement and pica. This affected 1 of 1 clients identified in the investigation of #83899-I (Client #1). Finding follows: Interviews and record reviews on 6/17/19 and 6/18/19 revealed Client #1 left the fenced back yard of her facility on 6/14/19 at approximately 5:30 p.m. without staff knowledge. A staff person at a neighboring home saw Client #1 squatting by the sandbox located between her facility and the facility next door. The staff person returned Client #1 to her home and noticed the back yard gate was open. Staff estimated Client #1 had been gone about five minutes. There were no	W 249	W 249 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, the direct care associate needs to be trained on each specific individual that they provide supports to. At all ISP, the QIDP will go over all informed consents and restriction to ensure that the level of supervision is documented. The QIDP will ensure that all staff are trained on all informed consents and restrictions. Each client's ISP will be incorporated into a personal active treatment schedule. The active treatment schedule will be followed by Direct Support Associates daily. Policy 8050 -factor 8 Program Services and Supports will be trained to all employees that support Mosaic's person served. QIDP will train all of the staff on the level of supervision on this home. DSS (Direct Support Supervisor) or DSSp (Direct Support Specialist) will monitor the level of supervision and active treatment schedule in the weekly documentation audits and observations. Person responsible: Program Manager and QIDP	07-22-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 injuries or ill effects noted. Client #1 was 23 years old with a diagnosis including profound intellectual disability, autism, depression, anxiety disorder and pica (ingestion of non-edibles). Client #1 was independently ambulatory. She was non-verbal without functional communication skills. Client #1's Individual Support Plan (ISP) dated 5/12/19 noted she had a history of going outside without staff knowledge. Client #1 had an alarm on her bedroom door that sounded when she exited her bedroom. According to the ISP staff should "monitor all exit doors and her whereabouts at all times to ensure she does not leave the home without staff assistance." There were micro-switches on the walls near the exit doors that Client #1 could press to request to go outside. Client #1 had a program to notify staff (by pressing the switch) when she wanted to go outside. The program indicated a staff person should remain in the zone in the front of the home to monitor all exit doors to ensure Client #1 did not leave without staff supervision. The program also noted, "When (Client #1) goes into her back yard, monitor her closely so she does not exit the yard." When interviewed on 6/18/19 at 3:20 p.m. Direct Support Associate (DSA) E stated she worked at 101 Kelly's Court at the time of the incident on 6/14/19. She had returned from an outing with a client to the Kelly's Court area, which consisted of three ICF/ID facilities on a circle driveway. DSA E noticed a client squatting near the sand box and swing set area between 102 Kelly's Court and 105 Kelly's Court. As DSA E got closer she saw the person was Client #1. There were no other staff in sight. DSA E accompanied Client #1 back	W 249		

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W 249	Continued From page 2 to her home at 102 Kelly's Court. DSA E noted the gate to the fenced back yard was open. DSA E returned Client #1 to her home and notified the staff she had been outside. DSA E said Client #1 appeared uninjured and there was no sign she ingested sand or other non-edible items. DSA E notified on-call supervisors and the on-call nurse after returning Client #1 to 102 Kelly's Court. When interviewed on 6/17/19 at 3:20 p.m. DSA A stated she worked at 102 Kelly's Court on 6/14/18 at the time of the incident and she was assigned to Client #1, in addition to two other clients. DSA A stated after dinner and clean up, Client #1 and DSA B were sitting on a couch in the dining room. DSA A went to the adjacent living room to start a video movie for other clients. Within about five minutes, DSA B told DSA A that another staff person had returned Client #1 to the house after finding her outside. DSA A said she took Client #1 to the bathroom to change her incontinence brief and check her for injuries. DSA A saw no injuries or signs of any ill effects. DSA A said a staff person was supposed to stay in the central area of the home (dining room area) to monitor the main area and the exit doors. The front door and the exit door from the dining room to the patio and fenced-in yard didn't have alarms or chimes. The exit door in the bedroom wing was alarmed. DSA A said DSA B monitored the main area of the house from the dining room when DSA A went to the living room to start the movie. When interviewed on 6/18/19 at 11:30 a.m. DSA B stated she worked at the facility at the time of the incident. She said DSA A was assigned to Client #1. DSA B was a new staff at the agency. She worked at 105 Kelly's Court for 2-3 weeks and she covered at 102 Kelly's Court at the time	W 249		

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W 249	Continued From page 3 of the incident. After dinner, DSA B and Client #1 sat on the couch in the dining room. DSA B was monitoring her clients by watching the dining room area and the bedroom hallway. She said she didn't know a staff person was supposed to monitor the main area and the exit doors at all times, but from where she was positioned, she was doing that. DSA D went out the exit door from the dining room to the patio/yard. DSA D said nothing as she went out. DSA B assumed DSA D had gone outside to be with a client who was sitting in a swing on the patio. Client #1 got up from the couch and also went out the exit door, shortly after DSA D went outside. DSA B assumed DSA D would supervise Client #1 in the yard. Approximately 5-7 minutes later, or less, a staff person from another house brought Client #1 to 102 Kelly's Court and said she had been outside the yard and the gate was open. When interviewed on 6/18/19 at 2:45 p.m. DSA C said he worked at the facility at the time of the incident. He said he walked through the dining room area toward the living room when he saw DSA D go out the dining room/patio door. DSA C said he heard DSA D say something like she was stepping outside. DSA D did not say she was leaving or that she was taking a break. DSA C said staff typically went out the front door when they took a break. DSA C stated Client #1 immediately followed DSA D as she went out the door. DSA C assumed DSA D would be in the yard supervising Client #1. He said DSA B was sitting on the dining room couch near the door when DSA D and Client #1 went out the door. DSA C had worked at the facility about four months at the time of the incident. He said he was aware Client #1 needed to have staff with her when outside, due to her history of plica. DSA C	W 249		

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W 249	Continued From page 4 said he did not know Client #1 had a history of elopement/wandering. When interviewed on 6/18/19 at 10:30 a.m. DSA D stated she worked at the facility at the time of the incident. DSA D worked at the facility for about one year. After dinner, around 5:20 or 5:30 p.m.., DSA D said she left the house to go to 105 Kelly's Court to take a break. DSA D said DSA B was in the kitchen area and DSA D said she told DSA B that she was leaving. DSA D said she did not see Client #1 as she left and she felt sure Client #1 had not followed her out the door. DSA D said a staff person was supposed to stay in the main dining room area at all times to monitor the area and the exit doors. DSA B was in the kitchen area when DSA D left the house, so she assumed DSA B monitored the area. DSA D said she interacted briefly with the client on the patio swing and then she went out the gate to 105 Kelly's Court. She said she didn't see Client #1 in the yard. DSA D said she thought she shut the gate. When interviewed on 6/18/19 at 3:30 p.m., the Direct Support Supervisor said Client #1 would not have been able to open the gate on her own, so it must have been left open. When interviewed on 6/17/19 at 3:00 p.m. the Interim Associate Director (IAD) acknowledged a staff person had found Client #1 outside of her facility and yard, without staff supervision. The IAD stated according to Client #1's ISP, she required supervision when outside due to a history of pica and elopement. The IAD said since the incident, the facility had put locks on the fence gates, retrained staff and implemented a procedure for a staff person to be responsible for	W 249		

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W 249	Continued From page 5 monitoring the main area and exit doors of the home. Record review of the agency handbook revealed staff should provide effective services and supports for people served. According to the handbook, the agency supported clients 24 hours per day, seven days per week.	W 249		