

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 1016		Date: June 29, 2021		
Facility Name: Mosaic – 102 Kelly’s Court		Survey Dates: April 5 – April 21, 2021		
Facility Address/City/State/Zip 102 Kelly’s Court Forest City, IA 50436		#96879-I & #96837-I		
LK				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

64.60	481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations,” to enforce a fine to cite a facility. This rule is intended to implement Iowa Code Section 135C.2(3).	II	\$500.00	Upon Receipt
64.33	481—64.33(135C) Allegations of dependent adult abuse. 64.33(1) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481-Chapter 52 (I,II,III)			
52.2	481—52.2(235E) Persons who must report dependent adult abuse and the reporting procedure for those persons			

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235E	<p>52.2(2) Reporting suspected dependent adult abuse in facilities or programs a. If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the person’s designated agent who shall then notify the Department within 24 hours of such notification or the next business day.</p> <p>Iowa Code section 235E.2(3)(a) 3. a. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person’s designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours.</p>			
W153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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</p>			

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	<p>officials in accordance with State law through established procedures.</p> <p>DESCRIPTION: Based on interview and record review, the facility failed to report an allegation of abuse/mistreatment to the appropriate state agency (Department of Inspections and Appeals). This affected 1 client identified during the investigation of #96879-I (Client #1). Finding follows:</p> <p>Record review regarding a separate incident revealed when the facility conducted an investigation involving Direct Support Associate (DSA) E, they learned of additional staff concerns regarding DSA E. During her facility interview on 2/05/21, DSA F spoke of an incident that occurred on 12/21/20. She reported Client #1 returned from a visit with his father around 6:30 p.m. on 12/21/20. DSA E guided Client #1 to his room and told him to go to bed. DSA E did not allow Client #1 to leave his room for a period of time and kept telling him to go to bed. Client #1 came out of his room later in the evening for a snack. DSA F said she reported the incident the same evening to the supervisor. Additional record review revealed no General Event Report</p>			
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	<p>regarding this incident could be located in Client #1's chart.</p> <p>When interviewed on 4/07/21 at 4:05 p.m. the Associate Director(AD) said no supervisor informed management staff of the allegation made by DSA F regarding the incident on 12/21/20. She stated the supervisor should have reported it to management staff. The facility management staff first heard of the allegation on 2/05/21 when conducting an investigation regarding another incident involving DSA E. The AD acknowledged the facility did not investigate the allegation regarding the incident on 12/21/20 or report it to the Department of Inspections and Appeals (DIA). The AD stated, "That's a problem."</p> <p>During a follow-up interview on 4/08/21 at 8:45 a.m. the AD reported she reviewed the incident with the agency Executive Director and they determined the facility didn't need to conduct a formal investigation or report the incident to DIA because it was not an allegation of abuse. The AD said it was her understanding that DSA E told Client #1 to stay in his room, but did not physically block his egress from the room. He came out of his room later in the evening for a snack. The AD said management staff questioned</p>			
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	<p>Direct Support Supervisor (DSS) A about the incident when they learned of it in February 2021. DSS A said she checked into the allegation at the time and found no evidence of abuse. The AD provided a hand written summary written by DSS A dated 12/30/20 regarding the incident. DSS A wrote DSA F made the allegation on 12/27/20 that DSA E had blocked Client #1 from leaving his room. DSS A noted she talked with DSA E on 12/29/20 and she denied the allegation. DSS A indicated she spoke with DSA E regarding clients having the right to have freedom of movement in their home. DSS A provided the summary to the AD on or around 4/08/21.</p> <p>When interviewed on 4/08/21 at 10:45 a.m. DSS A stated she recalled DSA F told her of the 12/21/20 incident on 12/27/20. DSA F told DSS A that DSA E stood in front of Client #1's door to block him from leaving his room. DSS A said she asked DSA E about the incident and she denied it. DSS A said she felt like she addressed the situation. She said she told the Program Manager about the incident around the time it occurred. DSS A said she wrote a summary of the incident on 12/30/20, but hadn't shared the written summary with management staff until she gave it to the AD-ICF on 4/08/21.</p>			
