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 01/22/2020

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 The annual health facilities survey was conducted 1/6/20 - 1/22/20. In addition to the survey, the investigation of #87902-I, #88128-C, #88146-C, and # 88156-I was completed. As a result of the annual health facilities survey, deficiencies were cited at W125, W159, W249, W252, W268, W289, and W440. Additionally, state code 64.18 (1) was also cited. As a result of the investigation of #87902-I, an Immediate Jeopardy was determined at W186 on 1/9/20 due to facility failure to ensure adequate staffing to effectively meet the needs of all clients. Additional deficiencies cited due to the investigation included W125, W249, and W375. A condition-level deficiency was cited at W158. As a result of the investigation of #88128-C, #88146-C, and #88156-I, no deficiencies were cited. ********** ********** 481-64.18(135C) Records. 64.18(1) Resident record. The licensee shall keep a permanent record about each resident, with all entries current, dated, and signed. (II) The record shall include: k. Physician's orders for medication and treatments in writing, which shall be signed by the physician quarterly, and diet orders, which shall be renewed yearly; (III) This RULE is not met as evidenced by:	W 000	3/1/20 PC 3/30/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Associate Director — (X6) DATE: 02-28-2020

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 000	Continued From page 1 Based on interview and record review, the facility failed to ensure 90-Day Physician Orders were obtained for all clients prior to the effective date. This affected 3 of 3 sample clients (Client #6, #7, and #8) and 1 client (Client #2) added to the sample. Finding follows: 1. Observation on 1/6/20 revealed Certified Medication Aide (CMA) A assisted Client #2 to take his noon medications. Additional observation on 1/7/20 revealed CMA A assisted Client #2 to take his morning medications. Record review on 1/8/20 revealed Client #2's 90-Day Physician Orders, with a valid date of 11/5/19 - 2/5/20. The physician signed the orders on 11/14/19, nine days after the valid date. Additional record review revealed Client #2's previous 90-Day Physician Orders, valid 8/5/19 - 11/5/19. The physician signed the orders on 8/10/19, five days after the orders were valid. 2. Record review on 1/8/20 revealed Client #6's 90-Day Physician Orders, with a valid date of 11/5/19 - 2/5/20. The physician signed the orders on 11/14/19, nine days after the valid date. Additional record review revealed Client #6's previous 90-Day Physician Orders, valid from 8/5/19 - 11/5/19. The physician signed the orders on 8/10/19, five days after the orders were valid. 3. Record review on 1/9/20 revealed Client #7's 90-Day Physician Orders, valid 11/5/19 - 2/5/19. The physician signed the orders on 1/9/20; 68 days after the orders were valid.	W 000	W000 Mosaic will provide person served with nursing services in accordance with their specific needs. Specifically, all nursing staff will be trained on when and how to obtain 90-day orders for each person served and ensure that the doctor signature is on the 90-day orders. All person served when admitted into Mosaic will be seen by a doctor within 30 days of admission to acquire a new primary doctor and to get the 90 day orders for that person served. Person(s) Responsible: Nursing staff	03-15-2020

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W 000	Continued From page 2 Additional record review revealed Client #7's previous 90-Day Physician orders, valid 8/5/19 - 11/5/19. The physician signed the orders on 8/6/19, one day after they were valid. When interviewed on 1/9/20 at 9:55 a.m., the Registered Nurse Manager explained the nurse who was responsible to obtain the orders had been off but stated she was confident the facility had them but she did not know where they were. The RNM confirmed the facility obtained Client #7's 90-Day Physician Orders for 11/5/19 - 2/5/20 on 1/9/20. 4. Observation on 1/6/20 revealed CMA A assisted Client #8 with taking her noon medications. Record review on 1/7/20 revealed Client #8 was admitted to the facility on 10/15/19. Continued record review revealed "Admission Physician Orders", signed by the physician on 11/18/19, more than 30-days after she was admitted to the facility. Additionally, the orders noted Client #8 was admitted to the facility on 10/24/19. When interviewed on 1/14/20 at 8:45 a.m., the Associate Director (AD) confirmed the 90-Day Physician Orders were signed by the physician after they were effective. She said the orders should have been obtained before they were effective.	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	W 125	W125 Protection of Clients Rights Mosaic will ensure the rights of all clients. Therefore, Mosaic will allow and encourage individuals to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints	

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W 125	Continued From page 3 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 the rights of all clients as evidenced by failure to ensure all restrictive interventions were incorporated into client programming and failure to ensure clients were assisted out of bed and to complete their morning routines in a timely manner. This affected 3 of 3 sample clients (Client #6, #7, and #8) and all clients who resided within the facility (Client #1, #2, #3, #4, and #5) . Findings follow: 2. Record review on 1/8/20 revealed Client #6's 90-Day Physician Orders, signed by his physician on 11/14/19. The orders instructed Client #6 was to receive 150 mg of Trazodone at 8:00 p.m. The order noted the medication was to be used to treat depression and to decrease anxiety and insomnia related to depression. Additional record review revealed no programming in place to assist Client #6 to work toward a reduction of the sleep medication. Review of facility policies revealed "Behavior Support and Intervention Plans", last revised 3/20/17. The policy instructed all restrictive interventions would be incorporated into a plan with the intent to lead to less restrictive way to manage the behavior. Additionally, the policy instructed all drugs used for managing behavior were to be incorporated into a behavior support plan.	W 125	and the right to due process. Specifically, both guardian and Human Rights Committee will review and consent to a restriction. At a minimum verbal consent will be obtained by guardian and Human \rights Committee prior to implementing a restriction. All verbal consents will be followed with a written consent. Guardians written consent will be reviewed by the Human Rights Committee. This will be monitored by the Quality Manager through quality audits and monthly Human Rights Committee meetings. QIDP will ensure that all rights restrictions are on the BSP and the Informed consents to be reviewed. Verification of informed consents for restrictive measures being utilized are also reviewed during monthly file reviews led by the Quality Manager. Person(s) Responsible: Support Service Specialist/DIDP Quality Assurance	03-15-2020

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W 125	Continued From page 4 Additional review revealed the policy "Mosaic Bill of Rights", effective 7/1/03. The policy instructed physical, mechanical, and chemical restraints would only be used as part of a plan agreed on by the team. When interviewed on 1/8/20 at 2:55 p.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed programming was not in place for the use of sleep medication for either Client #6 or Client #8. 3. Observation on 1/7/20 at 7:25 a.m. revealed Client #7 wore a Wanderguard band on his ankle. Record review on 1/7/20 revealed Client #7's BSP "Decrease Target Behaviors", last updated 11/3/19. The BSP addressed target behaviors of aggression, self-injurious behaviors (SIBs), and exiting. The BSP instructed for incidents of aggression and SIB, staff were to stay calm and quietly talk to Client #7, find activities to redirect Client #7 to, and ask Client #7 to show you what he needed, encouraging him to "lead the way." The BSP instructed staff to call the nurse and request a neurological check after incidents of Client #7 banging his head on a hard surface. The BSP included procedures for staff to follow to decrease elopement. The program instructed Client #7's assigned staff to wear a white bracelet and report Client #7, and give his bracelet, to another staff if unable to visually monitor Client #7. Staff were to monitor all exit doors and complete five minute checks on Client #7 when he was in his bedroom during waking hours. The BSP noted alarms were on the side door, which led to the parking lot and on the front door; the side door which led to the courtyard was to have	W 125		

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W 125	Continued From page 5 a switch for Client #7 to press to ask to go outside. The BSP failed to include the use of the Wanderguard System. When interviewed on 1/7/20 at 3:15 p.m., the QIDP confirmed the Wanderguard system was not identified in Client #7's BSP. 4. Record review on 1/6/20 revealed a General Events Report (GER), dated 1/4/20, after Client #6 eloped from the facility and went to the neighboring facility while one staff was in the kitchen preparing lunch and the other two staff were assisting other clients in their bedrooms. When interviewed on 1/6/20 at 3:15 p.m., Direct Support Specialist Professional/Certified Medication Aide (DSSP/CMA) A reported on 1/4/20 when first shift arrived to work, Client #8 started to exhibit inappropriate behaviors which included yelling, hitting the walls, and hitting toward staff. DSSP/CMA A said when Client #8 was having inappropriate behaviors all other clients were to be removed from the area Client #8 was in. DSSP/CMA A explained Client #8 was in the dining room when she was having inappropriate behaviors on 1/4/20 and all staff who worked were assisting but did not have to use any hands-on interventions with Client #8. DSSP/CMA A stated after Client #8 began to calm, at approximately 9:00 a.m., the staff were able to start assisting the other clients. DSSP/CMA A confirmed all the clients in the facility were late getting out of bed, having breakfast, and all morning medication was given late. DSSP/CMA A said she called Licensed Practical Nurse (LPN) A and obtained permission to give all morning medications since it was past	W 125		

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W 125	Continued From page 6 the allotted timeframe. When interviewed on 1/7/20 at 8:55 a.m., Direct Support Associate (DSA) F said on 1/4/20 Client #8 was in the dining room yelling and hitting the table when first shift arrived at 7:00 a.m. until approximately 9:00 a.m. She said once Client #8 calmed, staff started to assist the others clients to get up. DSA F explained when Client #8 exhibited inappropriate behaviors her program instructed to have all others moved away for safety. She said all three staff who worked were monitoring and assisting with Client #8 until approximately 9:00 a.m. when she began to calm. DSA F said because staff were assisting with Client #8, the other clients, Client #1 - #7, were not assisted to get up until late therefore all morning medications were given late and breakfast was served late. She reported client accountability had not been determined until later in the shift due to Client #8's behavior. When interviewed on 1/7/20 at 9:50 a.m., DSA H reported on 1/4/20 she arrived to work at approximately 9:00 a.m. She said Client #8 had been having behaviors so she immediately went and started to assist other clients to get up. DSA H confirmed the clients were still in bed when she arrived to work. DSA H explained staff had not assisted to get the other clients up because Client #8's program instructed to remove everyone away from Client #8 when she exhibited inappropriate behaviors to ensure the safety of everyone around. DSA H confirmed all morning medications and breakfast was late on 1/4/20 after everyone was assisted to get up late due to Client #8's behavior. When interviewed on 1/7/20 at 3:15 p.m. the	W 125		

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W 125	Continued From page 7 QIDP confirmed Client #8's PBSP instructed to remove all other clients from her vicinity during behavioral incidents and her staff was to monitor her from a distance until she calmed down. The QIDP stated she was not aware staff did not assist the other clients to get up on 1/4/20 resulting in all morning medications and breakfast being late. She stated staff should have assisted the other clients to get up while Client #8's staff monitored her. Additional record review revealed staff failed to document Client #8 had any behavioral incidents on 1/4/20, failed to document anything regarding the other clients getting up and having breakfast late, and failed to complete GERs for Client #1 - #8 after medications were given after the ordered time. Review of facility policies revealed the "Mosaic Bill of Rights", effective 7/1/03. The policy included clients had the right to considerate and respectful interactions and to be treated with honesty and dignity. When interviewed on 1/8/20 at 2:30 p.m., the Associate Director (AD) confirmed a GER should have been completed for all medications given late on 1/4/20. She stated Client #8's assigned staff should have monitored her while the other two staff assisted the other clients to get up, even if it was to do individual activities in their bedrooms until Client #8 calmed. She said staff should have documented Client #8's behavior on her program data. The AD explained staff would have normally completed a T-Log (part of the electronic record system) on Client #8's behavior because it affected all the other clients who resided in the facility. She stated staff should	W 125		

