DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 16G113 | A. BUILDING ______ B. WING ______ | C 11/06/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOSAIC-217 MAPLE AVENUE | 217 MAPLE AVENUE NEVADA, IA 50201 |

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| W 000 | INITIAL COMMENTS<br><br>The annual survey was conducted 11/4/19 - 11/6/19, in addition to investigation #87047-I.<br><br>Investigation #87047-I resulted in defciencies cited at W234 and W287.<br><br>No deficiencies were cited in regard to the annual recertification survey. | W 000 | POC 1/6/20 | |
| W 234 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(5)(i)<br><br>Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.<br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record reviews, the Qualified Intellectual Disability Professional failed to clarify supervision levels for a client with a known history of elopement. This affected 1 of 1 client identified in the investigation of #87047-I (Client #4). Findings follow:<br><br>Record review on 11/04/19 revealed a facility investigation regarding Client #4's elopement on 10/31/19 at approximately 12:00 p.m. Direct Support Associate (DSA) A and DSA B accompanied Client #4 and five other Maple Ave home clients to a Halloween lunch and party at the Mosaic office building in Nevada. While at the office building, Client #6 fell and injured himself, which caused DSA B to focus her attention on Client #6 as Client #4 left the area. A while later, DSA A and DSA B were assisting clients to get on the vans to go home. They noticed Client #4 was not in sight. DSA A went to search the office building as DSA B stayed with the clients on the | W 234 | W234 INDIVIDUAL PROGRAM PLAN<br>The facility will ensure the written training program is designed to implement the objectives in the individual program plan specific to the method to be used. Specifically, the QIDP will clarify the supervision needs of the client with a known history of elopement. Additionally, staff will be retrained on the supervision specific to community settings, as described in the client's ISP and PBSP. This will be monitored through monthly active treatment observations.<br><br>Person(s) Responsible:<br>Program Manager | 01/06/20 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 1/5/20

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 234 | Continued From page 1 | W 234 | | |

vans. A sheriff deputy arrived shortly after the two staff had noticed Client #4 was missing. The deputy informed the staff that Client #4 had been found in the parking lot behind the county courthouse, trying to open the doors of vehicles. It was estimated Client #4 was missing from staff sight for 10-15 minutes.

According to the state of Iowa Climatologist the temperature in the Nevada, Iowa area around noon on 10/31/19 was 38 degrees Fahrenheit, with a wind chill of 30 degrees. The skies were clear.

Additional record review on 11/04/19 revealed Client #4 was 32 years old with a diagnosis including severe intellectual disability, seizure disorder, osteoporosis and spina bifida. Client #4 is non-verbal without functional communication skills. He was independently ambulatory, but wore a Posey vest, which staff could hold as needed when Client #4 was unsteady. Client #4 had three falls in the past four months resulting in injuries. Client #4 had seizures, with a recent increase in the month of October. Client #4 had seven seizures in October, but six of those were during overnight hours when in bed, when the seizures typically occurred. Client #4 had a behavior support program (BSP) with various target behaviors including elopement and pica (ingestion of non-edibles). The incidence of pica in the past year was very low, with no significant incidents. The facility used a Wanderguard system at the Maple Ave home and Client #4 wore a Wanderguard bracelet on his ankle. The system sounded an alarm when Client #4 attempted to go out an exit door. The BSP noted Client #4 had a history of leaving the house without staff supervision. According to Client #4's

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| W 234 | Continued From page 2 annual Individual Support Plan (ISP) last updated 8/27/19, staff should check on Client #4 every 5-10 minutes. The ISP also noted Client #4 liked to go outside and "He likes to go for walks but needs staff assistance outside of the home." According to Client #4's Comprehensive Functional Assessment (CFA) dated 12/16/18, he did not use traffic lights, sidewalks and crosswalks without staff assistance. The CFA also indicated Client #4 could not ask for directions, indicate his name, phone number or address or carry and identification card.<br><br>When interviewed on 11/04/19 at 1:50 p.m. the House Manager said she was assisting with the lunch and party at the Mosaic office on 10/31/19. The two staff and six clients from the Maple Ave home attended, along with staff and clients from two other group homes. The House Manager recalled at one point when most of the Maple Ave clients were getting done eating lunch, DSA A came up to her and said he thought Client #4 was missing, but he had found the client in another room, coloring with staff from another group home. The House Manager said she reminded DSA A that staff needed to communicate with one another regarding client supervision. The House Manager remained in the kitchen and dining room area, assisting with the lunch. The House Manager said she received a call on her cell phone at 12:08 p.m. from the Program Manager, asking her to do a head count to see if any clients were missing. The Program Manager said the Mosaic office in Urbandale had received a call from the police/sheriff department in Nevada that a non-verbal male had been found in their parking lot. The House Manager said she began checking and was walking toward the front of the office building when she saw a law enforcement | W 234 | | |

