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

PRINTED: 01/22/2021
FORM APPROVED
OMB NO. 0938-0391

OK 1/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G113	A. BUILDING ______ B. WING ______	C 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A Focused Infection Control Monitoring Visit was completed on 11/3/20. At the time of the Focused Infection Control Monitoring Visit no deficiencies were cited.	W 000	POC 7/6/20	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff reported potential abuse according to established policies and procedures. This affected 2 of 2 clients identified as a result of investigations #87052-I (Client's #1 and #2). Findings Follow: Record review on 11/2/20 revealed an Investigation Summary Report dated 8/26/20. The investigation was for an incident occurring at another ICF/IID home; however, while being interviewed on 8/29/19 at 1:20 p.m. Direct Support Supervisor (DSS) A also reported she witnessed inappropriate interactions by Direct Support Associate (DSA) A with Clients #1 and Client #2 at Mosaic - 217 Maple home. She stated on 8/13/19 she witnessed DSA A use a table to block an entrance to keep Client #1 out of the kitchen. He also used two hands to physically push Client #1 back into a chair when he attempted to stand up. It was also reported he	W 153	W153 STAFF TREATMENT OF CLIENTS The facility will ensure that all allegations of mistreatment, neglect or abuse as well as injuries of an unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures. Staff will report potential abuse according to policies and procedures. Specifically, all staff will be trained on the Adult Abuse and Reporting Reasonable Suspicion of a Crime in Long Term Care Facilities policy. This will be monitored through routine supervisor observations in the home. Person(s) Responsible: Program Manager	07/06/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Bretthauer (Digitally signed by Brandi Bretthauer; Date: 2021.01.22 17:15:10 -06'00')	Executive Director	1/22/21

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 153	Continued From page 1	W 153		

used physical prompts to push Client #2 back down in her wheelchair when she attempted to stand. Further review of the investigation summary revealed these allegations were not reported to administration or the state agency until a separate investigation at a different house on 8/26/19.

Record review on 11/2/20 revealed a written statement provided to the facility by DSS A. The statement noted on 8/13/19 she witnessed DSP A physically block Client #1 with two hands on his shoulders. She stated DSP A pushed him back into a chair in the living room, blocking him from getting up. She also witnessed DSP A use a table to block Client #1 from entering the kitchen. The statement further documented DSP A physically used two hands to push Client #2 back into her wheel chair when she attempted to stand.

Record review on 11/2/20 revealed the facility's abuse policy, last approved 6/28/18, instructed staff to immediately separate the alleged abuser and the individual served. The policy further directed, "All employees are required to report any apparent abuse or neglect, the name of the alleged perpetrator, the name of the dependent adult to their direct support or independent contractor program supervisor, program manager, habilitative manager, associate director, or executive director. Reports are to made immediately after they occurred or the staff member became aware of the incident. Reports of suspected abuse must be made immediately."

When interviewed on 11/2/20 at 11:45 a.m. the Associate Director (AD) confirmed DSS A should have reported the alleged mistreatment of Client #1 and Client #2 immediately. She stated DSS A

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W 153	Continued From page 2 had been trained on the abuse policy and all staff were retrained after the incident. The AD stated this incident was discovered during another investigation involving DSP A and another home he worked in. She stated DSP A was terminated by the facility for verbal interactions and not following facility policy of treating clients with dignity and respect.	W 153		