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W 125	Continued From page 8 have documented something regarding the incident.	W 125		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review the facility failed to maintain minimum compliance with the Condition of Participation (CoP) - Facility Staffing. The facility failed to ensure adequate staff to meet identified client needs, specifically supervision needs. Cross reference W186: Based on observation, interview, and record review, the facility failed to ensure adequate staffing and/or effective utilization of available staff to meet the identified needs of clients. Staff failed to consistently provide monitoring and supervision as instructed in client program plans. These findings resulted in a determination of Immediate Jeopardy on 1/9/20 at 12:02 p.m. due to failure to provide adequate staff and/or ineffective utilization of staff to ensure the health and safety of clients. The facility developed and implemented a removal plan, which included increased supervision and training of staff. The Immediate Jeopardy was removed on 1/14/20 at 8:45 a.m.	W 158	W158 Facility Staffing Mosaic will provide supervision and programming as needed. DSS (Direct Support Supervisor) will assist and demonstrate the programming and safety to the DSA's (Direct Support Associates)The supervisor's presences is intended to direct and role model implementation and decision making and ensure DSA's understand and are able to implement the plans. DSS will be doing periodic observations and feedback with the DSA's and document their findings. The completion and findings of the observations will be monitored by the Associate Director. The zoning protocol has been removed from programming. A strict no food policy has been implemented to prevent food being brought into the home. All solid foods will be stored in the locked pantry. DSA's will have the key to the pantry and offer the individuals snacks on a regular basis and will provide access whenever requested by the individuals. Drinks and snacks not considered a choking risk will still be readily avalaible to the people in the home. During meal and snack times, there will be an assigned DSA in the kitchen area. The wanderguard sensor will now be on the person instead of in a backpack. DSA's will do periodic checks to ensure the wanderguard is on person. The other Mosaic homes in the area will be alerted if/when this person is leaving their home to assist in supervision. Person(s) responsible: Direct Support Supervisor Support Services Specialist/QIDP	02-18-2020
W 159	QIDP CFR(s): 483.430(a)	W 159		

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W 159	Continued From page 9 Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Intellectual Disabilities Professional (QIDP) failed to effectively and consistently coordinate, integrate, and monitor client services and supports. This affected 3 of 3 sample clients (Client #6, #7, and #8). Findings follow: 1. Record review on 1/7/20 revealed Client #6's Individual Support Plan (ISP) programs. Review of the programs revealed the following: a. "Task Completion", last updated 11/30/19, instructed Client #6 was to complete a minimum of five tasks on first and second shift Monday, Wednesday, and Friday. The program instructed staff to offer Client #6 options of tasks to do, and noted he enjoyed helping with meal preparation and setting the table, and he should clean his bedroom daily. The program did not include any additional tasks to encourage Client #6 to complete. When interviewed on 1/8/20 at 1:30 p.m., the QIDP explained she knew what tasks Client #6 was completing when staff documented the tasks in the comments of the program data. The QIDP confirmed staff inconsistently documented tasks he was completing. b. "Food Groups", last updated 11/30/19, instructed Client #6 was to identify foods in the five food groups on first shift Tuesday, Wednesday, and Thursday's. The program instructed Client #6 would identify food in the basic food groups. If he needed assistance, he	W 159	W 159 QIDP Each clients active treatment program will be integrated, coordinated and monitored by a Qualified Intellectual Disability Professional. Specifically, a quality audit will be completed, following all 30 day and annual ISPs to ensure consultant recommendations are incorporated and active treatment schedules are updated. The Associate Director will be made aware if any plans are not updated within the 30 days of planning to determine a course of action. Within 30 days of a clients admission, there will be an ISP meeting held and an ISP and goals implemented. The QIDP will complete a CFA for all person served and will program for needs for each person. All adaptive equipment will be trained on and available for all individuals. There will be preferred tasks or items that person served likes to do so they are not bored or anxious. All staff will be trained in MANDT techniques and building relationships. Mosaic staff will be trained on behavior programming and routine observations will document staff implementing the plans and/or needed coaching. Training will continue on an annual basis and if need arise. Person(s) Responsible: Support Service Specialist/QIDP	03-15-2020

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W 159	Continued From page 10 could look at the picture of a food pyramid. When interviewed on 1/8/20 at 1:30 p.m., the QIDP explained she was not sure how Client #6 was to identify food groups, if it was by showing him a food item or if he was to verbally state a food and what food group it belonged to. She stated she knew there was a food pyramid hung in a cabinet in the kitchen. c. "Toothbrushing", last updated 11/30/19, instructed Client #6 was to brush his teeth daily after breakfast and supper. Staff were to document on first and second shift Monday through Friday if he brushed his teeth with two or less verbal cues. Criteria for completion was for Client #6 to complete 20 shifts for two consecutive months. Data reviews noted the percentage Client #6 was at and not the number of trials he completed. When interviewed on 1/8/20 at 1:30 p.m., the QIDP confirmed the goal was not consistent with data being collected. 2. Record review on 1/7/20 revealed Client #7's ISP was effective 4/8/19, prior to Client #7 moving to 102 Kelly's Court from another agency facility on 8/11/19. Additionally, the ISP noted Client #7 lived at 105 Kelly's Court. When interviewed on 1/7/20 at 3:15 p.m., the QIDP confirmed a 30-day meeting was not held after Client #7 moved to 102 Kelly's Court. She stated she was not aware she had to have a 30-day meeting since he had moved from another facility within the agency. The QIDP explained after Client #7 moved to 102	W 159		

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W 159	Continued From page 11 Kelly's Court she transferred the ISP he had in place but failed to update the information to reflect he lived at 102 Kelly's Court. 3. Record review on 1/7/20 revealed Client #7's Comprehensive Functional Assessment (CFA), reviewed 6/25/19, prior to Client #7 moving to 102 Kelly's Court from another agency facility. The QIDP failed to review Client #7's CFA within 30-days of his admit to 102 Kelly's Court. When interviewed on 1/7/20 at 3:15 p.m., the QIDP confirmed she did not review Client #7's CFA after his admit to 102 Kelly's Court from another agency facility. 4. Review on 1/7/20 of Client #7's ISP programs revealed the following: a. "Sits at table during meals", last updated 11/3/19, instructed staff were to offer Client #7 an alternative meal if he did not want what was offered. The program failed to include how staff were to determine he did not what was offered or when staff were to offer an alternative meal. When interviewed on 1/7/20 at 3:15 p.m., the QIDP explained staff were to offer an alternative meal after Client #7 refused the meal one time. The QIDP confirmed the program did not instruct when to offer an alternative meal. b. "Take Medications", last updated 11/3/19, instructed staff were to place Client #7's seizure medications in a food of his preference. If he refused to eat the food item, wait a few minutes and offer again. If Client #7 continued to refuse	W 159		

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W 159	Continued From page 12 the item, the program instructed staff to try again at a later time and noted Client #7 had an extended medication time. The program instructed the rest of Client #7's medications were to be crushed into a fine powder and added to a food item or mixed in a liquid. The program failed to include what the extended medication time was. When interviewed on 1/7/20 at 3:15 p.m., the QIDP said she was not sure what Client #7's extended medication time was. She explained Client #7's seizure medications were changed to a liquid form and therefore were to be mixed with liquids and not food items. The QIDP stated the entire program needed revised to reflect the changes with Client #7's medications. c. "Communicate Wants and Needs", last updated 11/3/19, instructed staff to present Client #7 with a communication board with things he might want or need at least one time per shift. When interviewed on 1/7/20 at 3:15 p.m., the QIDP explained staff should keep Client #7's picture board within his reach to use but confirmed the instruction was not included in the program. d. "Behavior Support Plan (BSP): Decrease Target Behaviors", last updated 11/3/19, identified target behaviors of aggression, self-injurious behaviors (SIBs), and exiting. The program noted Client #7 resided at 105 Kelly's Court and noted he had incidents of exiting the facility since he moved to 105 Kelly's Court. The program instructed staff to stay calm and quietly talk to Client #7 when he engaged in aggression or SIB, find activities to redirect him to, and ask Client #7	W 159		

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W 159	Continued From page 13 to show you what he wanted. The program noted his mother reported rubbing/massaging his head would sometimes help to calm him. The program instructed staff to wear an assigned bracelet for his accountability, turn over the bracelet and his supervision if unable to visually monitor him, and staff were to position to see all exit doors. The program noted the door which led to the courtyard had a switch to teach Client #7 to press it to communicate he wanted to go outside. The program failed to identify additional activities to attempt to engage Client #7 in, failed to provide instruction on what staff were to do if Client #7 continued to engage in aggression or SIB, and failed to provide any instruction on what to do if Client #7 eloped from the facility. When interviewed on 1/7/20 at 3:15 p.m., the QIDP confirmed the program did not include any type of activities for staff to attempt to engage Client #7 in. She explained staff were verbally instructed to block Client #7 when he engaged in SIB by using a pillow or their hand but confirmed blocking was not included within his program. She confirmed there was no direction for what staff were to do if Client #7 had eloped. The QIDP said the entire program needed more detail. She said all of Client #7's programs needed updated but she had not gotten to them yet. 5. Record review on 1/7/20 revealed Client #8's ISP, approved on 1/6/20. The ISP noted Client #8 had moved to the facility on 10/15/19 and her 30-day meeting was conducted on 11/12/19. The QIDP failed to implement the ISP or corresponding programs until 1/5/20 and 1/6/20. When interviewed on 1/7/20 at 3:15 p.m., the	W 159		

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W 159	Continued From page 14 QIDP confirmed Client #8's meeting was held on 11/12/19 but she had not implemented Client #8's ISP or programs until 1/5/20 and 1/6/20. She stated she had not completed them sooner because she was behind. 6. Record review on 1/7/20 of Client #8's ISP programs revealed the following: a. "Cooking", approved 1/5/20, instructed Client #8 was to assist with preparing one side course of the meal. Review of Client #8's CFA noted preparing a side dish was a strength of Client #8's. When interviewed on 1/8/20 at 2:55 p.m., the QIDP explained she developed Client #8's Cooking Program because Client #8 wanted to cook more. The QIDP acknowledged preparing a side dish was identified as a strength in Client #8's CFA. The QIDP said Client #8 was scared to use the stove so they started a program to help her become more comfortable in the kitchen. The QIDP stated she should have developed the program around Client #8 assisting to make the main entrée, which was an identified need. b. "Take Medication", approved on 1/5/20, instructed Client #8 would request her medication at the appropriate times. The program noted Client #8 would have a watch with a timer set for her identified medication times. When interviewed on 1/7/20 at 3:15 p.m., the QIDP confirmed Client #8 did not have a watch to use with the program. She said they had looked for watches but the watches either did not have all the options needed or were children's watches.	W 159		