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| W 234 | Continued From page 3<br>officer at the entry area of the building. A staff person confirmed to the officer the person found in the parking lot of the courthouse was a Mosaic client, and Client #4 returned to the Mosaic office in a sheriff's car. The House Manager said Client #4 was not injured. He was wearing a jacket and sweatpants. The House Manager stated neither Client #4's ISP or BSP addressed his level of supervision when he was not at the Maple Ave home. The Mosaic office didn't have alarms on the exit doors. The facility later determined Client #4 went out a back door of the office building that was never used. The House Manager said if staff took Client #4 on a community outing to a store, they would keep him in sight, but his supervision level at the office was not clear. The clients infrequently went to the office building for special events.<br><br>When interviewed on 11/04/19 at 3:15 p.m. DSA A stated he and DSA B accompanied the six Maple Ave clients to the Mosaic office building on 10/31/19 for a Halloween lunch and party. They arrived at approximately 11:00 a.m. and had lunch in the office building dining room. After lunch, DSA A was getting clients cleaned up and noticed Client #4 was not in the dining room. DSA A went to look for Client #4 and found him in another room, coloring with a staff person from another group home. DSA A walked Client #4 back toward the dining room, but they met up with DSA B and Client #6. Client #4 held onto DSA B's hand and the three of them walked back down the hall, away from the dining room. That was the last time DSA A saw Client #4 until the sheriff deputy brought him back. DSA A said he went back into the dining room and assisted the four other clients to clean up and get ready to go back home. DSA B came into the dining room | W 234 | | |

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with Client #6 and said he had fallen. Client #6 was bleeding from a laceration above his eye. The agency nurse and DSA B took Client #6 from the dining room to attend to him. DSA A assisted the four Maple Ave clients in the dining room to the lobby area to begin getting them on the vans to go home. DSA B began assisting clients onto the van she was driving. DSA A assisted a client to the van he was driving and then noticed he did not see Client #4. He asked DSA B if she knew Client #4's whereabouts and she said she thought he was in the dining room. DSA A went inside to check the office building. He said he checked every room, thinking Client #4 might be hiding, which he did sometimes. DSA A couldn't find Client #4 and returned to the front lobby of the building, which is when he saw that law enforcement had arrived. They returned Client #4, who was smiling. DSA A estimated 10-15 minutes had passed from when he had last seen Client #4 until the sheriff deputies returned him to the Mosaic office. DSA A said he was aware Client #4 had a history of elopement and had attempted to leave the house in the past when DSA A was working, but the alarm sounded and staff were right behind him. DSA A said he knew staff needed to be with Client #4 when he was outdoors, but he had not been told/trained regarding the level of supervision needed when at the Mosaic office building. DSA A said he was aware of the back door at the office building, but it was never used. DSA A stated he assumed it was a fire exit and was alarmed.

When interview on 11/05/19 at 9:00 a.m. DSA B stated she and DSA A accompanied the six Maple Ave clients to a Halloween lunch and party at the Mosaic office building on 10/31/19, arriving at approximately 11:00 a.m. After lunch, DSA B said

