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 09/03/2020

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 investigation of #89772-C resulted in a deficiency cited at W368. No deficiencies were cited related to the on-site Infection Control Survey completed 9/03/20, but the following concerns were noted: - The facility had another employee take co-workers temperatures as a screening process for staff as they came into work, but they did not document staff temperatures or implement a screening questionnaire. - During an observation on the afternoon of 9/01/20, a staff person and client began to unload clean dishes from the dishwasher without first washing/sanitizing their hands. The revisit of the annual survey resulted in deficiencies being re-cited at W159 and W440. The other deficiencies cited during the survey had been corrected.	W 000	POC 11/1/20	
W 159	QIDP CFR(s): 483.430(a) 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 facility failed to ensure the Qualified Intellectual Disability Professional had adequate training and effectively performed her job duties. This affected 2 of 2 sample clients (Client #2 and Client #4) and potentially the other three clients residing at the facility (Client #3, Client #5 and Client #6). Finding follows: 1. Record review on 9/02/20 revealed recent	W 159	Mosaic will ensure each client's active treatment program is integrated, coordinated and monitored by a qualified intellectual disability professional. The QIDP will be re-trained on completing data summaries monthly on all programs. The QIDP will complete the data summary then notify the supervisor(s) to review and make additional notes as necessary. The QIDP will report completion of the data summary to the Associate Director each month. The Associate Director is responsible for monitoring the QIDP's work. People responsible: QIDP, Associate Director Date Completed: 11/01/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Kay Hall	Associate Director	10-23-2020

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.

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 09/03/2020

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 159	Continued From page 1 monthly data reviews of client programs for Client #2 and Client #4 could not be located in their electronic charts. When interviewed on 9/02/20 at 2:00 p.m. the Qualified Intellectual Disability Professional (QIDP) said she was fairly new to the position and had not completed any data reviews of client programs. The previous QIDP left the agency in February 2020. The QIDP stated the only programs she had revised in the past several months were client behavior support programs (BSP). She added the use of deep pressure tactile interventions to Client #2 and Client #4's BSPs in April 2020. There were no data reviews for any of the client programs for at least the past six months to determine whether or not the clients were making progress on any of their programs. The QIDP indicated she had previously been a House Manager and had not had much training when she became the QIDP for the four ICF/IID homes. She also continued to be responsible for House Manager duties off and on over recent months, which took up much of her time. When interviewed on the afternoon of 9/02/20, the Associate Director confirmed data reviews/summaries of client programs had not been done since at least February 2020, when the previous QIDP left the agency. Upon additional review of Client #2 and Client #4's electronic records, the Associate Director located the last data reviews completed for the clients. The program data review was completed by the previous QIDP in January 2020 for the months of November and December 2019. No program reviews had been conducted for the past eight months.	W 159		

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 09/03/2020

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 159	Continued From page 2 2. Record review on 9/02/20 revealed Client #4's BSP, which listed target behaviors of biting objects, biting others, aggression, psychotic disorder behaviors, Pica (ingestion of non-edibles) and exiting bedroom without staff knowledge. Self-injurious behavior and food stealing were not listed as target behaviors, which meant those behaviors were not tracked/monitored. The teaching methods section of the BSP noted Client #4 had a history of food stealing, including taking food from others, off of the table or floor or from the kitchen. Client #4 was on a pureed diet, but had a history of taking and ingesting food that was regular texture. The BSP provided information to staff regarding ways to try to prevent the food stealing. The BSP also indicated staff should block self-injurious behavior, including head banging. A review of General Event Reports (GERS) from April to August 2020 revealed multiple incidents when Client #4 displayed self-injurious behavior (including biting self, hitting self and banging head on hard objects) and two incidents when Client #4 grabbed regular texture food items from the trash can and consumed them. Client #4 vomited after an incident of eating regular texture pizza. When interviewed on 9/02/20 at 2:00 p.m. the QIDP acknowledged Client #4's BSP didn't include objectives to address self-injurious behavior or food stealing/inappropriate food acquisition. She agreed those behaviors were problematic for Client #4 and should have been included in the target behavior objectives.	W 159		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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 09/03/2020

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 368	Continued From page 3 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure medications were consistently given in compliance with physician's orders. This affected 1 of 1 client identified during the investigation of #89772-C (Client #1). Finding follows: Record review on 9/02/20 revealed General Event Reports (GERS) dated 2/22/20 and 2/23/20, indicating Client #1 did not receive her medications on the morning of 2/22/20 due to no staff person showing up to pass morning medications and Client #1 refusing her morning medications on 2/23/20. The morning medications included medications for a seizure disorder. Client #1 had three documented seizures on 2/23/20 and went to the Emergency Room. Her family opted to take Client #1 to their family home for an extended visit in the late afternoon of 2/23/20. Client #1 was 33 years old with a diagnosis including moderate intellectual disability, epilepsy and recurrent seizures, intermittent explosive disorder and bipolar disorder. Client #1 was admitted to the facility on 10/15/19. According to the 30-day Individual Support Plan (ISP) completed 11/12/19, Client #1 had a history of seizures. The ISP noted Client #1's history of seizures was discovered after her admission to the facility and the facility had followed up with a neurology appointment. Client #1 had a program to request her medications at appropriate times.	W 368	For immediate resolution following the incident staff were instructed to contact a supervisor any time an employee does not arrive to their scheduled shift and/or does not arrive at the home for medication administration. Completed: 10/13/20 Mosaic will ensure a system for drug administration that assures all drugs are administered in compliance with the physician's orders. In addition, staff will review the Medication Supports policy which indicates: All employees or independent contractors working directly with people receiving services are responsible for knowing what medication a person takes, what it is for, scheduled times and what possible side effects might be. All staff will be given access to the E-MAR in Therap. This will be reviewed with staff through new hire training and periodically through Medication Administration Observations. Staff will also review the Scheduling policy which states staff must call a supervisor if the person scheduled to work does not arrive at the home as scheduled. The DSS is responsible to ensure a Certified Medication Assistant (CMA) or nurse is scheduled to pass medications at all medication administration times. The Direct Support Supervisor will review the Attendance and Scheduling policy and Medication Supports policy with staff. The Nursing Supervisor and Associate Director will review any medication errors and make recommendations for correction. In addition, nursing personnel will review the Medication Supports policy to ensure they asses the need to contact a physician for potentia side effects when a medication error is reported to them.	