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W 159	Continued From page 15 She said they plan to stop tomorrow after an appointment to see if they could find a watch to use for the program.	W 159		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate staffing and/or effective utilization of available staff to meet the identified needs of clients. Staff failed to consistently provide monitoring and supervision as instructed in client program plans. This affected 2 of 3 sample clients (Client #6 and #7) and 1 client (Client #5) added to the sample during the investigation of #87902-I. Findings follow: Record review on 1/6/20 revealed a General Events Report (GER), completed 1/4/20, after Client #6 eloped from the facility and went to a neighboring facility. The facility self-reported the incident to the Iowa Department of Inspections and Appeals and initiated an internal investigation into the incident. According to Weather Underground, the weather on 1/4/20 at approximately 10:53 a.m. was cloudy and 25 degrees Fahrenheit with five mile winds	W 186	Mosaic will provide supervision and programming as needed. DSS (Direct Support Supervisor) will assist and demonstrate the programming and safety to the DSA's (Direct Support Associates)The supervisor's presences is intended to direct and role model implementation and decision making and ensure DSA's understand and are able to implement the plans. DSS will be doing periodic observations and feedback with the DSA's and document their findings. The completion and findings of the observations will be monitored by the Associate Director. The zoning protocol has been removed from programming. A strict no food policy has been implemented to prevent food being brought into the home. All solid foods will be stored in the locked pantry. DSA's will have the key to the pantry and offer the individuals snacks on a regular basis and will provide access whenever requested by the individuals. Drinks and snacks not considered a choking risk will still be readily available to the people in the home. During meal and snack times, there will be an assigned DSA in the kitchen area. The wanderguard sensor will now be on the person instead of in a backpack. DSA's will do periodic checks to ensure the wanderguard is on person. The other Mosaic homes in the area will be alerted if/when this person is leaving their home to assist in supervision. Person Responsible: Direct Support Supervisor Support Services Specialist/QIDP	02-18-2020

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W 186	Continued From page 16 and no precipitation. Observation on 1/6/20 of the facility revealed the facility was the first of three agency facilities located on a one-way horseshoe drive, followed by 105 Kelly's Court and then 101 Kelly's Court. The main entrance of the facility entered into a foyer with double doors leading into the dining room. To the right was a hallway with client bedrooms, bathrooms, and an exit door at the end of the hallway. The living room was located off the dining room, adjacent to the main entrance, and the kitchen was located off the back left side of the dining room. A peninsula counter separated the kitchen and dining room, with a doorway at the end of the peninsula counter and a wall on the other side of the doorway. The hallway exit door was unable to be seen from the kitchen; the main entrance and an exit door on the left side of the dining room could be visualized when looking into the dining room from the kitchen. Observation on 1/6/20 revealed the Direct Support Manager (DSM) met individually with each staff who work first and second shift and re-trained Client #6's Positive Behavior Support Plan (PBSP). This included Certified Medication Aide (CMA) A, Direct Support Specialist Professional/Certified Medication Aide (DSSP/CMA) A, Direct Support Associate (DSA) A, DSA B, DSA C, DSA D, DSA E, and DSA F. On 1/7/19, the DSM trained staff who did not work on 1/6/20, which included DSA G and DSA H. Record review on 1/7/20 revealed Client #6's "PBSP: Relationships with Others", approved on 11/11/19. The program addressed target behaviors of verbal aggression, physical	W 186		

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W 186	Continued From page 17 aggression, property destruction, and exiting the home. Restrictive measures included the use of behavior modifying medications, supervised phone calls and visits with family, a locked bicycle, the use of the wanderguard in the lining of his backpack, and the use of walkie-talkies when unattended outside. The PBSP instructed staff to encourage Client #6 to focus on the positive aspects of his day, to use a picture board choose calming activities, provide Client #6 with structure, encourage participation in activities, exercise, and household tasks; and redirect potential trigger topics of conversations. The PBSP instructed staff were to follow the bracelet procedure with Client #6. When Client #6 began to exhibit precursor behaviors, staff were to redirect him, remind him to make good/safe choices, use his picture board to choose a calming activity. When Client #6 exhibited aggression and/or property destruction staff were to verbally redirect him and give him space and time without having any demands or requests. If Client #6 continued and was unable to stop, staff were to call 911 for assistance. During a crisis state, staff were to ensure the safety of Client #6 and all others by using the least amount of interaction necessary for safety. The program instructed staff to ensure proper supervision and to call 911 if unable to provide proper supervision. The PBSP noted Client #6 was able to visit 101 and 105 Kelly's court for short time frames; staff were to get approval from the other facility and then go with him. The PBSP noted Client #6 could go outside, including to calm down, when he requested a walkie-talkie from staff. Client #6 was to respond to staff, with his walkie-talkie, to let staff know his whereabouts and he was to stay in the circle drive of Kelly's Court.	W 186		

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W 186	Continued From page 18 In conjunction with the PBSP, was a Walkie-Talkie Procedure, undated. The procedure instructed Client #6's was to seek out his staff, identified by a bracelet, to request a walkie-talkie to go outside. Client #6 had been trained to respond to staff with his whearabouts while outside and trained to stayed in the circle drive of Kelly's Court. Client #6's staff was to check-in with him every couple of minutes to ask his whereabouts but to engage in unnecessary communication as this was a time for Client #6 to calm down. The procedure instructed staff to watch Client #6 from inside the facility. The procedure instructed the walkie-talkies were to be kept in the staff room and turned off when not is use so staff could access them when Client #6 requested one. Additionally, Client #6's PBSP included the Bracelet Supervision Procedure, last revised 9/2/19, which instructed Client #6's staff was to wear a brown bracelet. The assigned staff was to give the bracelet and accountability of Client #6 to another staff when unable to provide adequate supervision. Continued record review revealed the Dining Room Zone Procedure, undated. The procedure instructed one staff was to be assigned to work in the dining room at all times. When the staff needed to leave the dining room, they were to have another staff cover the dining room. The responsibilities of the staff in the dining room included being able to monitor all exits in the home which included all three exit doors, to be aware of all clients in the dining room, implement client Behavior Support Plans for clients who attempted to leave the building, and to know who was coming into and leaving the building. The	W 186		

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W 186	Continued From page 19 procedure again instructed staff to report off to another staff who agreed to cover the dining room zone prior to leaving the dining room. 2. Continued observations on 1/6/20 revealed the following: a. At 3:45 p.m., DSA D assisted a client to the living room and then went to assist Client #8 in the bathroom. At 4:08 p.m., DSA D returned to the dining room and asked if Client #6 was outside. When asked if she reported Client #6's accountability and bracelet to another staff, DSA D said she "probably should have" while she was assisting other clients. When asked if staff were supposed to, DSA D shrugged her shoulders and said she did not know for sure if she was supposed to report Client #6's accountability and bracelet to another staff. b. At 3:50 p.m., DSA B was in the dining room and walked with Client #2 into the kitchen, leaving no staff in the dining room. DSA B and Client #2 left the kitchen and went to the bathroom. When interviewed at approximately 4:03 p.m., DSA C looked around the dining room and said Client #6's staff was to monitor the dining room but was unsure who Client #6's assigned staff since client accountability was changed after the shift began. DSA C said she was supposed to cook and went back into the kitchen. At approximately 4:04 p.m., DSA B and Client #2 returned to the dining room. c. At 5:35 p.m., DSA D was in the kitchen cleaning when Client #7 walked to the kitchen pantry, DSA B followed him leaving the dining room without a staff present. The Direct Support Manager (DSM) entered the dining room and	W 186		

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W 186	Continued From page 20 informed DSA B and DSA D there was no staff in the dining room. DSA B explained Client #7 walked to the pantry and she was attempting to get him to leave the pantry. The DSM stated staff needed to communicate with each other better and a staff needed to be in the dining room. DSA B returned to the dining room while DSA D prompted Client #7 out of the pantry; Client #7 went to the dining room with the I-Pad. d. At 5:55 p.m., Client #5 was sitting in a leather chair in the dining room by the peninsula kitchen counter. As DSA B, DSA C, and DSA D were all huddled together trying to figure out if a pair of headphones were broken, Client #5 went into the kitchen and started to grab food from the refrigerator and shove it into her mouth. The Surveyor informed the staff Client #5 was taking and eating food from the refrigerator. DSA E approached Client #5 and Client #5 hurriedly walked toward her bedroom. The Direct Support Manager (DSM) came from the living room and prompted Client #5 to spit the food out; Client #5 refused. The DSM then encouraged Client #5 to chew if she was not going to spit the food out; the DSM stayed beside Client #5 while DSA B brought a glass of water and a bowl. The DSM continued to encourage Client #5 to spit the item into the bowl and Client #5 continued to refuse. The DSM asked DSA D to stay with Client #5 while she assisted DSA B to document the incident and contact the on-call nurse. Additional observations on 1/7/20 revealed the following: a. At 7:20 a.m., Client #6 and Client #8 were in the kitchen preparing their breakfast with DSA F. The Surveyor did not observe DSA F wearing	W 186		

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W 186	Continued From page 21 Client #6's assigned bracelet. Client #7 sat in the dining room using an I-Pad; CMA A was present in the dining room. At 7:22 a.m., CMA A walked down the bedroom hallway, back to the dining room, and then went into the medication room, leaving the dining room without any staff. Client #7 walked to the medication room door and CMA A closed the door. Client #7 banged his head on the wall by the door three times. As the Surveyor informed DSA F Client #7 was banging his head, CMA A opened the door, briefly spoke to Client #7, and then closed the door again. Client #7 banged his head two times on the wall by the medication room door, walked to the other side of the dining room, and banged his head two more times on the wall. DSA F stepped into the kitchen doorway and said "(Client #7) come here." Client #7 walked over by the Surveyor and banged his head two times on the wall. DSA F stated his name and Client #7 sat in the leather chair. DSA F turned and continued to assist Client #6 and Client #8. b. At 7:25 a.m., the Surveyor asked DSA F if a staff was supposed to be present in the dining room. DSA F stated she thought staff were able to be in the kitchen. DSA F stated she would ask the DSM and said again she thought it was okay for staff to be in the kitchen. DSA F stayed in the kitchen, assisting Client #6 and Client #8; Client #7 sat in the dining room with no staff present. c. At 7:30 a.m., Client #6 sat at the dining room table eating his breakfast and Client #7 sat in a chair in the dining room using an I-Pad with no staff present in the dining room. DSA F continued to assist Client #8 to make her breakfast in the kitchen. DSA G entered the dining room at approximately 7:35 a.m. and prompted Client #7	W 186		

