Citation Numl 5372	per:			Date: Sept	ember 7, 2021
Facility Name Mosaic East 4			Survey I July 7, 2	Dates: 2021 – July 29,	2021
Facility Addre 3114 E 42 <sup>nd</sup> St Des Moines, I					
Des momes, i	0wa 30317	LK	Survey a	and #98362-I	
Rule or Code Section	Natur	e of Violation	Class	Fine Amoun	t Correction date
64.60	conditions of particle CFR Part 483, Subpa- 480 effective October reference and incorr rules. A copy of the on request from the Department of Inspe- Lucas State Office E 50319. Classification of vio determined by the d in 481-Chapter 56, F enforce a fine to citer This rule is intended Section 135C.2(3). DESCRIPTION:	to implement Iowa Code	1	\$10,000.00	Upon Receipt
W158	The facility must en staffing requirement	sure that specific facility ts are met.			
	facility failed to compl Participation (COP) F failed to ensure staff	and record review, the y with the Condition of acility Staffing. The facility were adequately trained on procedures to competently			

Facility Administrator

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Facility Name:			Survey	Dates:		
Mosaic East 42	2 <sup>nd</sup> Street			2021 – Jul	ly 29, 20	21
Facility Address/City/State/Zip 3114 E 42 <sup>nd</sup> St. Des Moines, Iowa 50317						
		LK	Survey	and #9830	62-I	
Rule or Code Section	Natu	re of Violation	Class Fine Amount Correction date			Correction date

W189The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.Based on interviews and record reviews, the facility failed to consistently ensure staff were adequately trained to perform the essential functions of their job at a level which promoted the best possible outcomes for the individuals served. This affected 1 of 1 individuals involved in 98362-1 (Client #1). Findings follow:Record review revealed a facility investigation dated 7/1/21. The investigation indicated shortly after 5:00 a.m. on 6/25/21 Direct Support Associate (DSA) A and DSA B found Client #1 in bed unresponsive. The report indicated staff attempted to call their supervisor who did not answer the phone. Staff then called 911 where they were instructed to initiate CPR and use the AED machine in an attempt to revive the client.		and consistently respond to client medical situations and communicate client needs to appropriate medical personnel.		
facility failed to consistently ensure staff were adequately trained to perform the essential functions of their job at a level which promoted the best possible outcomes for the individuals served. This affected 1 of 1 individuals involved in 98362-I (Client #1). Findings follow: Record review revealed a facility investigation dated 7/1/21. The investigation indicated shortly after 5:00 a.m. on 6/25/21 Direct Support Associate (DSA) A and DSA B found Client #1 in bed unresponsive. The report indicated staff attempted to call their supervisor who did not answer the phone. Staff then called 911 where they were instructed to initiate CPR and use the	W189	initial and continuing training that enables the employee to perform his or her duties		
dated 7/1/21. The investigation indicated shortly after 5:00 a.m. on 6/25/21 Direct Support Associate (DSA) A and DSA B found Client #1 in bed unresponsive. The report indicated staff attempted to call their supervisor who did not answer the phone. Staff then called 911 where they were instructed to initiate CPR and use the		facility failed to consistently ensure staff were adequately trained to perform the essential functions of their job at a level which promoted the best possible outcomes for the individuals served. This affected 1 of 1 individuals involved		
DSA A performed CPR on Client #1 while he laid		dated 7/1/21. The investigation indicated shortly after 5:00 a.m. on 6/25/21 Direct Support Associate (DSA) A and DSA B found Client #1 in bed unresponsive. The report indicated staff attempted to call their supervisor who did not answer the phone. Staff then called 911 where they were instructed to initiate CPR and use the AED machine in an attempt to revive the client.		

