STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G105	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1000 1ST STREET SE	1000 FIRST STREET SE CLARION, IA 50525

(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 annual health facilities survey was conducted 1/22/20 - 1/29/20. As a result, deficiencies were cited at W125, W153, W226, and W440.	W 000		
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 was obtained for all restrictive measures utilized. This affected 1 of 2 sample clients (Client #3). Finding follows: Record review on 1/27/20 revealed Client #3's Informed Consent Form, signed by his guardian on 4/3/19. The consent included the use of psychotropic medications (Melatonin and Risperidone), the use of Valium prior to dental appointments, the use of a physical hold or a restraint chair with a seatbelt and wrist tethers during dental appointments, door alarms on all exit doors of the facility, and the use of a gait belt when Client #3 left the facility. Continued record review revealed Client #3's Individual Support Plan (ISP) Program "Meds," last updated 1/5/20. The program noted Client #3 had a seizure disorder so it was necessary for him to swallow his medications, noting he may let the medication fall out of his mouth. The program	W 125	Protection of Client Rights Mosaic must ensure the rights of all clients. Therefore, Mosaic must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, Mosaic will ensure that all informed consents will coincide with the Positive Behavior Support Plans The QIDP will ensure that both the PBSP and informed consent reflect the same restrictions that the team has agreed upon before the informed consents are presented to the Human Rights committee for their approval. Responsible person(s): QIDP	02/29/2020

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.

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
	16G105	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1000 1ST STREET SE	1000 FIRST STREET SE CLARION, IA 50525

(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	Continued From page 1 instructed to try to administer Client #3's medications at different times throughout the allotted two-hour timeframe. The program continued to instruct if Client #3 had not taken his medication by the end of the allotted timeframe, staff were to hold Client #3's face to administer his medication. Staff were to document on a General Event Report (GER) if his face was held and document the amount of time the hold was used on a restraint sheet. The record lacked guardian written informed consent for holding Client #3's face to administer medication. Additional record review revealed Client #3's ISP Program "BSP", last updated 12/23/19. The BSP identified target behaviors of aggression and exits. The BSP instructed if Client #3 went outside at inappropriate time's staff were to use his gait belt and escort him back inside the facility. The BSP instructed staff to gently block Client #3 to protect themselves or others and continued to instruct staff were able to use Mandt techniques to redirect Client #3 or to escort him to another area. The record lacked guardian written informed consent for the use of Mandt techniques or escorting him to another area. The BSP also noted Client #3 was distracted by his I-Pad. The BSP instructed during meals and when using the bathroom, the I-Pad was to be removed from him, noting the I-Pad was able to be set near Client #3 but he was not to use it. The record lacked guardian written informed consent to remove the I-Pad during meals and when using the bathroom. Review of facility policies revealed "Promotion and Protection of Human Rights", last revised 9/1/17. The policy instructed "No rights of any	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G105	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1000 1ST STREET SE	1000 FIRST STREET SE CLARION, IA 50525

(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	Continued From page 2 person will be limited or restricted by Mosaic staff without due process and approval from the person receiving services, legal guardian and the Human Rights Committee (HRC) ... Informed Consent will be obtained prior to implementing any rights restriction." Additional policy review revealed "Behavior Support and Intervention Plans," last revised 3/20/17. The policy noted Mandt approved techniques could be used with approval prior to use. The policy instructed the use of restrictive or intrusive interventions were prohibited without prior informed consent. When interviewed on 1/28/20 at 11:40 a.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed Client #3's Informed Consent did not include all restrictive measures used with Client #3, which included holding Client #3's face for medication administration, the use of Mandt techniques and escorting, or the removal of his I-Pad during meals and when using the bathroom.	W 125		
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 ensure all allegations of client abuse	W 153	W153 Staff Treatment of Clients Allegations of Dependent Adults Abuse shall be reported and investigated pursuant to Iowa Code Chapter 235E and 481, Chapter 52. Mosaic's process when reporting Dependent Adult Abuse or any such incident is: Associate Director will report to Department of Inspections and Appeals with in 24 hours of the reported incident. If the AD is unable to get onto the DIA reporting site, they will call the Crisis Hotline and report, then they will follow up with self report when able to get onto Website Responsible person: Associate Director	02/14/2020