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W 186	Continued From page 22 to the table to eat his breakfast. d. At 7:40 a.m., Client #8 walked to her bedroom to change. Client #8's breakfast food was left sitting on the dining room table. e. At 7:58 a.m., a plate of food and cheese slices sat on the peninsula counter and a loaf of bread and eggs on the counter by the stove with no staff present in the kitchen. When asked, DSA H confirmed food items were not to be left sitting out. DSA H went into the kitchen and put the plate of food into the microwave and moved the cheese slices next to the bread and eggs. DSA H left the cheese slices, bread, and eggs on the counter and went back into the dining room. f. At 8:05 a.m., DSA H went to the kitchen, leaving no staff in the dining room until 8:10 a.m. when the Direct Support Manager (DSM) arrived at the facility and stayed in the dining room. 3. Review of facility General Event Reports (GERs) revealed the following: a. On 8/16/19, Client #5 handed staff her dinner plate. Staff took the plate to the kitchen sink and when the staff turned around, Client #5 had followed staff into the kitchen. Client #5 grabbed chicken, shoved it into her mouth, and attempted to run but tripped on the dishwasher door and fell. Client #5 got up and ran to her bedroom. Staff went to her bedroom and found Client #5 choking. Staff called 911 and notified the on-call nurse. Staff performed the Heimlich Maneuver; Client #5 threw up some liquids and was able to breathe again but did not appear to be breathing normally, threw up in her mouth, and also had foam in her mouth. Client #5 was taken to the	W 186		

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W 186	Continued From page 23 Emergency Room due to a partially blocked airway; she was admitted to the hospital. b. On 8/20/19, staff was in the kitchen cleaning and when staff turned around they observed Client #5 shoving a piece of chicken into her mouth. Client #5 had been sitting in a chair in the dining room when she reached over and took the chicken off the counter in front of the microwave. Staff was instructed by other staff not to follow Client #5 as she may attempt to swallow the chicken without chewing it. Staff went to Client #5's room and found Client #5 attempting to catch her breath and she put her hands up in the air. Staff attempted the Heimlich Maneuver but Client #5 refused and went back to the dining room. Staff gave Client #5 water and Client #5 spit it up. Staff called 911 for Emergency Medical Services (EMS) to come assess Client #5. Client #5 threw up four times before EMS arrived at the facility. EMS staff assessed Client #5 and stated Client #5 was fine, her airway was clear, and they felt Client #5 was trying to make herself thrown up. Staff continued to monitor Client #5, offered bites of pudding approximately every ten minutes. Staff noted Client #5 threw up two more times. c. On 8/23/19, Client #5 ran to the kitchen and stole food. Staff followed Client #5 back to her bedroom and encouraged Client #5 to chew the food. Staff provided Client #5 with water. Staff noted they stayed with Client #5 to ensure she would not choke, noting Client #5 threw up "quite a few times." On-call nursing was notified and went to asses Client #5. The nurse noted Client #5 would not allow her to assess her therefore the nurse stayed beside Client #5 to observe her. The nurse noted Client #5 appeared okay, had no further incidents of vomiting, but was	W 186		

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W 186	Continued From page 24 intermittently spitting saliva on the floor, noting it was an usual behavior for Client #5. d. On 8/31/19, Client #7 was observed by a client at 105 Kelly's Court leaving 102 Kelly's Court and told staff at 105 Kelly's Court. The staff went outside and met Client #7 in the circle drive. Staff at 102 Kelly's Court noted the last time they observed Client #7 he was in the living room while the staff was in the kitchen cleaning and working with other clients. Staff reported the alarm at 102 Kelly's Court had been turned off and his assigned staff had left on an outing with other clients. e. On 9/2/19, Client #6 was observed walking down the driveway by a staff sitting in her car on break. The staff did not observe any other staff with Client #6 therefore approached Client #6 and began to talk to him. Client #6 returned to the facility and as Client #6 and the staff entered, the front door alarm sounded. According to the GER, staff checked the back door, which lead to a fenced in area, and found the gate was unlocked. Client #6 reported he left the facility out of the back door. f. On 9/10/19, Client #5 grabbed putty the maintenance worker had left out. Client #5 was immediately given fluids and notified the nurse. Due to the package having no information regarding the toxicity of the spackle/putty, Client #5 was transported to the Emergency Room. The Emergency Room instructed staff to continue to push fluids. g. On 10/24/19, staff found Client #6 walking down the road by himself. The staff stopped and spoke to Client #6; Client #6 got into the van and	W 186		

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W 186	Continued From page 25 returned to the facility with the staff. h. On 11/1/19, staff prepared medications in a chocolate twinky and presented it for the client. As the client considered eating the twinky, Client #5 stole and ate it. I. On 11/15/19, staff went to check on Client #5 in her bedroom. Staff found deodorant on her bedroom floor, with the top off and had been bitten. Staff noted the deodorant had been on a small table in the dining room. j. On 1/4/20, Client #6 left the facility and went to 101 Kelly's Court without staff knowledge. Staff was in the kitchen, preparing lunch and talking with Client #6. Client #6 went to his bedroom and when staff went to check on his approximately ten minutes later, Client #6 was not in his room and one walkie-talkie was gone. k. On 1/6/20, staff was in the dining room attempting to figure out a headset problem and "didn't have my eye on her close enough". Client #5 was in the recliner by the kitchen, got up and ran to the refrigerator and ate a part of a stick of butter. Additional record review of Client #5's Behavior Support Plan (BSP), last updated 11/30/19, addressed target behaviors to include biting objects, attempt to or actually biting others, aggression, psychotic disorder behaviors, displacement of liquids from the bottles, PICA (eating non-edible items), and exiting her bedroom without staff knowledge. The BSP included preventative measures to reduce food stealing. The BSP instructed staff to monitor her very closely at mealtimes, position between Client	W 186		

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W 186	Continued From page 26 #5 and others food, have Client #5 be the first or the last to get served during meals, and to use a bus tub to clear her dishes from the table. The BSP instructed if Client #5 stole food staff were to prompt her to remove the food from her mouth, replace stolen food from other clients, and engage Client #5 in the present activity. The BSP noted Client #5 would tend to steal food after she has had a PICA and instructed staff to watch all items left out and make sure sinks were rinsed of soap and other debris. Review of Client #7's Behavior Support Plan (BSP), last updated 11/3/19, noted target behaviors of aggression, self-injurious behaviors, and exiting. The BSP instructed Client #7's assigned staff was to wear a white bracelet. The bracelet was to be given to another staff to assume accountability of Client #7 if his assigned staff was unable to visually monitor Client #7. The BSP instructed staff to position themselves to see all exit doors and noted there were alarms on the side door and the front door. The door which exited to the courtyard would have a switch Client #7 was to be taught to use to communicate he wanted to go outside. The BSP instructed staff to redirect Client #7 to an activity and ask him to show what he needed when he engaged in aggression or self-injurious behaviors. The BSP instructed staff to call the nurse following incidents of banging his head against hard objects and request the nurse complete a neurological assessment. Continued record review revealed staff were trained on 8/3/19 to implement the Dining Room Zone Procedure, the Bracelet Supervision Procedure, client to staffing ratios, staff assignments, along with several other trainings.	W 186		

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W 186	Continued From page 27 Following an Interdisciplinary Team (IDT) meeting on 8/21/19, the QIDP trained staff to ensure all food was covered or put away to reduce Client #5's opportunities for food stealing and trained staff on zoning the main area of the home, especially before and after meal/snack times. Staff were retrained on the Bracelet Supervision Procedure and the Dining Room Zone Procedure numerous times since 8/21/19, including during the Surveyors observations on 1/6/20 and 1/7/20. When interviewed on 1/6/20 at 3:15 p.m., Direct Support Specialist Professional/Certified Medication Aide (DSSP/CMA) A reported on 1/4/20 at approximately 9:30 a.m. she began the morning medication pass. She said when she finished with the medication pass, she went to assist another client; DSA H was in the dining room and DSA F was assisting a client in their bedroom. DSSP/CMA A said when she returned, DSA H was in the kitchen, and she asked where Client #6 was. DSA H reported he was in his bedroom. DSSP/CMA A stated she went to check and Client #6 was not there. DSSP/CMA A explained Client #6 had a walkie-talkie he carried with him but he did not answer when DSA H called him on it. She said she went to the 105 Kelly's Court and Client #6 was not there. She said when she left she found him walking from 101 Kelly's Court toward 105 Kelly's Court, it was about 11:00 a.m., and Client #6 returned to the facility with her. She reported Client #6 was wearing a Columbia jacket, sneakers, sweatpants, and had a backpack with him. DSSP/CMA A reported DSA H should have remained in the dining room until another staff was in there. She stated Client #6's staff was to have an assigned bracelet but staff accountability was not assigned because Client #8 was having	W 186		

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W 186	Continued From page 28 behaviors and because of staffing changes. DSSP/CMA A explained Client #6 had two backpacks and one had a wanderguard band attached to the inseam. She said Client #6 took the backpack without the wanderguard band when he left. DSSP/CMA A said DSA H called and reported to the on-call supervisor and thought she called the on-call nurse. She said she did not see any injuries on Client #6 and he did not report any injuries. DSSP/CMA A stated she called the on-call nurse and reported all morning medications were late and was instructed to give them. When interviewed on 1/7/20 at 8:55 a.m., DSA F said on 1/4/20 Client #8 was in the dining room yelling and hitting the table until approximately 9:00 a.m. and then they started to assist the others clients to get up. She said she was Client #6's assigned staff but stated client accountability was not assigned until later in the shift. She said at approximately 10:00 a.m., Client #6 was in the dining room and she reported him over to DSA H, who was in the dining room, and she went to assist another client. DSA F said she was with the other client during the entire incident and when she returned to the dining room, Client #6 was inside. She said Client #6 appeared to be in a good mood and had his walkie-talkie. DSA F stated the other walkie-talkie was dead. DSA F explained she would set the walkie-talkies out on the table so Client #6 had access to them. She stated Client #6 would not ask for them but if he could see them, he would normally take one, which was a good indicator he was going to walk out. DSA F explained Client #6 had a wanderguard band in his backpack but he took the backpack without the band so the alarm did not go off either. She said Client #6 did not	W 186		

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W 186	Continued From page 29 always take a backpack when he would leave the facility and did not know why Client #6 did not wear the wanderguard band. DSA F stated she was unsure if the kitchen was part of the dining room zone and said when he eloped on 1/4/20, DSA H was in the kitchen making lunch. DSA F confirmed CMA A did not give her Client #6's bracelet when he was in the kitchen making breakfast with her on 1/7/20. DSA F explained the medication passer was not able to stay and monitor the dining room but if another staff took Client #6's bracelet and accountability, then the staff would not be able to leave to assist any other clients. DSA F stated she did not know how to implement the dining room zone while still meeting the needs of everyone else in the facility. DSA F said she asked the DSM and the QIDP on 1/6/20 but was not given a clear answer how to. When interviewed on 1/7/20 at 9:15 a.m., Client #6 said on 1/4/20 he helped staff make lunch and then went to his bedroom. He said he was upset so he got his bag, left the facility, and went to 101 Kelly's Court. Client #6 said he brought his walkie-talkie when he left and his worked but the one the staff had was not working. Client #6 stated he started to walk to 105 Kelly's Court when DSSP/CMA A found him and they returned to the facility. Client #6 said he did not get injured but he did get cold when he walked to 101 Kelly's Court. He reported he was wearing a hoddie, jeans or sweatpants, and his sneakers. Client #6 said there was a wanderguard band in one of his backpacks so he took his backpack without the wanderguard band. Client #6 explained he did not like to wear the wanderguard band on his ankle but had not tried it on his wrist. Client #6 said he would be willing to try wearing the wanderguard band on his wrist.	W 186		