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Des montes, towa 30317		LK	Survey a	and #98362-I	
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

<ul> <li>in his bed. Shortly after arrival the paramedics informed staff Client #1 passed away. The investigation further revealed DSA A and DSA B failed to follow "Change of Condition" protocol when they called their supervisor before 911. The investigation also indicated staff failed to move the client to the floor to perform CPR, but rather attempted it while the client remained on his bed.</li> <li>Record review revealed Client #1 was 42 years old and diagnosed with mild intellectual disabilities. Some additional diagnoses included, but were not limited to: spastic quadriplegic, cerebral palsy, GERD, disease of the stomach and duodenum, intestinal obstruction, constipation, tachycardia, dysphagia, severe sepsis without septic shock, hypoglycemia and colostomy.</li> <li>Record review revealed a Death Certificate, dated 7/8/21, listed aspiration/probable small bowel obstruction as the cause of death.</li> <li>1. Record review revealed a policy for "Safety and Protection," last revised 2/22/21. The policy indicated in an ICF/ID setting overnight employees would check on each person at least hourly. The policy further indicated ISP's would</li> </ul>		
		Page <b>3</b> of <b>2</b>

Facility Administrator

Date

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3114 E 42 <sup>nd</sup> St.						
Des Moines, Ic	owa 50317	LK	Survey	Survey and #98362-I		
			Surveya	anu #90302-i		
Rule or		<u>II</u>		Fine Amount	Correction	
Code	Natu	re of Violation	Class		date	
Section						

designate additional supports as needed. Review of Client #1's ISP Plan, dated 8/31/20, revealed the client needed to be checked every 30 minutes for safety and supervision.		
When interviewed on 7/7/21 at 11:30 p.m. DSA A confirmed she worked the NOC (overnight shift) on the night of 6/24/21 to 6/25/21. The DSA reported when she came on duty around 11:00 p.m. on 6/24/21 she was informed by staff on the previous shift the client had a few episodes of		
emesis. The DSA stated she checked on the client every hour as she was supposed to that night. The DSA confirmed her supervisor told her to keep a "close eye," but did not explain he needed to be monitored more than once per hour.		
The DSA revealed Client #1's bedroom was in the back of the house and indicated she and DSA B sat in the front of the home all night in the living room area. When she checked the client at 5:00 a.m. she found him warm and unresponsive.		
DSA A stated she tried to wake the client up, but did not check his pulse. The DSA confirmed she called her supervisor right away and when he did not answer she called 911 where she was told to perform CPR and use the AED machine. The		
DSA confirmed she performed CPR and used the AED with the client on his bed for several minutes until the EMT's arrived who moved the client to		Page 4 of 2

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	n	
the floor and attempted CPR. The DSA stated shortly after this the EMT's informed her the client had passed away.		
When interviewed on 7/8/21 at 12:02 a.m. DSA B also confirmed he worked the same shift with DSA A. DSA B confirmed he was made aware Client #1 was sick and they were to keep an eye on him. The DSA stated they completed the		
usual check of once per hour. The DSA was not aware checks needed to be completed more often than every hour.		
When interviewed on 7/8/21 at 12:12 a.m. the NOC Direct Support Supervisor (DSS) confirmed he worked the overnight shift on 6/24/21 with DSA A and DSA B. The DSS indicated he visited		
the house but was responsible for several houses and visited each one. The DSA confirmed when he came on shift he was informed Client #1 vomited three times during the previous shift and		
was told to have his staff keep a close eye on the client by the DSS. The NOC DSS stated regular checks on Client #1 were at hourly intervals, but when he told staff to keep a close eye on the client that meant more often than hourly. When		
asked how often that would be he said maybe more like 30 minutes, but confirmed he never told staff every 30 minutes. The NOC DSS confirmed		Page 5 of 2

