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

PRINTED: 04/20/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G103	A. BUILDING _____ B. WING _____	C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-718 S 13TH STREET	718 SOUTH 13TH STREET NEVADA, IA 50201

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W 000	INITIAL COMMENTS As the result of the investigation of #74859-I a deficiency was cited at W189.	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff notified the supervisor and/or Qualified Intellectual Disability Professional (QIDP) of ongoing attempts by a client to leave the facility without staff knowledge/supervision. The staff also failed to promptly notify supervisory/management staff of an actual elopement, when staff discovered the client outside of the facility. This involved 1 of 1 client identified during the investigation of #74859-I (Client #1). Finding follows: 1. Record review of the facility investigation on 4/02/18, revealed Client #1 had an elopement from the facility on the early evening of 2/15/18. Direct Support Associates (DSA) A, B and C were present at the time of the incident, caring for six clients. Staff reported they noticed Client #1 outside after dinner time, possibly between 5:30 p.m. and 6:00 p.m. Staff did not report the incident until 2/22/18. Additional staff interviews and record review revealed Client #1 had a recent history of attempting to leave the facility, which was known by staff, but had not been reported to the supervisor or QIDP.	W 189	W189 STAFF TRAINING PROGRAM The facility will provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, staff will be retrained on Mosaic's Incidents and Injuries Policy and reporting requirements, as well as client behavior support plans. Documentation of training will be maintained by the facility. This will be monitored through monthly observations in the homes and through monthly coaching. Person(s) Responsible: Program Manager	04/20/18

POC 4/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carl Mau — TITLE: Exec. Director — (X6) DATE: 4/24/18

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 189	Continued From page 1 According to the web site Weather Underground, the temperature in Nevada, Iowa on 2/15/18 at 5:53 p.m. was 31 degrees Fahrenheit with a wind chill of 23 degrees. Client #1 was 40 years old with a diagnosis including Severe Intellectual Disability, Anxiety Disorder, Pica (ingestion of non-edibles) and Other Behavioral and Emotional Disorders. Client #1 was independently ambulatory. He/she was non-verbal without functional communication. Based on staff memory and record review, it appears Client #1's last elopement was in 2010. Client #1's Individual Support Plan (ISP) was dated 3/30/17 and valid through 2/19/18. The ISP made no mention of a history of elopement. According the the ISP, staff should check on Client #1 every 5 minutes if the client was in his/her bedroom in order to ensure the client was not engaging in Pica behavior and had not taken property from other clients. The ISP indicated staff should check on Client #1 every 5-10 minutes when he/she was in the enclosed back yard. The ISP provided no other information regarding level of supervision (when not in bedroom or in the back yard). Client #1's Behavior Support Plan (BSP) listed targeted behaviors of Pica (ingestion of inedibles), Self-Injurious Behavior, Aggression and Obsessive behavior, which included repeatedly opening doors. A section of the BSP entitled, "Communicative intent of Targeted Behaviors," included "Elopement: this is for a sensory need. Door chimes are not in place for	W 189		

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W 189	Continued From page 2 (Client #1) due to level of supervision. If (Client #1) tries leaving without staff assistance, staff need to document and notify DSS/QIDP." Record review on 4/04/18 revealed no GERs regarding elopement or elopement attempts from 11/01/17 to 2/15/18. When interviewed on 4/03/18 at 3:20 p.m. DSA A confirmed he worked at the facility on second shift on 2/15/18, along with DSA B and DSA C. DSA A stated he went to the "back room" (a smaller side room with a computer that does not not have a direct view to the main living area of the house) after supper for about 10 minutes. DSA A said he told the other two staff where he went. He estimated the time at around 5:30 p.m. or 6:00 p.m. DSA A thought he saw Client #1 standing near the front door around the time he went to the back room. DSA A came back to the main area of the house after about 10 minutes. He saw DSA C near the dining table, talking on her personal cell phone. DSA B sat on the couch near the front door, with his back to the front door. DSA B watched television. DSA A noticed the front door open, went to the door and looked out. DSA A saw Client #1 sitting on the sidewalk that led from the front door to the driveway. He estimated Client #1 was about 10 feet from the front door. DSA A did not recall exactly what Client #1 wore, but thought the client did not wear a coat or shoes/slippers. DSA A and DSA B brought Client #1 back inside the house. DSA A said Client #1 did not appear to be in any distress. The client appeared to be his/her normal self. DSA A reported he worked at the house fairly regularly for about one to two months prior to this incident. He read through Client #1's	W 189		