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W 186	Continued From page 30 When interviewed on 1/7/20 at 9:50 a.m., DSA H reported on 1/4/20 she arrived to work at approximately 9:00 a.m. She said Client #8 had been having behaviors so she just went and started to assist other clients to get up. She said at approximately 10:40 a.m. or 10:50 a.m., Client #6 was in the dining room. She said he did not want to help prepare lunch and she watched as he went into his bedroom. DSA H said she returned to the kitchen and was draining Tuna at the kitchen sink with her back toward the dining room and all three exterior doors. DSA H stated she went to do a ten-minute check and Client #6 was not in his room. She reported DSSP/CMA A assisted to look for him while she called the neighboring facilities, 105 Kelly's Court and 101 Kelly's Court, and was told he was at 101 Kelly's Court. DSA H said DSSP/CMA A found Client #6 walking toward 105 Kelly's Court from 101 Kelly's Court. DSA H said once inside, Client #6 told her he had his walkie-talkie with him. She said she check the other walk-talkie and it was turned off. DSA H reported she called the on-call supervisor and reported the incident but did not call the on-call nurse and was unsure if DSSP/CMA A did. DSA H said she thought staff were supposed to report to the on-call nurse so the nurse could assess the client. DSA H stated she did not observe any injuries on Client #6. DSA H reported she did not have Client #6's assigned bracelet and thought DSA F had his bracelet. DSA H said she thought the kitchen was part of the dining room zone. She explained Client #6 would also leave the facility through the hallway exit door, which also had a wanderguard alarm on it. DSA H said Client #6 took his backpack without the wanderguard band in it so the alarm did not sound when he left the facility. DSA H said she	W 186		

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W 186	Continued From page 31 was not sure why Client #6 did not wear the wanderguard band and said the QIDP stated he would rip it off if he was mad. DSA H said Client #6 did not say why he left but recalled he had gotten upset earlier because the internet was not working. She said DSSP/CMA A explained the internet was not working and Client #6 said he would go somewhere they would help him. When interviewed on 1/7/20 at 2:45 p.m., DSSP B said on 1/4/20 she worked at 101 Kelly's Court. She reported as they were getting ready for lunch, approximately 11:30 a.m., Client #6 came into the facility. She said Client #6 told her staff at 102 Kelly's Court did not know he had left. She said she asked if he had his walkie-talkie and he said he left it at the facility. DSSP B said she told Client #6 he needed to let his staff know he was at 101 Kelly's Court. She said Client #6 stated he was hungry and she encouraged him to go back to 102 Kelly's Court to eat his lunch. She said she stood outside and watched as Client #6 walked inside 102 Kelly's Court. DSSP B said Client #6 was at 101 Kelly's Court for five, at most ten, minutes. She reported Client #6 was wearing a grey hoodie, black sweat pants, sneakers, and had his backpack. When interviewed on 1/7/20 at 3:15 p.m., the Qualified Intellectual Disabilities Professional (QIDP) stated she was not aware on 1/4/20 all other clients were late to get up and complete the morning routine because all staff were monitoring Client #8 who was exhibiting inappropriate behaviors. The QIDP stated Client #8's staff should have monitored her while the other staff assisted the other clients. The QIDP stated it was not fair to leave all the other clients in bed.	W 186		

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W 186	Continued From page 32 When interviewed on 1/9/20 at 9:00 a.m., the Associate Director (AD) explained the DSM worked in the facility for almost three months to work with and train staff. She stated she felt the facility should have had a better understanding and routine than what it had; she gave the example staff should have known the kitchen was not part of the dining room zone. The AD explained if staff did not know how to run and implement programming, the DSM should have been directing and guiding the staff how to since this was why the DSM had been working in the facility. The above findings resulted in a determination of Immediate Jeopardy on 1/9/20 at 12:02 p.m. due to failure to provide adequate staff and/or ineffective utilization of staff to ensure the health and safety of clients. The facility developed and implemented a removal plan, which included increased supervision and training of staff. The Immediate Jeopardy was removed on 1/14/20 at 8:45 a.m.	W 186		
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:	W 249	W 249 Program Implementation As soon as the interdisciplinary team has formulated an individual program plan, each person served will receive continuous active treatment consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objective identified in the individual program plan. Specifically, each person's ISP will be incorporated into a personal active treatment schedule. The active treatment schedule will be followed by the direct support associates. DSA's will be trained on how to do active treatment and to follow the plan as written. DSA's will be trained on all active treatment procedures. DSS and QIDP will do periodic observations to ensure	

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W 249	Continued From page 33 Based on observation, interview, and record review, the facility staff failed to consistently implement client programs, as written. This affected 3 of 3 sample clients (Client #6, #7, and #8). Findings follow: 1. Observation on 1/6/20 revealed the following: a. At 3:45 p.m., DSA D assisted a client to the living room and then went to assist Client #8 in the bathroom. At 4:08 p.m., DSA D returned to the dining room and asked if Client #6 was outside. When asked if she reported Client #6's accountability and bracelet to another staff, DSA D said she "probably should have". When asked if staff were supposed to, DSA D shrugged her shoulders and said she did not know for sure if she was supposed to report Client #6's accountability and bracelet to another staff. b. At 3:50 p.m., no staff were present in the dining room. At 4:03 p.m., the Surveyor asked DSA C, who was in the kitchen, if a staff was supposed to be in the dining room. DSA C looked around the dining room and said Client #6's staff was to monitor the dining room but was unsure who Client #6's assigned staff since client accountability was changed after the shift began. DSA C said she was supposed to cook and went back into the kitchen. At approximately 4:04 p.m., DSA B returned to the dining room. c. At 5:35 p.m., DSA D was in the kitchen cleaning when Client #7 walked to the kitchen pantry, DSA B followed him leaving the dining room without a staff present. The Direct Support Manager (DSM) entered the dining room and informed DSA B and DSA D there was no staff in the dining room. DSA B explained Client #7	W 249	active treatment schedules and procedures are being followed and document results. The completion and findings of the observations will be monitored by the Associate Director. Person(s) Responsible Support Service Specialist/QIDP Direct Support Supervisor	03-15-2020

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W 249	Continued From page 34 walked to the pantry and she was attempting to get him to leave the pantry. The DSM stated staff needed to communicate with each other better and a staff needed to be in the dining room. DSA B returned to the dining room while DSA D prompted Client #7 out of the pantry; Client #7 went to the dining room with the I-Pad. Additional observations on 1/7/20 revealed the following: a. At 7:20 a.m., Client #6 and Client #8 were in the kitchen preparing their breakfast with DSA F. The Surveyor did not observe DSA F wearing Client #6's assigned bracelet. Client #7 sat in the dining room using an I-Pad; CMA A was present in the dining room. At 7:22 a.m., CMA A walked down the bedroom hallway, back to the dining room, and then went into the medication room, leaving the dining room without any staff. 1/7/20 At 7:25 a.m., the Surveyor asked DSA F if a staff was supposed to be present in the dining room. DSA F stated she thought staff were able to be in the kitchen. DSA F stated she would ask the DSM and said again she thought it was okay for staff to be in the kitchen. DSA F stayed in the kitchen, assisting Client #6 and Client #8; Client #7 sat in the dining room with no staff present. b. At 7:30 a.m., Client #6 sat at the dining room table eating his breakfast and Client #7 sat in a chair in the dining room using an I-Pad with no staff present in the dining room. DSA F continued to assist Client #8 to make her breakfast in the kitchen. DSA G entered the dining room at approximately 7:35 a.m. c. At 8:05 a.m., DSA H went to the kitchen, leaving no staff in the dining room until 8:10 a.m.	W 249		

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W 249	Continued From page 35 when the Direct Support Manager (DSM) arrived at the facility and stayed in the dining room. Record review on 1/7/20 revealed a General Events Report (GER), dated 1/4/20, which noted Client #4 had eloped from the facility while one staff was in the kitchen preparing lunch and the other two staff were assisting other clients in their bedrooms. Record review on 1/7/20 revealed Client #6's "PBSP: Relationships with Others", approved on 11/11/19. The program addressed target behaviors of verbal aggression, physical aggression, property destruction, and exiting the home. Restrictive measures included the use of behavior modifying medications, supervised phone calls and visits with family, a locked bicycle, the use of the wanderguard in the lining of his backpack, and the use of walkie-talkies when unattended outside. The PBSP instructed staff to encourage Client #6 to focus on the positive aspects of his day, to use a picture board to choose calming activities, provide Client #6 with structure, encourage participation in activities, exercise, and household tasks; and redirect potential trigger topics of conversations. The PBSP instructed staff were to follow the bracelet procedure with Client #6. When Client #6 began to exhibit precursor behaviors, staff were to redirect him, remind him to make good/safe choices, use his picture board to choose a calming activity. When Client #6 exhibited aggression and/or property destruction staff were to verbally redirect him and give him space and time without having any demands or requests. If Client #6 continued and was unable to stop, staff were to call 911 for assistance. During a crisis state, staff were to ensure the safety of Client #6	W 249		

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W 249	Continued From page 36 and all others by using the least amount of interaction necessary for safety. The program instructed staff to ensure proper supervision and to call 911 if unable to provide proper supervision. The PBSP noted Client #6 was able to visit 101 and 105 Kelly's court for short time frames; staff were to get approval from the other facility and then go with him. The PBSP noted Client #6 could go outside, including to calm down, when he requested a walkie-talkie from staff. Client #6 was to respond to staff, with his walkie-talkie, to let staff know his whereabouts and he was to stay in the circle drive of Kelly's Court. In conjunction with the PBSP, was the Walkie-Talkie Procedure, undated. The procedure instructed Client #6's was to seek out his staff, identified by a bracelet, to request a walkie-talkie to go outside. Client #6 had been trained to respond to staff with his whereabouts while outside and trained to stayed in the circle drive of Kelly's Court. Client #6's staff was to check-in with him every couple of minutes to ask his whereabouts but not to engage in unnecessary communication as this was a time for Client #6 to calm down. The procedure instructed staff to watch Client #6 from inside the facility, if possible. The procedure instructed the walkie-talkies were to be kept in the staff room and turned off when not is use so staff could access them when Client #6 requested one. Additionally, Client #6's PBSP included the Bracelet Supervision Procedure, last revised 9/2/19, which instructed Client #6's staff was to wear a brown bracelet. The assigned staff was to give the bracelet and accountability of Client #6 to another staff when unable to provide adequate supervision.	W 249		