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he believed regular checks on the client were 60 minutes and did not know his ISP indicated checked needed to be done every 30 minutes under regular circumstances.		
When interviewed on 7/19/21 at 2:34 p.m. the Qualified Intellectual Disabilities Professional (QIDP) confirmed Client #1's supervision at the time of his death was every 30 minutes for safety and supervision. The QIDP confirmed he did not know why the client needed 30 minute checks when the majority of the clients in the home were on 60 minute checks. The QIDP guessed it was some previous health concern from before he took over two years ago. The QIDP indicated the supervision level should have been updated and accurate in the ISP, but confirmed at the time of his death he should have been checked on every 30 minutes when healthy and more often when sick.		
When interviewed on 7/8/21 at 10:00 a.m. RN A confirmed she was informed Client #1 vomited around 4:15 p.m. on 6/24/21. The RN stated she visited with the client in his bedroom and did an assessment of the client around 4:30 p.m. The RN admitted she did not document the assessment and confirmed she should have. When asked why Client #1 had 30 minute		

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	supervision the RN stated she was not sure why he needed it. She stated when she left she bassed care of the client to the on-call nurse and instructed them to isolate the client due to bossible Covid and monitor him. When asked what "monitor him" meant she indicated it meant check on him more often than every 30 minutes. 2. Record review revealed a policy for "Change of Condition" (COC), last revised 3/2/20. The bolicy indicated "Mosaic will ensure that all berson working with people served, as well as supervisors, are trained and empowered to seek medical attention immediately if the situation deemed it so." The document further revealed "In the case of a medical emergency Mosaic employees and contractors will not hesitate to call 911 immediately." The policy further directs staff to call 911 and initiate CPR if a client is unconscious. The policy stated staff will be trained on the policy during initial orientation and 'at least annually thereafter." When interviewed on 7/8/21 the Associate Director (AD) revealed DSA A last received COC training on 11/1/19 and DSA B last received training on 1/16/20. The AD confirmed the policy stated staff would be trained on COC at least		
6	annually and both staff were overdue.		Page <b>7</b> of <b>2</b>

Facility Administrator

Date

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	<ul> <li>When interviewed on 7/8/21 at 10:00 a.m. RN A confirmed staff should have checked Client #1's pulse and called 911 before they called their supervisor.</li> <li>3. Record review revealed a facility investigation dated 7/1/21. The investigation indicated staff (DSA A and DSA B) failed to move the client to the floor to perform CPR, but instead attempted CPR while the client remained on his bed.</li> </ul>		
W192	For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.		
	Based on interviews and record reviews, the facility failed to consistently ensure staff were adequately trained to ensure important medical information was communicated to appropriate medical personnel. This affected 1 of 1 individuals involved in 98362-I (Client #1) and one additional client from the annual survey (Client #5). Findings follow:		

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Rule or Code Section	Natu	re of Violation		Class	Fine Amou	nt Correction date	