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W 189	Continued From page 3 programs and information, but did not see anything about Client #1 having elopement behavior. DSA A reported a supervisor didn't really train him, just told him to read the client information. He said staff were not assigned to clients, they shared the responsibility, but each staff person documented on two clients. DSA A said he did not recall how often Client #1 should be checked when in his/her room. DSA A thought it was around 10 minutes from when he last saw Client #1 until he found the client on the sidewalk. He said he had never seen Client #1 attempt to go outside the front door by him/herself or even open the front door. DSA A said he now realized he should have reported the incident right away and should have written a GER. He didn't do it because Client #1 seemed fine. DSA A finally did report it, about a week later. DSA A said staff had been trained to keep at least one staff in the main living area to supervise clients in the living room, dining room and kitchen areas. He said DSA B and DSA C were both in the main area, but neither paid attention to Client #1. When interviewed on 4/03/18 at 3:00 p.m. DSA B confirmed he worked at the facility on second shift 2/15/18, along with DSA A and DSA C. He said DSA A saw Client #1 outside sometime after dinner, but did not know the time of the incident. DSA B said it was possible the incident happened around 6:00 p.m. DSA B took Client #2 to the bathroom and came out of the bathroom when he saw DSA A going out the front door. DSA A said, "Hey, hey, he's outside." DSA B followed and saw Client #1 sitting down on the ground, near the agency van in the driveway. DSA B did not recall what Client #1 wore at the	W 189		

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W 189	Continued From page 4 time, but thought the client did not have on a coat or shoes/slippers. He and DSA A brought Client #1 back into the house. The client did not shiver and seemed OK. DSA B worked many times at the facility in his 13 years as a staff person. He did not recall who trained him. He said he was familiar with Client #1's programs. DSA B explained staff were not assigned to specific clients; all staff shared the client supervision. They discussed who would do the charting/documentation for each client. DSA B said Client #1 usually spent time in his/her bedroom or in the living room. He did not know how often staff were supposed to check on Client #1 when he/she was in the bedroom, but thought it was every 15 minutes. DSA B said he did not know how much time had passed from when he last saw Client #1 until the he saw the client outside. He recalled seeing Client #1 at dinner time. DSA B said he saw Client #1 try to go out the door several times in the past, but staff always directed Client #1 back inside. Client #1 did not simply open the front door; the client tried to leave the house. DSA B said he saw Client #1 try to go out the front door earlier that day. He did not documented these prior attempts because he was not the staff person primarily involved. He said he thought the staff person who was most involved should have written a GER. Regarding the incident on 2/15/18, DSA B said he thought DSA A should have written the GER. He and other staff were trained to have at least one staff stay in the front area to monitor clients. He said he did not recall where DSA C was at the time of the incident. DSA C was unavailable for interview at the time of the DIA investigation. In the facility interview	W 189		

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W 189	Continued From page 5 conducted 2/23/18, DSA C reported she sa at the dining table eating around the time of the incident. She said Client #2 was also at the table. DSA C said she noticed the front door was open and she heard another staff say Client #1 was outside. The other two staff went outside and brought Client #1 into the house. DSA C was a newer staff at the home and stated she had not seen Client #1 try to go out the door before. The Program Manager provided an agency policy on 4/03/18 entitled, "Incident and Injuries". According to the policy, staff were supposed to immediately complete a GER for client elopements. When interviewed on 4/04/18 at 2:45 p.m. the Program Manager confirmed staff should have completed a GER and reported the incident to a management/supervisory staff on the same day as the incident. 2. A review of the daily behavioral data and notes during the same period revealed staff documented Client #1 attempted to go outside without staff knowledge/supervision on 11/26/17, 12/13/17, three times on 2/10/18 and five times on 2/11/18. The documentation revealed Client #1's elopement attempts had been increasing in the days leading up to the elopement on 2/15/18. There was no documentation by DSA D of Client #1 attempting to go outside without staff. DSA E had documented the multiple elopement attempts on 2/10/18 and 2/11/18. When interviewed on 4/04/18 at 9:25 a.m. DSA D confirmed she was a full-time first shift staff who worked at home for about three to four years. She was very familiar with Client #1. DSA D said she saw Client #1 try to go out the front door in	W 189		