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W 249	Continued From page 37 Continued record review revealed the Dining Room Zone Procedure, undated. The procedure instructed one staff was to be assigned to work in the dining room at all times. When the staff needed to leave the dining room, they were to have another staff cover the dining room. The responsibilities of the staff in the dining room included being able to monitor all three exits in the home, to be aware of all clients in the dining room, implement client Behavior Support Plans for clients who attempted to leave the building, and to know who was coming into and leaving the building. The procedure again instructed staff to report off to another staff who agreed to cover the dining room zone prior to leaving the dining room. Review of Client #7's Behavior Support Plan (BSP), last updated 11/3/19, noted target behaviors of aggression, self-injurious behaviors, and exiting. The BSP instructed Client #7's assigned staff was to wear a white bracelet. The bracelet was to be given to another staff to assume accountability of Client #7 if his assigned staff was unable to visually monitor Client #7. The BSP instructed staff to position themselves to see all exit doors and noted there were alarms on the side door and the front door. The door which exited to the courtyard would have a switch Client #7 was to be taught to use to communicate he wanted to go outside. The BSP instructed staff to redirect Client #7 to calmly and quietly talk to Client #7, redirect him to an activity, and ask him to show what he needed when he engaged in aggression or self-injurious behaviors. The BSP instructed staff to call the nurse following incidents of banging his head against hard objects and request the nurse complete a neurological assessment.	W 249		

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W 249	Continued From page 38 When interviewed on 1/9/20 at 8:20 a.m., the Qualified Intellectual Disabilities Professional confirmed staff failed to follow Client #6 and Client #7's programs. She stated staff were to be in the dining room to be able to monitor all three exit doors as instructed in the programs. The QIDP confirmed on 1/4/20 staff failed to follow the Dining Room Zone Procedure when the staff went into the kitchen leaving no staff in the dining room. When interviewed on 1/8/20 at 2:30 p.m., the Associate Director (AD) confirmed on 1/4/20 staff failed to follow the Dining Room Zone Procedure. During a follow-up interview on 1/9/20 at 9:00 a.m., the AD confirmed the ktichen was not considered part of the Dining Room Zone Procedure 2. Observation on 1/7/20 at 7:20 a.m. revealed Client #7 walked to the medication room door and CMA A closed the door. Client #7 banged his head on the wall by the door three times. As the Surveyor informed DSA F, who was in the kitchen, Client #7 was banging his head, CMA A opened the door, briefly spoke to Client #7, and then closed the door again. Client #7 banged his head two times on the wall by the medication room door, walked to the other side of the dining room, and banged his head two more times on the wall. DSA F stepped into the kitchen doorway and said "(Client #7) come here." Client #7 walked over by the Surveyor and banged his head two times on the wall. DSA F stated his name and Client #7 sat in the leather chair. DSA F turned and continued to assist Client #6 and Client #8 with preparing their breakfast.	W 249		

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W 249	Continued From page 39 Record review on 1/7/20 revealed Client #7's BSP "Decrease Target Behaviors", last updated 11/3/19. The BSP addressed target behaviors of aggression, self-injurious behaviors (SIBs), and exiting. The BSP instructed for incidents of aggression and SIB, staff were to stay calm and quietly talk to Client #7, find activities to redirect Client #7 to, and ask Client #7 to show you what he needed, encouraging him to "lead the way." The program noted Client #7's mother reported rubbing/massaging his head was helpful at times. The BSP instructed staff to call the nurse and request a neurological check after incidents of Client #7 banging his head on hard surfaces. The BSP included procedures for staff to follow to decrease elopement. The program instructed Client #7's assigned staff to wear a white bracelet and report Client #7, and give his bracelet, to another staff if unable to visually monitor Client #7. Staff were to monitor all exit doors and complete five minute checks on Client #7 when he was in his bedroom during waking hours. The BSP noted alarms were on the side door which lead to the parking lot and the front door; the side door which lead to the courtyard was to have a switch for Client #7 to press to ask to go outside. Staff failed to call the nurse and request a neurological check was completed after Client #7 engaged in banging his head on the wall. When interviewed on 1/9/20 at 8:20 a.m., the QIDP confirmed staff failed to follow Client #7's BSP as directed. She stated if Client #7 banged his head on hard surfaces, staff were to call the nurse and request the nurse come and complete a neurological check of Client #7.	W 249		

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W 249	Continued From page 40 3. When interviewed on 1/6/20 at 3:15 p.m., Direct Support Specialist Professional/Certified Medication Aide (DSSP/CMA) A reported on 1/4/20 when first shift arrived to work, Client #8 started to exhibit inappropriate behaviors which included yelling, hitting the walls, and hitting toward staff. DSSP/CMA A said when Client #8 was having inappropriate behaviors all other clients were to be removed from the area Client #8 was in. DSSP/CMA A explained Client #8 was in the dining room when she was having inappropriate behaviors on 1/4/20 and all staff who worked were assisting with the behavior but did not have to use any hands-on interventions with Client #8. When interviewed on 1/7/20 at 8:55 a.m., Direct Support Associate (DSA) F said on 1/4/20 Client #8 was in the dining room yelling and hitting the table when first shift arrived at 7:00 a.m. until approximately 9:00 a.m. She said once Client #8 calmed, staff started to assist the others clients to get up. DSA F explained when Client #8 exhibited inappropriate behaviors her program instructed to have all others moved away for safety. She said all three staff who worked were monitoring and assisting with Client #8 until approximately 9:00 a.m. when she began to calm. Record review on on 1/7/20 revealed Client #8's Positive Behavior Support Plan (PBSP) "Social Stories", approved on 1/6/20. The PBSP addressed target behaviors of verbal aggression, physical aggression, and property destruction. The PBSP instructed staff to present Client #8 with social stories which were three to four steps long to assist her with preparing what came next in her routine. Staff were to continue to review	W 249		

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W 249	Continued From page 41 social stories with Client #8 throughout her day, in increments of up to four hours to provide direction and prepare her for what came next. The timeframe could be shortened if there were schedule changes or if she exhibited undesirable behaviors. The PBSP instructed if Client #8 began to engage in target behaviors, staff were to assure her safety and the safety of others around her by removing all other clients from the area, using good body positioning until all others were removed. Client #8's assigned staff was to maintain line of sight of Client #8 while keeping all interactions to a minimum. Once calm, Client #8 was to "restore the environment to its previous state (clean/safe)." The program instructed staff to document daily, on each shift, any incidents of target behaviors exhibited by Client #8 Record review revealed no documentation of Client #8's reported behavioral incident on 1/4/19. When interviewed on 1/7/20 at 3:15 p.m. the QIDP confirmed Client #8's PBSP instructed to remove all other clients from her vicinity during behavioral incidents and her staff was to monitor her from a distance until she calmed down. The QIDP confirmed staff should have assisted the other clients while Client #8's staff monitored her, per her program. When interviewed on 1/8/20 at 2:30 p.m., the Associate Director (AD) Client #8's assigned staff should have monitored her while the other two staff assisted the other clients to get up, even if it was to do individual activities in their bedrooms until Client #8 calmed. She said staff should have documented Client #8's behavior on her program data. The AD explained staff would have normally completed a T-Log (part of the electronic record	W 249		

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W 249	Continued From page 42 system) on Client #8's behavior because it affected all the other clients who resided in the facility. She stated staff should have documented something regarding the incident.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan 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 2 of 3 sample clients (Client #6 and #7). Findings follow: Record review on 1/7/20 and 1/8/20 revealed monthly program data reviews. The reports identified each client's formal programming, the total score toward each identified objective, the total number of times program documentation was completed each month, and the analysis of progress. The reports noted the following: 1. Client #6's monthly program data from September 2018 - November 2018 revealed the following programs, frequency of documentation, and the analysis of progress: a. "Exercise" program was to be documented Monday thru Friday on first and second shift. Staff documented the program 14 times in September. The QIDP noted Client #6 was making progress	W 252	W252 Program Documentation Data relative to accomplishment of the criteria specified in person served individual program plan objectives will be documented in measurable terms. Specifically, each person served 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 associates. DSS will update the window sheets to specify when each goal is to be worked on and use the window sheets to document in Therap daily and this will be monitored with weekly programmatic reports from Therap. The QIDP will continue to do monthly Q notes for each person served. The DSS's will be retrained on how to do documentation audits. Person(s) Responsible: Support Service Specialist/QIDP Direct Support Supervisor	03-15-2020

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W 252	Continued From page 43 and commented "Trial counts up and so is (Client #6's) progress toward this goal." Staff documented the program 14 times in October. The QIDP noted Client #6 was making progress. Data summaries for November were not completed. b. "Task Completion" program was to be documented Monday, Wednesday, and Friday on first and second shift. Staff documented 15 times in September with the QIDP determined he was making progress and commented, "Trial counts up and (Client #6) is maintaining his progress. Staff documented the program 12 times in October; the QIDP noted he was maintaining with no additional comments. Data summaries for November were not completed. c. "Food Groups" program was to be documented Tuesday, Wednesday, and Thursday on first shift. Staff documented eight times in September. The QIDP assessed Client #6 was maintaining progress and commented "Trial counts increasing but will continue to work with staff on having (Client #6) follow the steps of this goal." Staff documented the program six times in October and the QIDP determined his progress was fluctuating. Data summaries for November were not completed. d. "Tooth brushing" program was to be documented Monday thru Friday on first and second shift. Staff documented 14 times in September. The QIDP determined Client #6 was making progress and commented "Trial counts up and so is (Client #6's) progress toward this goal. Staff documented on the program 16 times in October; the QIDP determined Client #6 was maintaining. Data summaries for November were	W 252		

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W 252	Continued From page 44 not completed. e. "PBSP: Relationships with Others" was to be documented daily on first, second, and the overnight shift. Staff documented forty times in September. The QIDP determined Client #6 was not making progress toward the goal and noted "(Client #6) continues to have issues with exiting and verbal aggression. Will continue to address this concern with his communication pictures." Staff documented zero times in October. The QIDP noted Client #6 was "maintaining" progress and noted "Increase in elopement and verbal aggressions. IDT to discuss PBSP changes if needed." Data summaries for November were not completed. 2. Client #7's monthly program data from September 2019 - November 2019 revealed the following programs and frequency of documentation: a. "Sit at Table during Meals" was to be documented on Tuesday, Thursday, and Saturday one time on both first and second shift. Staff documented 21 times in September. The QIDP determined Client #7 was making progress and noted the trial counts were up from the previous month. In October, staff documented the program 17 times; the QIDP determined Client #7 was making progress. Data summaries for November were not completed. b. "Take Medications" was to be documented daily on first and second shift, Staff documented 20 times in September and the QIDP determined Client #7 was making progress. Staff documented the program 18 times in October.	W 252		