	<ol> <li>Record review revealed a facility investigation dated 7/1/21. The facility investigation revealed Client #1 had an emesis in his bedroom at 3:55 p.m. when staff attempted to help him out of bed. The client was seen shortly after by his regular nurse RN A. Around an hour later at dinner time the client again had an emesis and staff notified the on-call nurse (Registered Nurse (RN) B). Around 8:30 p.m. or 9:00 p.m. Direct Support Associate (DSA) C heard the client gagging in his room. Shortly after DSA C reported the emesis to her co-worker DSA D (also a CMA) who passed on the information to the Direct Support Supervisor (DSS) just before 10:00 p.m. The DSS texted and called the RN B (the on-call nurse) around 10:00 p.m., but did not receive a response to the call or the text message. The investigation further revealed the next morning shortly after 5:00 a.m. on 6/25/21 DSA A and DSA B found Client #1 in bed unresponsive. Staff called their supervisor who did not answer before they called 911. EMT's arrived shortly after and pronounced Client #1 was 42 years old and diagnosed with mild intellectual disabilities. Some additional diagnosis (although not all inclusive) include Spastic quadriplegic, cerebral palsy, GERD, disease of the stomach</li> </ol>				
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constipation, Tachycardia, Dysphagia, Severe Sepsis without septic shock, hypoglycemia and colostomy. Record review revealed a Death Certificate dated 7/8/21 listed aspiration/probable small bowel obstruction as the cause of death.Record review of Client #1's ISP Plan dated 8/31/20 revealed the client communicated "very effectively" through facial expressions, vocalizations and eye gaze. The ISP further stated Client #1 would look at your right hand if he wanted to answer you with a yes, your left
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girlfriend with whom staff assisted him to plan dates with.		
Record review revealed a policy for Injuries and Incidents dated 11/17/20 which outlined the process for notification of medical personnel in the event of a medical concern. The policy indicated in an ICF/ID if staff identified a medical concern with a client they "must" call a nurse. If they did not receive a return call from the nurse they needed to call again in 5 minutes. If still no response from a nurse they needed to call a supervisor or designated on-call personnel until they reached someone. If a medical emergency staff are instructed to call 911 first and then call a supervisor.		
When interviewed on 7/8/21 at 10:00 a.m. RN A (Client #1's regular nurse) confirmed she completed an assessment of the client around 4:00 p.m. after being told he had an emesis and didn't feel well despite being busy with 2 other client problems. The RN stated she completed an assessment of the client and asked him how he felt. She reported the client stated he felt okay and she asked him if he would be okay if she went home as it was the end of her day. She noted the client said yes it was okay if she went home. The RN confirmed the client was a reliable		

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communicator. She then turned his care over to RN B who was the on-call nurse for the night. The RN admitted she failed to document her assessment of the client and stated she should have. When she left she told staff to isolate him due to potential Covid-19 and monitor him. When asked what "monitor him" meant she indicated it meant check on him at least every 30 minutes or less and report any further problems. When interviewed on 7/19/21 at 6:20 p.m. DSA C confirmed she was aware Client #1 had thrown up earlier in the shift while getting dressed. DSA C stated she didn't actually see Client #1 until after dinner as she had been in the front of the house working and he was isolated to his bedroom in the rear. DSA C stated around 8:45 p.m. (give or take 15 minutes) she was doing paperwork in the back of the home outside Client		
and he said yes. She said she had never seen him that sweaty before that night. Shortly after she heard him gagging he had 2 more small emesis. She stated he did not look like he felt well, so she stayed in the bedroom with him for		
the remainder of her shift at 11:00 p.m. During her time in the room with Client #1 she asked him		Page 12 of 2

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if he needed to go to the hospital 3 or 4 times. The client answered yes he felt he needed to go each time. She stated this was very unlike him as he never admitted being sick for fear of missing fun activities and hated going to the hospital. DSA C told DSA D about the client's self- assessment of needing hospitalization, then they both told the DSS on duty over the phone. DSA C reported the DSS indicated she didn't feel the client was really that sick and did not plan to send him to the hospital. DSA C stated she had only worked in the field 4 or 5 months and decided to defer to her supervisor who probably knew better than she did.		
When interviewed on 7/20/21 at 9:40 a.m. DSA D confirmed he worked the evening shift with DSA C on 6/24/21. He confirmed he was the Certified Medication Aide (CMA) in the house and was aware Client #1 had vomited three times during the shift. After the first emesis at 3:55 p.m. DSA D stated he took the clients vitals which were normal and RN (RN A) did an assessment of the client. He remembered the RN said keep checking on him and take his vitals. DSA D stated DSA C told him Client #1 reported he needed to go the hospital, so they called the DSS and told her over the phone. He stated he did not feel the client needed to go to the hospital in his		Page <b>13</b> of 2