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	<p>When interviewed on 4/09/21 at 11:00 a.m. the Program Manager said she was new to her role at the time of the incident in late December 2020. She said she didn't recall DSS A telling her about the incident regarding DSA E keeping Client #1 in his room. The AD was also present for the interview and said they didn't believe DSA E could have physically blocked Client #1 in his room if he didn't want to stay there. DSS A talked with both staff about the incident around the time it happened. The facility didn't report it to DIA. The surveyor encouraged the facility to report the allegation of abuse to DIA as soon as possible.</p> <p>When interviewed on 4/12/21 at 2:10 p.m. DSA F stated she recalled the incident on 12/21/20 between DSA E and Client #1. DSA F said Client #1 had returned from a family outing around 6:30 p.m. DSA E guided Client #1 to his room, which was typical when he returned from outings to see if he needed to be changed. DSA F then heard DSA E yelling at Client #1 to go to bed. Client #1 typically did not go to bed so early in the evening. DSA E stood in Client #1's doorway and blocked the client from leaving his bedroom. DSA F saw Client #1 try to leave the room, but DSA E blocked him with her body and arms. DSA E told Client #1 to go to bed and pointed at his bed. DSA F said DSA E blocked Client #1's doorway</p>			
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64.33	<p>and prevented him from leaving for several minutes. DSA E later checked on Client #1 and saw him lying on his bed. He later left his room to come out for an evening snack. DSA F said she called a supervisor to report the incident.</p> <p>The agency Abuse, Neglect and Exploitation policy noted all people supported should be treated with dignity and respect. According to the policy immediate action should be taken to ensure the client is protected from further harm. The incident should be immediately reported and the agency should follow the notification expectations for state regulatory agencies. Any suspected incident of abuse, neglect or exploitation must be documented utilizing a General Event Report. A facility investigation should be initiated immediately upon receipt of an allegation.</p> <p>481-64.33(2)(135C)Separation of accused abuser and victim. Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the department’s abuse investigation is completed and abuse determination is made</p>	II	\$500.00	
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W155	<p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>Based on observation, interview and record review, the facility failed to separate an alleged perpetrator from the client he reportedly mistreated. This affected 1 client identified during the investigation of #96837-I (Client #1). Finding follows:</p> <p>Observation on 4/06/21 at approximately 7:00 a.m. revealed Client #4 told Direct Support Associate (DSA) A DSA H grabbed Client #1 and dragged him down the hallway the night before. Client #4 demonstrated a grabbing motion above his wrist. Approximately 7:30 a.m. Client #4 again indicated DSA H had grabbed Client #1's arm and dragged him to his room. DSA A promptly reported the allegation to a management staff by phone.</p> <p>Observation on 4/06/21 at 3:16 p.m. revealed DSA H working at the facility with Client #1. DSA H remained at the facility until the surveyor left at approximately 4:25 p.m.</p> <p>During interview on 4/06/21 at 3:20 p.m. the Associate Director (AD) said the facility looked into an allegation of abuse that reportedly</p>			
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	<p>occurred at the facility on the evening of 4/05/21. She indicated the alleged incident on the evening of 4/05/21 happened during the time period when Client #1 returned from a visit with his father. The AD stated Client #1 typically had difficulty with returning to the facility after an outing with his father. When asked why DSA H had not been separated from working with Client #1, the AD said a facility investigator had talked with Client #1's father and determined abuse had not occurred.</p> <p>On 4/06/21 at 4:10 p.m., the AD provided a summary of a conversation with Client #1's father dated 4/06/21 and written by the Program Manager. According to the written summary, Client #1's father brought him back to the facility around 7:00 p.m. on 4/05/21. Client #1 did not want to exit his father's vehicle, so his father and step-mother physically assisted him from the vehicle to an agency wheelchair. Client #1's father said they got Client #1 inside the facility door and he then left. Client #1's father indicated he was not present in the facility after Client #1 went inside.</p> <p>During interview on 4/06/21 at approximately 4:35 p.m. the surveyors explained to the AD the allegation made by Client #4 was regarding what</p>			
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	<p>occurred after Client #1 went into the facility from his family outing, not what transpired outside the facility. The AD acknowledged the facility had not thoroughly investigated the allegation that DSA H grabbed Client #1 and dragged him down the hallway. She said she thought Client #1's father had been present for the entire interaction. The AD called the facility and asked them to immediately separate DSA H from Client #1 at approximately 4:45 p.m.</p> <p>The agency Abuse, Neglect and Exploitation policy noted all people supported should be treated with dignity and respect. According to the policy immediate action should be taken to ensure the client is protected from further harm.</p> <p>FACILITY RESPONSE:</p>			
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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 1016		Date: June 29, 2021		
Facility Name: Mosaic – 102 Kelly’s Court		Survey Dates: April 5 – April 21, 2021		
Facility Address/City/State/Zip 102 Kelly’s Court Forest City, IA 50436		#96879-I & #96837-I		
LK				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

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Facility Administrator

Date

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