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W 252	Continued From page 45 The QIDP noted Client #7 was making progress and commented "Not all data accounted for." Data summaries for November were not completed. c. "Communicate Wants and Needs" was to be documented Tuesday, Thursday, and Saturday on first and second shift. Staff documented 13 times in September. The QIDP determined Client #7 was making progress. In October, staff documented the program 16 times; the QIDP noted Client #7 was making progress and had a slight increase from the previous month. Data summaries for November were not completed. d. "Sits on Toilet" was to be documented daily by first shift. Staff documented 15 times in September. The QIDP determined Client #7 was making progress and commented "Trial counts up and (Client #7) is showing progress toward this goal." Staff documented the program nine times in October; the QIDP determined Client #7 was maintaining progress.. Data summaries for November were not completed. e. "Push Switch to ask to go Outside" was to be documented daily on first and second shift. Staff documented 19 times in September. The QIDP determined Client #7 was making progress and commented, "Trial counts way up from previous month and so is (Client #7's) progress." In October, staff documented the program 16 times. The QIDP determined Client #7 was maintaining progress. Data summaries for November were not completed. f. "Decrease Target Behaviors" was to be documented on daily by first, second, and third shift. Staff documented 44 times in September.	W 252		

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W 252	Continued From page 46 The QIDP noted Client #7's progress was fluctuating and commented the self-injurious behavior was probably up because his phone had been broken. Staff documented the program 41 times in October. The QIDP determined Client #7's progress was fluctuating, noting he progressed with exiting but his self-injurious behavior had increased. Data summaries for November were not completed. Review of facility policies revealed the "Service Documentation" policy, dated 6/4/19. The policy instructed all documentation was to be completed by employees before leaving their shift. Th epolicy continued to instruct staff should complete documentation throughout their shift to ensure the most accurate documentation. When interviewed on 1/7/20 at 3:15 p.m., the QIDP confirmed staff failed to consistently document program data as instructed in each program. She explained she made determinations on a client's progress toward the goals based on the limited data she does get and by her observations when she is in the facility. She confirmed she had not completed the November data reviews yet. She stated the agency practice was to have all monthly data reviews completed by the 15th of the month but explained she had been busy and was behind.	W 252		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client.	W 268	W 268 Conduct Towards Clients Mosaic policies and procedures will promote the growth, development and independence if the person served. Specifically, each person served will have personal active treatment schedule. The active treatment schedules will promote daily living, social and community skills. Training will continue on an annual basis and as need arises. Staff will be trained on each person's active treatment	

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(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 268	Continued From page 47 This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility staff failed to ensure all clients were provided with meaningful activities to promote growth and development; and failed to engage clients in activities to increase skills and maintain independence. This affected 3 of 3 sample clients (Client #6, #7 and #8) and five clients added to the sample (Client #1 - #5). Findings follow: Observation on 1/6/20 revealed the following: a. At 12:20 p.m., Client #4 was assisted from her wheelchair into a recliner in the living room. Certified Medication Aide (CMA) A turned the television on and left the room; Client #4 sat in the recliner with her head down, intermittently closing her eyes, until approximately 1:15 p.m. when CMA A assisted her to go use the bathroom. CMA A failed to offer Client #4 any activities to participate in while she sat in the living room. b. At 1:10 p.m. Client #1 sat at the dining room table, with a sensory item near her, playing with a walkie-talkie while Direct Support Associate (DSA) A sat next to her looking at charts. Client #1 continued to sit with no activities offered until 1:25 p.m. when she was provided a magnet activity. Client #1 was asked if she liked the new game, she attempted the game one time, then sat and rocked in her wheelchair while DSA A continued to complete some paperwork. At 1:40 p.m., Client #1 moved some of the paperwork on the table and continued to lightly rock in her wheelchair until the Surveyor left the facility at 1:55 p.m.	W 268	schedule. DSS and SSS will be doing periodical observations to ensure active treatment is occurring All Mosaic staff will work towards each person served having a meaningful day. Person(s) Responsible: Support Services Specialist/QIDP Direct Support Supervisor	03-30-2020

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W 268	Continued From page 48 c. At 1:20 p.m., Client #5 came to the dining room and sat in a leather chair, which had heating and massage options but was not turned on, and lightly rocked. Client #5 continued to sit in the chair with no activities offered until the Surveyor left the facility at approximately 1:55 p.m. d. From 3:50 p.m. until approximately 4:00 p.m., Client #5 sat in the dining room in the leather chair, looking into the kitchen, while DSA C began to get items out to prepare supper. DSA C failed to encourage Client #5 to assist or explain to Client #5 what she was doing. At 4:00 p.m., Client #5 independently walked to her bedroom. e. On 1/6/20 at 4:30 p.m. Client #3 and Client #4 sat in the living room, with the television on, while DSA E used her cellular phone and then folded laundry. Client #3 was looking toward the dining room and Client #4 sat with her head down. When asked what the activity was, DSA E stated the clients were watching television. DSA E continued to fold clothes without encouraging Client #3 or Client #4 to assist. Client #4 continued to sit in the living room, with her head down, and the television on until approximately 5:00 p.m. when the Direct Support Specialist Professional/Certified Medication Aide (DSSP/CMA) assisted her to the medication room. f. At 4:35 p.m., DSA E positioned Client #3 at the dining room table. Client #1, Client #2, and Client #3 sat at the dining room table without any activities offered. When asked what the activity was, the QIDP looked around the room and said "good question." The Surveyor asked DSA B what the activity was. DSA B stated this was her first day at the facility in approximately six months and	W 268		

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W 268	Continued From page 49 was "not really trained." Client #1, Client #2, and Client #3 continued to sit at the dining room table, with no activities until the Surveyor stepped outside at approximately 4:50 p.m. Facility staff failed to offer Client #1, #2, #3, #4 and #5 meaningful activities to engage in to promote their growth and development. b. Observations on 1/6/20 during the supper meal revealed staff cleaned the dining room tables, prepared and served all food items onto plates, and poured all liquids into glasses. Client #8 carried her drinks to the table while DSA E carried Client #8's pre-plated meal and set the plate on the table. Observations on 1/7/20 following the breakfast meal revealed DSA F scraping, rinsing, and loading dishes into the dishwasher, washed the counters, and washed the dining room tables while Client #8 sat on the couch in the dining room. DSA F failed to encourage Client #8 to assist with the breakfast clean up. Record review on 1/7/20 revealed Client #8's Comprehensive Functional Assessment (CFA), dated 11/5/19. According to the CFA, Client #8 had strengths in the area of washing tables, setting and clearing the table, pouring liquids, serving from dishes, serving the appropriate amount, and rinsing and loading dishes into the dishwasher. c. DSA B placed a pre-plated meal and drinks on the table then verbally prompted Client #7 to the table to eat supper. Following the meal, Client #7 sat on the couch in the dining room while staff cleared his dishes without prompting him to	W 268		

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W 268	Continued From page 50 assist. DSA C then washed the dining room tables without prompting Client #7 to help. Record review on 1/7/20 revealed Client #7's CFA, last reviewed 6/25/19, revealed Client #7 had needs in the areas of setting a table, clearing the table, washing tables, scraping dishes, rinsing dishes, loading dishing into the dishwasher, pouring from a pitcher, using condiments, serving from serving dishes, serving reasonable amount of food, d. Client #6 went to the kitchen, obtained his pre-plated meal, and carried the plate to the table. DSA E brought Client #6's pre-poured drinks to him at the table. Following the meal, DSA E was in the kitchen cleaning when Client #6 brought his dishes and placed them in the sink. DSA E continued to clean but failed to encourage Client #6 to assist with supper clean-up. Record review on 1/8/20 revealed Client #6's CFA, last reviewed 11/30/18. The CFA noted Client #6 had needs in the areas of correctly portioning food and placing dishes into the dishwasher. The CFA noted Client #6 had strengths in the areas of setting the table, pouring liquids, serving himself from serving dishes, serving a reasonable amount of food, washing table and counters, clearing the table, and rinsing dishes. When interviewed on 1/7/20 at 3:15 p.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed all clients should be offered meaningful activities to engage in. The QIDP stated the active treatment provided during observations by the Surveyor did not match the needs of the clients. She stated the clients should	W 268		

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W 268	Continued From page 51 be engaged in various activities, tasks, and chores.	W 268		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all interventions to manage inappropriate client behavior were incorporated into the individual program plan. This affected 2 of 3 sample clients (Client #7 and #8). Findings follow: 1. Observation on 1/7/20 at 7:20 a.m. revealed Client #7 walked to the medication room door and CMA A closed the door. Client #7 banged his head on the wall by the door three times. As the Surveyor informed DSA F, who was in the kitchen, Client #7 was banging his head, CMA A opened the door, briefly spoke to Client #7, and then closed the door again. Client #7 banged his head two times on the wall by the medication room door, walked to the other side of the dining room, and banged his head two more times on the wall. DSA F stepped into the kitchen doorway and said "(Client #7) come here." Client #7 walked over by the Surveyor and banged his head two times on the wall. DSA F stated his name and Client #7 sat in the leather chair. DSA	W 289	W289 Management of Inappropriate Client Behaviors Mosaic will use systematic interventions (e.g. positive behavior supports, MANDT techniques, IStart techniques) to manage inappropriate client behaviors and will incorporate into the person's individual program plan through a Behavior Support Plan (BSP). BSP's will be written for individuals that require restrictive measures to manage inappropriate behaviors. The QIDP is responsible to ensure that all restrictive measures are addressed in the ISP. ISP's will be reviewed during periodical file reviews. The QIDP will ensure all training of ISP and goals are completed as needed and when plan has been updated. Person(s) Responsible: Support Services Specialist/QIDP	03-30-2020

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W 289	Continued From page 52 F turned and continued to assist Client #6 and Client #8 with preparing their breakfast. At 7:25 a.m., Client #7 was observed to wear a wanderguard band on his ankle. Record review on 1/7/20 revealed Client #7's BSP "Decrease Target Behaviors," last updated 11/3/19. The BSP addressed target behaviors of aggression, self-injurious behaviors (SIBs), and exiting. The BSP instructed for incidents of aggression and SIB, staff were to stay calm and quietly talk to Client #7, find activities to redirect Client #7 to, and ask Client #7 to show you what he needed, encouraging him to "lead the way." The BSP instructed staff to call the nurse and request a neurological check after incidents of Client #7 banging his head on a hard surface. The BSP included procedures for staff to follow to decrease elopement. The program instructed Client #7's assigned staff to wear a white bracelet and report Client #7, and give his bracelet, to another staff if unable to visually monitor Client #7. Staff were to monitor all exit doors and complete five minute checks on Client #7 when he was in his bedroom during waking hours. The BSP noted alarms were on the side door which lead to the parking lot and the front door; the side door which lead to the courtyard was to have a switch for Client #7 to press to ask to go outside. The BSP failed to include additional instruction on how staff were to intervene if Client #7 continued to engage in aggression or SIB, failed to include the use of the Wanderguard System, and failed to include any instruction for staff to follow if Client #7 attempted to or actually eloped from the facility. When interviewed on 1/7/19 at 3:15 p.m., the Qualified Intellectual Disabilities Professional	W 289		