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opinion because his vitals were okay and he didn't seem that sick. He told the overnight shift who took over at 11:00 p.m. about the client's illness and to keep a close eye on him. When interviewed on 7/20/21 at 10:35 a.m. the DSS confirmed and emphasized Client #1 was "very reliable" when asked questions and made clear distinctions between yes and no. The DSS stated she was aware of Client #1's emesis at 3:55 p.m. and at dinner time. She stated she was informed just before 10:00 p.m. by DSA C and DSA D of the client gagging and additional emesis around 9:00 p.m. The DSS stated she did not remember being told by staff that Client #1 stated he needed to go to the hospital. The DSS agreed that would be very important information to tell the on-call purse as the client was very		
agreed that would be very important information to tell the on-call nurse as the client was very reliable and often tried to cover up illness from staff so he wouldn't miss any fun activities. In		
another interview on 7/8/21 at 12:03 p.m. the DSS revealed she texted the on-call nurse (RN B) at 9:59 p.m. that the client had an additional small		
emesis and a temperature of 97.3. She stated RN B did not respond to the text message, so she called her at 10:01 p.m. and she did not answer.		
She confirmed the 10:01 p.m. phone call was her last attempt to communicate with RN B for the night and the only information she passed was		Page 14 of 2

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	the additional emesis and the client temperature			
	in her text message.			
	When interviewed again on 7/21/21 at 1:20 p.m.			
	RN A confirmed Client #1 was very competent			
	and could answer questions accurately and			
	reliably. She confirmed she has had many			
	conversations with the client about health and			
	sickness and admitted sometimes he tries to hide			
	illness from her in hopes of not missing out on			
	something fun. She further stated if Client #1			
	stated he was sick he was likely sick and his word			
	could be counted on, he knew what he was			
	talking about. The RN stated it should be considered a medical concern if the client said he			
	needed to go to the hospital. She stated at that			
	point nursing should have been notified in this			
	case when the client reported his need for			
	hospitalization. She further stated she believed if			
	either one of her PM Supervisors would have been notified the client said he needed to go to			
	the hospital they would have sent him. She			
	questioned whether the information was passed			
	onto a supervisor.			
	2. Record review on 7/27/21 of a facility incident			
	report dated 9/16/20 for Client #5 revealed she			
	was taken to the hospital after a possible choking			
	incident and emesis during dinner. The report			
U		1	1	Page 15 of 2

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		LK		Survey a	ind #98362-I		
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revealed further hospital test indicated the client was anemic with a hemoglobin count of 5.3 and in need of several units of blood and an antibiotic for potential pneumonia. Further test revealed larger amounts of stool, a distended bladder and eventually test found a GI bleed. Further review of the document revealed the DSS was with the client at the hospital on 9/16/20. The DSS informed RN B about the anemia. The RN then asked whether Client #2 had any recent black stools. The DSS informed the RN she called out to the house and staff confirmed recent black stools for Client #2. Record review of an elimination report from 9/1/20 to 9/16/20 for Client #2 revealed no blood in her stool. When interviewed on 7/28/21 at 10:50 a.m. the DSS confirmed she was at the hospital with Client #2 on 9/16/20. She stated while there she talked with RN B and told her about the diagnosis of anemia. She stated the RN immediately asked		
about black stools. The DSS stated she then called Client #2's house and talked with staff who confirmed the client had black stools recently on the overnight shift. The DSS informed the staff black stools indicated blood and it should have been reported right away. The DSS stated the staff indicated she did not know black stools were		

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Citation Numb 5372	er:			Date: Septem	nber 7, 2021	
Facility Name:		-	Survey I	Dates:		
Mosaic East 42	2 <sup>nd</sup> Street		July 7, 2	July 7, 2021 – July 29, 2021		
Facility Address/City/State/Zip 3114 E 42 <sup>nd</sup> St. Des Moines, Iowa 50317						
		LK	Survey a	and #98362-I		
				Fine Amount	Correction	
		e of Violation Class			date	
Section						