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
	16G105	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1000 1ST STREET SE	1000 FIRST STREET SE CLARION, IA 50525

(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 153	Continued From page 3 and/or mistreatment were reported to the Iowa Department of Inspections and Appeals (DIA), as required. This affected 1 of 5 discharged clients (Client #5). Finding follows: Record review on 1/23/20 revealed facility internal investigations. On 11/15/19, an investigation was initiated after Direct Support Associate (DSA) A reported DSA B held Client #5's bedroom door closed and blocked Client #5 from leaving his bedroom on 11/14/19. The internal investigation noted abuse was alleged and the alleged staff separated from contact with Client #5. The record lacked documentation the allegation was reported to the DIA. When interviewed on 1/23/20 at 1:00 p.m., the Qualified Intellectual Disabilities Professional (QIDP) stated the allegation was reported to DIA by e-mail because the Associate Director (AD) was locked out of the reporting website. She stated the website did not show any information regarding the facility self-reporting the allegation. During a follow-up interview on 1/28/20 at 10:35 a.m., the QIDP explained the AD was unable to locate the e-mail she sent to DIA reporting the allegation. She confirmed the record lacked documentation the allegation was reported to the DIA.	W 153		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.	W 226	Individual Program Plan Within 30 days after admission, the IDT must prepare, for each client and their plan. The QIDP will add the 30 day meeting on the Admission checklist. The QIDP will schedule a 30 day meeting prior to the 1st day of the admission/transfer of an individual. At that time the QIDP will go over plan with the IDT and they will identify needs and strengths and build programs from the individual needs. Responsible person(s): QIDP	02/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G105	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1000 1ST STREET SE	1000 FIRST STREET SE CLARION, IA 50525

(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 226	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to have an initial meeting to develop an Individual Support Plan (ISP) within 30-days of admission to the facility. This affected 1 of 2 sample clients (Client #3). Finding follows: Record review on 1/27/20 revealed Client #3 admitted to the facility on 7/29/19 from another agency facility. Continued record review revealed Client #3's Individual Support Plan (ISP), effective 4/1/19, noted the ISP meeting was held on 3/25/19, prior to Client #3 moving to the facility. The ISP was updated on 7/30/19 to reflect Client #3 moved to the facility on 7/29/19 from another agency facility. The record lacked documentation a 30-day meeting was conducted within 30-days of admit to the facility on 7/29/19. When interviewed on 1/28/20 at 11:40 a.m., the Qualified Intellectual Disabilities Professional (QIDP) explained she transferred and updated Client #3's ISP on 7/30/19 to reflect he moved but confirmed a 30-day ISP meeting was not held after Client #3 moved to the facility on 7/29/19.	W 226		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure quarterly (every 90 days) fire	W 440	Evacuation Drills the Facility must hold drills at least quarterly for each shift. Mosaic will schedule each shift quarterly Each shift will know when they are to run the evacuation drills by the schedule that is available to each employee that works in the homes. The schedule identifies what shift and time that the drill is to be ran. Responsible person(s) Scheduler, Direct Support Supervisor	02/29/2020

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
	16G105	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-1000 1ST STREET SE	1000 FIRST STREET SE CLARION, IA 50525

(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 440	Continued From page 5 drills were completed on all shifts. This potentially affected all clients (Client #1 - #4) who resided in the facility. Finding follows: Record review on 1/23/20 revealed facility fire drills conducted from January 2019 thru December 2019. The facility conducted second shift fire drills on 5/20/19, 8/6/19, and 11/7/19. The record lacked any second shift fire drills completed between January 2019 and April 2019. When interviewed on 1/23/19 at 10:10 a.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility failed to complete a second shift fire drill between January 2019 and April 2019. She stated the fire drill completed on 1/25/19 was scheduled to be run on second shift but stated the drill was run early, on first shift.	W 440		