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W 289	Continued From page 53 (QIDP) confirmed Client #7's BSP instructed staff to offer Client #7 activities to participate in when he engaged in aggression and/or property destruction but failed to include activities to offer to Client #7. The QIDP explained the school used a helmet with Client #7 during incidents of head banging but a helmet was not used at the facility as the Interdisciplinary Team did not feel it was needed. She said she had verbally instructed staff to use a pillow or their hand to block SIB but confirmed blocking was not included in the BSP. The QIDP confirmed the BSP lacked instruction on how staff were to respond to attempted or actual elopements. The QIDP confirmed the use of a Wanderguard was not included in Client #7's BSP. 2. Record review on 1/8/20 revealed Client #8's 90-Day Physician Orders, signed by her physician on 11/14/19. The orders instructed Client #8 was to receive Mirtazapine 15 milligrams (mg) at 8:00 p.m. for sleep. Additional record review revealed no programming in place to assist Client #8 to work toward a reduction of the sleep medication. 3. Record review on 1/7/20 revealed Client #8's Positive Behavior Support Plan (PBSP) "Social Stories", approved on 1/6/20. The PBSP addressed target behaviors of verbal aggression, physical aggression, and property destruction. The PBSP instructed staff to preset Client #8 with social stories which were three to four steps long to assist her with preparing what came next in her routine. Staff were to create the social stories in increments of up to four hours to offer Client 38 direction and prepare her for what came next. The timeframe could be shorted if there were	W 289		

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W 289	Continued From page 54 schedule changes or if she exhibited undesirable behaviors. The PBSP instructed if Client #8 began to engage in target behaviors, staff were to assure her safety and the safety of others around her by removing all other clients from the area, using good body positioning until all others were removed. Client #8's assigned staff was to maintain line of sight of Client #8 while keeping all interactions to a minimum. Once calm, Client #8 was to "restore the environment to its previous state (clean/safe)." The PBSP failed to include teaching any replacement behaviors and noted reinforcement Client #8 liked but failed to instruct staff on when to provide her reinforcement. When interviewed on 1/7/20 at 3:15 p.m., the QIDP explained Client #8's PBSP was developed around a program I-Start suggested to use with her. She explained staff developed the social stories based on the schedule of activities for each day. She stated it was not a written schedule but staff verbally reviewed activities up to four hour increments with Client #8. The QIDP confirmed staff were to remove other clients from the area for safety and her staff was to visually monitor Client #8 during behavioral incidents. The QIDP confirmed no replacement behaviors were being taught in her program; the PBSP instructed to give Client#8 with space and time to calm. The QIDP confirmed reinforcers Client #8 liked were identified within the PBSP but the program failed to provide instruction on when reinformcement was to be provided.	W 289		
W 375	DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug	W 375	W 375 Drug Administration The system for drug administration must assure that drug administration errors and adverse drug reactions are recorded. Specifically only certified medication aides and nurses will be allowed to administer medications. The person's	

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W 375	Continued From page 55 reactions are recorded. This STANDARD is not met as evidenced by: Based on interview and record review, the Certified Medication Aide (CMA) failed to document all medication errors in client records. This affected all clients (Client #1 - #8) who resided in the facility. Findings follow: Record review on 1/6/20 revealed a General Events Report (GER), dated 1/4/20. According to the GER, on 1/4/20 Client #6 eloped from the facility and went to the neighboring facility. The facility self-reported the incident to the Iowa Department of Inspections and Appeals and initiated an internal investigation into the incident. When interviewed on 1/6/20 at 3:15 p.m., Direct Support Specialist Professional/Certified Medication Aide (DSSP/CMA) A reported on 1/4/20 at approximately 9:30 a.m. she began the morning medication pass. She explained Client #8 had been exhibiting inappropriate behaviors when first shift arrived at 7:00 a.m. and all staff were assisting with Client #8's behaviors. She stated Client #8 did not calm until approximately 9:00 a.m., DSSP/CMA A stated she called the on-call nurse and reported all morning medications were late and was instructed to give them. When interviewed on 1/7/20 at 8:55 a.m., DSA F said on 1/4/20 Client #8 was in the dining room yelling and hitting the table until approximately 9:00 a.m. and then they started to assist the others clients to get up. DSA F confirmed DSSP/CMA A began the morning medication pass after Client #8 calmed and staff were able to	W 375	individual plan will designate the amount of support each person needs. Medication will be given according to the "Six Rights": Right person, Right medication, Right Route, Right time, Right Dose and Right Charting. Mosaic will promote as much independence for people served as possible. Mosaic will assist people served to gain skills to the greatest extent possible based on their ability and desire. Mosaic will ensure that all people served will receive their medication per the MAR. The nurses and CMA's will ensure medications are administered per the MAR during times of interruption from other events. The person administering medication will notify a supervisor if the events of the home are preventing medication administration per the MAR to assist with resolving the issue and adhering the MAR. Person(s) Responsible: CMA Nuring staff	03-30-2020

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W 375	Continued From page 56 start getting the other clients up after 9:00 a.m. When interviewed on 1/7/20 at 9:50 a.m., DSA H reported on 1/4/20 she arrived to work at approximately 9:00 a.m. She said Client #8 had been having behaviors so she just went and started to assist other clients to get up. DSA H confirmed DSSP/CMA A began to assist clients with their morning medications after each client was assisted to get up, which was after she arrived to work at 9:00 a.m. Record review of the Medication Administration Records (MARs) revealed the following: a. Client #1 was to receive Acetaminophen 1000 milligrams (MG), Baclofen 10 mg, 2 teaspoons of Benefiber Powder, 1 Calcium 600 with Vitamin D chewable tablet, Lisinopril 5 mg, 17 grams (g) of polyethylene glycol powder, Tramadol /HCL 100 mg, and Ammonium Lactate 12% lotion at 8:00 a.m. b. Client #2 was to receive Acetaminophen 650 mg, Benztropine MES 0.5 mg, Levothyroxine 125 mcg, Loratadine 10 mg, Omeprazole DR 20 mg tablet, Phenytoin Sodium extended release 300 mg, Senokot-S 8.6 - 50 mg, Budesonide 0.5 mg/2 mL, and Hydrocortisone 2.5% lotion daily at 8:00 a.m. c. Client #3 was to receive Ammonium lactate 12% lotion, Chlorthalidone 12.5 mg, two Cranberry tablets, Fluoxetine HCL 15 mg, 1 gas relief chew, Lisinopril 5 mg, Metoprolol Tartrate 25 mg, 17 g of polyethylene glycol powder, Risperidone 0.5 mg, Seoexon-S 2 tablets, Tramadol HCL 100 mg, and Vitamin D 1,000 unit 3 tablets at 8:00 a.m.	W 375		

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W 375	Continued From page 57 d. Client #4 was to receive Artificial Tear Drops in each eye, Centrum Multivitamin-Mineral 7.5 ml, 900 mg Cranberry tablets, Docusate Sodium 10 ml, Glycopyrrolate 1 mg, Milk of Magnesia Suspension two tablespoons, Phenobarbital 15 ml, Phenytoin 4 ml, Prednisolone 10 ml, Ranitidine 20 ml, Vitamin D 400 unit tablet, Benzoyl Peroxide 10% wash, Benzoyl Peroxide 5% gel, Cetaphil Moisturizing lotion, Nystatin 100,000 ointment, and Salicylic Acid 6% foam wash daily at 8:00 a.m. e. Client #5 was to receive Diphenhydramine 25 mg, Lorazepam 1 mg, and Risperidone 2 mg at 7:00 a.m Client #5 was to receive Benecalorie Liquid 7.5kcal/mL, Cephalexin 1000 mg, Cetirizine HCL 10 mg, Erthromycin 0.5% opthmalic ointment, Famotidine 20 mg, gas relief softgel 250 mg, Lamotrigine 150 mg, Lisinopril 5 mg, Milk of Magnesia suspension 30 ml, Quetiapine Fumarate 100 mg, Senexon-S 3 tablets, and Trihexphenidyl 2 mg at 8:00 a.m. f. Client #6 was to receive Clonidine HCL 0.2 mg, Fluticasone Prop 50 mcg spray, Loratadine 10 mg, and Denta 5000 Plus cream at 8:00 a.m. g. Client #7 was to receive Fluvoxamine Maleate 50 mg, Levetiracetam 1500 mg, Quetiapine Fumarate 100 mg, Topiramate 200 mg, Valproic Acid 500 mg, and Vitamin D3 1000 unit at 8:00 a.m. h. Client #8 was to receive Carbamazepine 600 mg, Clonazepam 0.5 mg, Escitalopram 5 mg, Lamotrigine 100 mg, Oxybutynin 10 mg, Risperidone 1 mg, and Trihexyphenidyl 2 mg at 8:00 a.m.	W 375		

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W 375	Continued From page 58 DSSP/CMA A signed Client #1 - #8's MAR as all medication were given. The record lacked completed GER's for Client #1 - #8 receiveing all morning medications outside of the scheduled timeframe. Review of facility policies revealed the policy "Medication Supports", last revised 1/1/15. The policy instructed all medications were to be given according to the six rights which included the right person, right medciation, right route, right time, right does, and right charting. The policy continued to instruct "In the event of true medication errors or adverse drug reactions, a GER report will be completed in Therap by the person finding the error, and the provide notified by completing a med error fax form ....True medication errors are defined as giving the wrong medication at the wrong time or to the wrong person. When interviewed on 1/8/20 at 2:30 p.m., the Associate Director (AD) confirmed a GER should have been completed on 1/4/20 for Client #1 - #8 after all morning medications were given late. She stated it was a true medication error for any medication given outside the one hour before or after the scheduled medication time.	W 375		
W 440	EVACUATION DRILLS CFR(s): 483.470(l)(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	W 440	W440 Evacuation Drills All drills will be put on the monthly schedule to ensure each shift conducts an evacuation drill quarterly. A Direct Support Associate will be assigned to complete the drill on the specific shift that it is assigned. The drills will be completed monthly and documentation will be submitted to the DSS. The DSS will submit to the Program Manager who will track all drills. Safety committee will review all drills monthly to ensure adherence to the requirements.	

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
	16G016	A. BUILDING _____ B. WING _____	C 01/22/2020

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 440	Continued From page 59 failed to ensure quarterly (every 90 days) fire drills were conducted on each shift. This potentially affected 8 of 8 clients (Client #1 - #8) who resided in the facility. Finding follows: Record review on 1/7/20 revealed facility fire drills completed January 2019 - December 2019. Fire drills on the third shift were conducted on 3/27/19, 6/28/19, and 9/26/19. The record lacked any third shift drill completed between October 2019 and December 2019. When interviewed on 1/14/20 at 8:45 a.m., the Associate Director (AD) confirmed the facility failed to ensure a fire drill was completed on the third shift between October 2019 and December 2019.	W 440	Person(s) Responsible: DSS (Direct Support Supervisor) Program Manager	03-15-2020