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| W 234 | Continued From page 5 she walked around the building with Client #4 and Client #6 and they checked out the party area, which also had coloring activities. This was after DSA A had brought Client #4 back to the dining room. A short while later, they headed back toward the dining room to get ready to go. As they were walking in a hallway back toward the dining room, Client #6 fell and was bleeding from a laceration above his eye. Client #4 kept walking ahead, in the direction of the dining room. This was the last time DSA A recalled seeing Client #4 until the sheriff deputies brought him back. DSA B attended to Client #6, who was injured. She assisted Client #6 to the dining room, where they sought additional medical attention from the agency nurse. DSA B said she was focused on Client #6 and didn't notice if Client #4 was in the dining room at that time. She and the nurse took Client #6 to the front lobby area. A short while later, she and DSA A began assisting the clients on the two vans to return to the Maple Ave home. DSA B had assisted three clients onto her van and she saw DSA A helping a client into his van. DSA A asked DSA B if she knew where Client #4 was. She said she thought he was in the dining room and DSA A went to look for him. Shortly after DSA A went inside to look for Client #4, a law enforcement officer arrived. The sheriff deputies returned Client #4 to the Mosaic office. DSA B estimated 10-15 minutes had passed from when she last saw Client #4 until the deputies brought him back. DSA B stated she had never been informed of Client #4's level of supervision when at the office building. She said she didn't know whether the exit doors at the office building had chimes/alarms on them. She didn't know of the back door in the office building. DSA B said staff kept Client #4 in sight when in the community, but she had not been told to keep | W 234 | | |

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him in sight at the agency office building. She noted Client #4 went to the office building every 2-3 months. DSA B said she knew Client #4 had a history of elopement and used a Wanderguard system at his house.

When interviewed on 11/05/19 at 10:00 a.m. a Story County Court Reported stated she was heading her to car in the back parking lot of the courthouse on 10/31/19 around noon, when she noticed a man trying to open the doors on a sheriff's van parked near her car. Within a minute, a deputy drove through the parking lot and the Court Reporter waved him over. They suspected the man was mentally disabled and unable to speak. She said Client #4 appeared to be cold and tried to get into her car and the deputy's car.

According to the Story County Sheriff's Office Event Report dated 10/31/19, the dispatcher received a call at 11:58 a.m. that a man was trying to get into vehicles behind the county jail. A deputy was on scene in less than one minute. According to the Event Report, the sheriff's office or deputy called Mosaic by 12:01 p.m. Client #4 got into a deputy car to warm up. The Event Report noted, "I'm out with Mosaic now" at 12:09 p.m. The last entry at 12:13 p.m. noted Client #4 had been returned to Mosaic with no further issue.

Observation on 11/05/19 revealed a parking lot behind the Story County Courthouse, which was approximately 200-220 feet from the back door of the Mosaic office building. A grassy area/lawn was between the office building and the parking lot. The back door didn't have any kind of alarm or chime when opened.

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| W 234 | Continued From page 7<br><br>When interviewed on 11/05/19 at 1:45 p.m. the Program Manager confirmed Client #4's supervision level when not at his home was not specified in the ISP or BSP. The Program Manage said DSA A and DSA B should have known they needed to closely supervise Client #4 while at the office building. The staff person who had been with Client #4 focused her attention on Client #6 after he fell and was injured. The Program Manager said the staff should have known to keep Client #4 in sight at the office building, but she was not aware of any training staff had prior to the elopement on 10/31/19 regarding level of supervision when not in the house. She said since the incident, staff were trained to keep Client #4 in sight when he was not in his house. Client #4's last elopement was 9/10/17, when he left the Maple Ave home without staff knowledge and was found by a neighbor walking down the street.<br><br>During a follow-up interview on 11/06/19 at 9:00 a.m. the Program Manager confirmed the 5-10 minute checks noted in Client #4's ISP were when Client #4 was in his home with the Wanderguard system. Staff should keep Client #4 in their line of sight when he was out of his home. | W 234 | | |
| W 287 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(3)<br><br>Techniques to manage inappropriate client behavior must never be used for the convenience of staff. | W 287 | W287 MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR<br>Please see next page. | |