9/16/20. She stated staff needed to be trained to recognize and report any changes in stool immediately to nursing. She confirmed this information was crucial and was concerned staff did not know.		Page <b>17</b> of	
had black stools she would either send them to the Emergency Room (ER) if it was large or schedule an appointment for the next day if it was small amount. The RN indicated a hemoglobin of 5.3 is extremely low and stated the client must have lost a lot of blood before this incident on			
elimination record showed no presence of blood in stools for the client for at least 2 weeks before 9/16/20. The RN stated she was concerned staff failed to document the black stools and make a nurse aware. RN B stated if she knew a client			
confirmed she was the nurse on-call on 9/16/20 when Client #2 went to the hospital. She confirmed she asked the DSS about black stools when she found out about the anemia. The RN confirmed staff should have documented black stools when they were observed and notified a nurse immediately who would have started a T- Log. The RN reviewed the record on 7/28/21 and confirmed there was no T-Log completed and the			
likely blood and would report and document any changes in stool the next time it occurred. When interviewed on 7/28/21 at 9:40 a.m. RN B			

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Rule or Code Section	Natu	Nature of Violation         Class         Fine Amount		Correction date		

	When interviewed on 7/28/21 at 3:15 p.m. RN A confirmed she was the nurse regularly assigned to Client #2. She confirmed she was aware of Client #2's hospitalization 9/16/20 to 9/24/20. When asked if Mosaic identified the problem with staff not reporting the black stools and performed any additional training as a result she stated she was not aware of any trainings. RN A stated she did not know staff had failed to report any black stools until she was asked about it during her interview on 7/28/21. The RN stated staff needed to be trained to report any changes in stools with any clients to keep individuals safe.		
W318	The facility must ensure that specific health care services requirements are met.		
	Based on interviews and record review, the facility failed to comply with the Condition of Participation (COP) Health Care Services. Facility nursing staff failed to consistently document medical assessments and be available to respond to reports of change in medical conditions for clients assigned to their care.		

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W331	The facility must provide clients with nursing services in accordance with their needs.		
	Based on interviews and record reviews, the facility nursing staff failed to competently perform designated job duties, including consistent documentation of medical assessments and availability of nursing staff to respond to reports of change in medical conditions for clients assigned to their care. This affected 1 of 1 clients involved in 98362-I (Client #1).		
	Record review revealed a facility investigation, dated 7/1/21, revealed Client #1 had an emesis in his bedroom at 3:55 p.m. when staff attempted to help him out of bed. The client was seen shortly after by his regular nurse (Registered Nurse) RN A. Around an hour later at dinner time the client again had an emesis and staff notified the on-call nurse (RN B). Between 8:30 p.m. and 9:00 p.m. Direct Support Associate (DSA) C heard the client gagging in his room. Shortly after this DSA C reported the emesis to her co-worker DSA D (also a CMA) who passed on the information to the Direct Support Supervisor (DSS) just before 10:00 p.m. The DSS then texted and called RN B (the on-call nurse) around 10:00 p.m., but did not receive a response to the call or the text		

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<ul> <li>message. The investigation further revealed shortly after 5:00 a.m. on 6/25/21 DSA A and DSA B found Client #1 in bed unresponsive. Staff called their supervisor who did not answer and then called 911 and EMT's arrived shortly after and pronounced Client #1 dead.</li> <li>Record review revealed Client #1 was 42 years old had diagnoses including mild intellectual disability, spastic quadriplegic, cerebral palsy, GERD, disease of the stomach and duodenum, intestinal obstruction, constipation, tachycardia, dysphagia, severe sepsis without septic shock, hypoglycemia and colostomy. Record review revealed a death certificate dated 7/8/21 listed aspiration/probable small bowel obstruction as the cause of death.</li> <li>Record review revealed a policy for Injuries and Incidents, dated 11/17/20, which outlined the process for notification of medical personnel in</li> </ul>		
the event of a medical concern. The policy indicated in an ICF/ID if staff identified a medical concern with a client they "must" call a nurse. If they did not receive a return call from the nurse they needed to call again in 5 minutes. If still no response from a nurse they needed to call a		
supervisor or designated on-call personnel until they reached someone. If a medical emergency	 	
		Page <b>20</b> of