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 09/03/2020

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 368	Continued From page 4 The program indicated Client #1 would set her alarm for 8:00 a.m., 12:00 p.m. and 8:00 p.m. to remind her it was time for her medication. A GER dated 2/22/20 noted the Program Manager was notified by staff at 9:49 a.m. that the medication passer had not shown up to pass morning medications. The Program Manager notified the on-call nurse. The on-call nurse determined the 8:00 a.m. medications could not be given due to the 2 hour window protocol (medications must be given within two hours of the scheduled time). According to the GER, staff were advised in the future to contact a supervisor within 15 minutes of the scheduled medication pass if the med passer did not show up. The GER indicated Client #1 did not receive her morning medications on 2/22/20, which included three seizure medications (Carbamazepine 600 mg, Clonazepam 0.5 mg and Lamotrigine 100 mg). Client #1's Medication Administration Record (MAR) was blank for 8:00 a.m. medications on 8/22/20. According to the MAR, Client #1 did receive her 7:00 p.m. medications on 2/22/20, which included the three seizure medications. A GER dated 2/23/20 noted Client #1 had been behavioral that morning and refused her morning medications. There was no documentation the facility nurse or a supervisor had been notified that Client #1 was refusing her medication. At approximately 9:30 a.m. Client #1 had a seizure, as evidenced by shaking, foaming at the mouth, and lips turning purple. The seizure lasted approximately 30 seconds and then Client #1 appeared to be in a deep sleep. Staff called 911, as well as the on-call nurse, Nurse Manager and the House Manager. The ambulance arrived and	W 368	People Responsible: Direct Support Supervisor, Associate Director, Nursing, Direct Support Associates. Date Completed: 10/13/20	

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 09/03/2020

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 368	Continued From page 5 transported Client #1 to the emergency room. The agency also contact Client #1's parents regarding the incident. Staff documented on the GER they left the ER to bring Client #1 back to the facility at approximately 1:00 p.m. and Client #1 had another apparent seizure on the agency van about 10 minutes after leaving the hospital. The seizure lasted 10-15 seconds. Staff contacted the hospital regarding the seizure and was told Client #1 should be fine since she had received seizure medication at the ER. Client #1's MAR for the 8:00 a.m. medication on 2/23/20 indicated the medications had been refused. A second GER dated 2/23/20 noted Client #1's parents arrived in the afternoon to take her for a home visit. While the parents were present, Client #1 appeared to have another seizure at 4:20 p.m., lasting about two minutes. Staff notified the Nurse Manager and took vital signs. The Nurse Manager arrived to assess Client #1 and speak with Client #1's parents. Client #1 left with her parents at approximately 5:00 p.m. for an extended home visit. When interviewed on 9/03/20 at 9:45 a.m. the Nurse Manager stated the on-call nurse who had worked on 2/22/20 and 2/23/20 had since passed away. The Nurse Manager said regarding the missed morning medications on 2/22/20, she would have either approved giving them late and/or tried to contact the physician, had she been the nurse notified of the situation. The Nurse Manager said Client #1 had been admitted to the facility in October 2019 and the family did not indicate a history of seizures. Client #1 wasn't taking seizure medication upon admission. Client #1 had seizure activity in November 2019 and the facility then discovered there was as history of	W 368		

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 09/03/2020

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 368	Continued From page 6 seizures. Client #1 began taking seizure medication in November and there were no further seizures until the incidents on 2/23/20. The Nurse Manager acknowledged the on-call nurse should have attempted to contact the physician on 2/22/20 to see whether the 8:00 a.m. medications could be given late. The medication passer on the morning of 2/23/20 should have contacted the on-call nurse to inform her Client #1 was refusing to take her 8:00 a.m. medications.	W 368		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold quarterly first shift fire drills. This potentially affected 5 of 5 clients residing at the facility from April 2020 through August 2020 (Clients #2-#6). Finding follows: Record review of agency fire drills on 9/01/20 revealed a first shift fire drill conducted in April 2020, a second shift fire drill conducted in May, a third shift fire drill conducted in June and a second shift fire drill conducted in August. There was no documentation of a fire drill held in July 2020. During interview on 9/01/20 at 3:50 p.m. the Associate Director confirmed the facility should have held a first shift fire drill in July 2020, but it had not been done.	W 440	Mosaic will hold evacuation drills at least quarterly for each shift of personnel. The Direct Service Supervisor (DSS) is responsible for assigning staff to complete drills. The DSS will submit the completed fire drill form to the Associate Director (AD) for review. Upon review the AD will verify the completed drill follows the annual schedule for all fire and tornado drills by shift by quarter. The AD is responsible for directing the DSS to conduct additional drills to remain in compliance. A Safety Committee reviews all drill completion monthly. The Executive Director (ED) will monitor compliance of drills through Safety Committee Meeting Minutes. People Responsible: Direct Service Supervisor, Associate Director, Executive Director Date Completed: 11/01/20	