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| W 287 | Continued From page 8<br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure staff provided adequate client supervision, without relying on an alarm system to provide for client safety. This affected 1 of 1 client identified in the investigation of #87047-I (Client #4). Findings follow:<br><br>Record review on 11/04/19 revealed a facility investigation regarding Client #4's elopement on 10/31/19 at approximately 12:00 p.m. Direct Support Associate (DSA) A and DSA B accompanied Client #4 and five other Maple Ave home clients to a Halloween lunch and party at the Mosaic office building in Nevada. While at the office building, Client #6 fell and injured himself, which caused DSA B to focus her attention on Client #6 as Client #4 left the area. A while later, DSA A and DSA B were assisting clients to get on the vans to go home. They noticed Client #4 was not in sight. DSA A went to search the office building as DSA B stayed with the clients on the vans. A sheriff deputy arrived shortly after the two staff had noticed Client #4 was missing. The deputy informed the staff that Client #4 had been found in the parking lot behind the county courthouse, trying to open the doors of vehicles. It was estimated Client #4 was missing from staff sight for 10-15 minutes.<br><br>Additional record review on 11/04/19 revealed the facility used a Wanderguard system at the Maple Ave home and Client #4 wore a Wanderguard bracelet on his ankle. The system sounded an alarm when Client #4 attempted to go out an exit door. The BSP noted Client #4 had a history of leaving the house without staff supervision. According to Client #4's annual Individual Support Plan (ISP) last updated 8/27/19, staff should | W 287 | W287 MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR<br>The facility will not use techniques to manage inappropriate client behavior for the convenience of staff. Specifically, the QIDP will be retrained on Mosaic's Positive Behavior Support Police and will ensure that plans and programming align with the policy. Additionally, the facility will ensure that staff implement the supervision guidelines as identified in client ISP and PBSP. This will be monitored through monthly active treatment observations.<br><br>Person(s) Responsible:<br>Program Manager | 01/31/20 |

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| W 287 | Continued From page 9<br>check on Client #4 every 5-10 minutes. The ISP also noted Client #4 liked to go outside and "He likes to go for walks but needs staff assistance outside of the home." According to Client #4's Comprehensive Functional Assessment (CFA) dated 12/16/18, he did not use traffic lights, sidewalks and crosswalks without staff assistance. The CFA also indicated Client #4 could not ask for directions, indicate his name, phone number or address or carry and identification card.<br><br>When interviewed on 11/04/19 at 1:50 p.m. the House Manager stated neither Client #4's ISP or BSP addressed his level of supervision when he was not at the Maple Ave home. The Mosaic office didn't have alarms on the exit doors. The facility later determined Client #4 went out a back door of the office building that was never used. The House Manager said if staff took Client #4 on a community outing to a store, they would keep him in sight, but his supervision level at the office was not clear. The clients infrequently went to the office building for special events.<br><br>When interviewed on 11/04/19 at 3:15 p.m. DSA A stated he was aware Client #4 had a history of elopement and had attempted to leave the house in the past when DSA A was working, but the alarm sounded and staff were right behind him. DSA A said he knew staff needed to be with Client #4 when he was outdoors, but he had not been told/trained regarding the level of supervision needed when at the Mosaic office building. DSA A said he was aware of the back door at the office building, but it was never used. DSA A stated he assumed it was a fire exit and was alarmed.<br><br>When interview on 11/05/19 at 9:00 a.m. DSA B | W 287 | | |

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| W 287 | Continued From page 10<br>stated she had never been informed of Client #4's level of supervision when at the office building. She said she didn't know whether the exit doors at the office building had chimes/alarms on them. She didn't know of the back door in the office building. DSA B said staff kept Client #4 in sight when in the community, but she had not been told to keep him in sight at the agency office building. She noted Client #4 went to the office building every 2-3 months. DSA B said she knew Client #4 had a history of elopement and used a Wanderguard system at his house.<br><br>When interviewed on 11/05/19 at 1:45 p.m. the Program Manager confirmed Client #4's supervision level when not at his home was not specified in the ISP or BSP. The Program Manage said DSA A and DSA B should have known they needed to closely supervise Client #4 while at the office building. The staff person who had been with Client #4 focused her attention on Client #6 after he fell and was injured. The Program Manager said the staff should have known to keep Client #4 in sight at the office building, but she was not aware of any training staff had prior to the elopement on 10/31/19 regarding level of supervision when not in the house. She said since the incident, staff were trained to keep Client #4 in sight when he was not in his house. Client #4's last elopement was 9/10/17, when he left the Maple Ave home without staff knowledge and was found by a neighbor walking down the street.<br><br>During a follow-up interview on 11/06/19 at 9:00 a.m. the Program Manager confirmed the 5-10 minute checks noted in Client #4's ISP were when Client #4 was in his home with the Wanderguard system. Staff should keep Client | W 287 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 16G113 | A. BUILDING ______<br>B. WING ______ | C<br>11/06/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOSAIC-217 MAPLE AVENUE | 217 MAPLE AVENUE<br>NEVADA, IA 50201 |

| (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 287 | Continued From page 11<br>#4 in their line of sight when he was out of his home. | W 287 | | |