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W 189	Continued From page 6 the past. She said she noticed it in the past few months. DSA D estimated it happened once or twice per week. She said she documented the incidents in the behavior program data. She had not written a GER or told a supervisor or the QIDP. When interviewed on 4/04/18 at 3:10 p.m. DSA E stated she worked at the facility part-time for about three years. She said Client #1's attempts to leave the facility was not a new behavior. DSA E said she asked someone in the past about documentation and was told to document the information in the behavior data, which is what she did. DSA E said during the attempts on 2/10/18 and 2/11/18, Client #1 was actively trying to go outside. Staff intervened each time and directed the client to stay inside. She said Client #1 liked to go outside when there was snow on the ground. When interviewed on 4/02/18 at 4:10 p.m. the Qualified Intellectual Disability Professional (QIDP) said she worked at the facility since August 2016 and Client #1 had not eloped from that time until 2/15/18. She did not know when Client #1 last eloped. The QIDP checked Client #1's records back to 2012 and could find information regarding elopements. She said elopement was not mentioned in Client #1's annual ISP. Client #1 would sometimes open doors, but had not left the facility in quite some time. The QIDP had briefly mentioned elopement in the BSP, but she said she was actually referring to the repeated door opening when she wrote, "Elopement is for a sensory need." The QIDP acknowledged this was poorly worded. The QIDP said the three staff working at the time of	W 189		

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W 189	Continued From page 7 the incident on second shift 2/15/18 were all fill-in staff from other homes, but they had worked previously at the S. 13th home. She said staff needed to document attempted elopements only when Client #1 attempted to leave the facility. Staff were not assigned to specific clients. Staff shared client responsibility and were expected to communicate regarding client supervision. Staff had "cheat sheets" for each client that listed client programs and health supports. Staff documented on those and later transferred that information to the computer. No documentation for Client #1 could be located for second shift 2/15/18, other than the General Event Report (GER) written a week later. Second shift staff had not documented on Client #1's health supports, programs or behavior program on 2/15/18. The QIDP said the supervisor typically trained fill-in staff. There were staff training forms at the house, so the supervisor could sign off when a staff person had been trained on clients and their programs. During a follow-up interview on 4/03/18 at 11:00 a.m. the QIDP said she was unable to locate client training sheets for the three staff present at the time of the incident. The QIDP clarified at the time of the incident, staff were supposed to check on Client #1 every five minutes when the client was in his/her bedroom. There was no enhanced level of supervision when the client was out of his/her room. Staff should just know the client's whereabouts. Staff were told to try to keep at least one staff person in the main common area of the home, to supervise the kitchen, dining room and living room when clients were present in those areas.	W 189		

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W 189	Continued From page 8 During a follow-up interview on 4/04/18 at 11:00 a.m. the QIDP said she was not aware of Client #1's multiple elopement attempts in the days leading up to the incident on 2/15/17. No staff person had informed her of those incident or other prior attempts. The QIDP said staff had only told her that Client #1 would sometimes open the exit door, but no one told her the client tried to go out. When interviewed on 4/03/18 at 10:00 a.m., the Direct Support Supervisor (DSS) stated she worked at the agency since December 2010, but did not work primarily at the S. 13th home until the past year. The DSS said she recalled when she started working at the agency, she heard Client #1 had eloped a few blocks away to observe a construction site where a nursing home was being built. (The nursing home opened in May, 2011, so it seems likely Client #1 eloped at some point in 2010.) The DSS was not aware of any further elopements by Client #1 until the incident on 2/15/18. The DSS said Client #1 had a history of Pica. Staff worked together to supervise the clients. The DSS said she thought she had trained DSA B at the S. 13th house, but did not recall training DSA A or DSA C. She said it was possible another supervisor had trained them, possibly even a supervisor who no longer worked at the agency. The DSS said the supervisors had not been filling out the training sheets when they trained fill-in staff. She thought they were probably supposed to fill them out. The DSS also mentioned staff had the "cheat sheets" to follow, which listed client health supports and programs. The DSS got a copy of the "cheat sheet" for Client #1, which listed health supports, behavior program, dietary information,	W 189		

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W 189	Continued From page 9 toileting information and other skills training programs (toothbrush, sign language, hand washing, etc.). The cheat sheet did not indicate Client #1 needed to be checked every 5 minutes when in his/her bedroom and said nothing about Client #1 attempting to leave the facility. The DSS said Client #1 needed to be supervised when outside due to his/her pica behavior. The client might try to ingest grass, plants, leaves, etc. During a follow up interview on 4/04/18 at 1:15 p.m. the DSS said she was not aware of Client #1's multiple elopement attempts in the days leading up to the incident on 2/15/17. No staff person had informed her of those incident or other prior attempts. The DSS said staff had only told her that Client #1 would sometimes open the exit door, but no one told her the client tried to go out.	W 189		