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	staff were instructed to call 911 first and then call		
	a supervisor.		
	Continued record review revealed a Mosaic Policy for Nursing Roles and Duties, last updated 11/17/20, indicated nursing staff participate in an on-call rotation and must be available "by phone, virtually or be on site as dictated by the health needs of the people supported." The policy further revealed nursing staff are to "stay informed" of any change in condition or of the		
	health needs for people served in ICF/ID homes. When interviewed on 7/8/21 at 10:00 a.m. RN A		
	(Client #1's regular nurse) confirmed she completed an assessment of the client around 4:00 p.m. after being told he had an emesis and		
	didn't feel well. The RN stated she did an assessment of the client and asked how he felt.		
	She reported the client stated he felt okay and she asked him if he would be okay if she went home as it was the end of her day. She noted the		
	client said yes it was okay if she went home. RN A confirmed he was a reliable communicator and		
	could clearly communicate yes and no. She then turned his care over to RN B who was the on-call nurse for the night. The RN admitted she failed to		
	document her assessment of the client and stated she should have documented it. When she left		
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she told staff to isolate him due to potential Covid- 19 and monitor him. When asked what "monitor him" meant she indicated it meant check on him at least every 30 minutes or less and report any further problems.		
When interviewed on 7/8/21 at 12:03 p.m. the DSS confirmed she was aware of Client #1's emesis at 3:55 p.m. and at dinner time an hour later. She stated she was informed just before 10:00 p.m. by Direct Support Associate (DA) C and DSA D of the client gagging and additional emesis around 9:00 p.m. The DSS revealed she texted the on-call nurse (RN B) at 9:59 p.m. that the client had a 3rd emesis, that it was small, and his temperature was 97.3. She stated RN B did not respond to the text message, so she called her at 10:01 p.m. and she did not answer. She confirmed the 10:01 phone call was her last attempt to communicate with RN B for the night and the only information she passed on was the additional emesis and the client's temperature by text message.		
When interviewed on 7/8/21 at 11:00 a.m. RN B confirmed she was on call from 4:00 p.m. on 6/24/21 to 8:00 a.m. on 6/25/21 assigned to several homes which included Client #1's home. She stated she received a call from the DSS		

Facility Administrator

Date

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around 4:30 p.m. about Client #1's first emesis. She then received another call from DSS B at 5:23 p.m. in regard to the second emesis for the client. She received a text message from DSS around 8:30 p.m. which stated the client had no more emesis and was acting like his usual self. RN B stated she received another text message from the DSS at 9:59 p.m. on 6/24/21 which indicated the client had another small emesis (3rd one) but his temperature was fine. The RN admitted she is not sure she ever saw that text until the next morning (6/25/21). She stated she turned off her text message notifications or she would never get any sleep. When asked if she received a call at 10:01 p.m. as the DSS reported, she said her phone did not show a missed call at that time. She stated she was likely sleeping by that time and may have missed it had the call come in. The RN admitted if she saw the 9:59 p.m. text message she likely would have called and asked some additional questions. When interviewed on 7/8/21 at 3:24 p.m. the Associate Director (AD) confirmed RN B should have been available for contact during her 16 bour on coll shift form 6/24/21 and			
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	hour on-call shift from 6/24/21 to 6/25/21 and		
should have seen the text message and/or	should have seen the text message and/or		
answered the phone call. She confirmed it is not			
an acceptable practice not to be available when			
	 <u> </u>	u	 Page 23 of

Facility Administrator

Date

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you are a nurse on call. She also provided a copy of the policy outlining nursing duties. She also confirmed RN A should have documented her assessment of Client #1 which happened around 4:00 p.m. on 6/24/21.		
FACILITY RESPONSE		

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Facility Administrator

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