STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G156	A. BUILDING _____ B. WING _____	C 11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 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 #79615-I was conducted 11/13/18 - 11/21/18. The investigation resulted in a determination of Immediate Jeopardy on 11/13/18 at 2:50 p.m. The IJ was removed on 11/20/18 at 4:18 p.m. As a result of the investigation, a Condition level deficiency was cited at W158. Standard level deficiencies were cited at W153, W154, W159, and W193. A deficiency was cited under Iowa State Code 50.7(4).	W 000	See attached POC 12/4/18	
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 all allegations of client mistreatment and/or abuse were reported to the Department of Inspections and Appeals (the Department), as required. This affected 1 of 1 client (Client #1) involved in the investigation of #79615-I. Finding follows: Record review on 11/13/18 revealed a facility General Event Report (GER), dated 10/19/18, for Client #1. Staff documented on the GER Client #1 had left the facility and went to the adjacent facility without his facility staff knowing. Interviews	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 with staff revealed Client #1 also alleged Direct Support Associate (DSA) F had been abusive toward him. The record lacked any documentation of the allegation of abuse. When interviewed on 11/14/18 at 3:05 p.m., Direct Support Associate/Certified Medication Aide (DSA/CMA) D said on 10/19/18 Client #1 had left his facility and arrived at the adjacent facility without his staff knowing. She explained Client #1 had scratches on him and reported DSA F did it to him. She stated this was reported to both the on-call supervisor and on-call nurse. DSA/CMA D confirmed she had been trained on Mandatory Reporter and the facility abuse reporting procedures. DSA/CMA D confirmed the allegation was not documented on a General Events Report (GER) and was unable to recall if she documented the allegation anywhere else. She stated she was instructed to complete a written statement but did not have it completed when her shift ended and the following day all the statements were gone. When interviewed on 11/14/18 at 3:45 p.m., DSA I explained she worked for a temporary staffing agency and was assigned to work in the facility adjacent to Client #1's facility on 10/19/18. DSA I said Client #1 arrived at the adjacent facility and reported his staff was not aware he left. DSA I said before Client #1 left with his facility staff, she let Client #1 know he could return to the adjacent facility if he continued to have issues at his facility. DSA I said approximately ten minutes later they received a call, the first one initially disconnected, but received another call. She said she heard crying and stated if it was Client #1 he could come back to the adjacent facility, then she heard someone in the background say something	W 153		

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W 153	Continued From page 2 like, "Hang up the damn phone." or "Give me the phone." DSA I said she went outside and observed Client #1 scream at DSA F who followed Client #1. DSA I said DSA F told her he had it but DSA I again told Client #1 he could go with her to the adjacent facility. DSA I said once inside, Client #1 was visibly upset, shaky, pale, and unsteady, so staff took his blood pressure and it was very high. DSA I said Client #1 reported DSA F took his suitcase, hit him in the face, pushed him, and held him down. She stated Client #1 had scratches and red marks on his face, chest, and hands. DSA I said she never spoke to anyone but heard DSA/CMA D and DSA/CMA E report the allegation to the on-call supervisor, the on-call nurse, and they also called the Direct Support Manager (DSM) and reported. DSA I confirmed she was a Mandatory Reporter and had been trained on the facility abuse reporting procedures. She stated she was instructed to write a statement, which she did. When asked about her statement not including anything regarding an allegation of abuse, only about Client #1 eloping, DSA I reviewed her statement and stated "I guess I did leave a lot of it out." When interviewed on 11/14/18 at 4:45 p.m., the Direct Support Supervisor (DSS) said she received a call on 10/19/18 from DSA/CMA E who informed her Client #1 came to the facility adjacent to his but was unsure if the facility staff knew he was gone. DSS reported DSA/CMA E stated she had already gone to Client #1's facility and was told Client #1 was there. DSS stated she instructed DSA/CMA E to immediately call and let Client #1's staff know he was at the adjacent facility. DSS said she was called again after Client #1 ran back to the adjacent facility and was	W 153		

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W 153	Continued From page 3 visibly upset, shaking, crying, and his blood pressure was elevated. DSS stated she was told DSA I had witnessed DSA F grab Client #1 as he was running toward the adjacent facility. DSS said she instructed all staff at the adjacent facility to write statements, or e-mail a statement to her. She stated she was then informed Client #1 had a scratch on his neck and redness on his hands. The DSS stated DSA/CMA E took pictures of Client #1's injuries and sent them to her but said she didn't print them out. DSS said she instructed staff to also call the on-call nurse. DSS said she told DSA/CMA E Client #1 could stay at the adjacent facility if he was still upset. DSS said Client #1 fell asleep and was assisted back to his facility after 9:00 p.m. when DSA F's shift ended. DSS stated she called the DSM and informed her of the incident and made a plan to investigate further on 10/20/18. The DSS said on 10/20/18 she went into the facility, the DSM was on speakerphone, while they interviewed Client #1. The DSS reported Client #1 said he was upset, didn't want DSA F there, and he lied when he said DSA F abused him. The DSS stated at this time she stopped the investigation after the DSM told her to since Client #1 was lying. When interviewed on 11/15/18 at 8:15 a.m., the DSM explained the DSS had called her on 10/19/18, along with several other people. She said she recalled one of the staff had called her with Client #1 on speakerphone. She said she could hear the staff tell Client #1 several times to tell her about DSA F and what he had done; she said she immediately instructed the staff to stop and decided to speak to Client #1 on 10/20/18 without staff present. The DSM said Client #1 would commonly say an African American staff hit him in the face, knocked him down, and either hit	W 153		

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W 153	Continued From page 4 or put their knee in his back when he was upset. The DSM said on 10/20/18 Client #1 immediately started to say these things so she stopped him and reminded him to tell her the truth. The DSM said Client #1 reported DSA F had reminded him not to leave without talking to staff and he (Client #1) physically aggressed DSA F, left the facility, and ran to the adjacent facility while DSA F followed him. The DSM said Client #1 then reported DSA F never knocked him down. The DSM explained once Client #1 rescinded the allegation, the Associate Director (AD), herself, and the DSS talked as a group and felt it was a false allegation. The DSM stated she never instructed the DSS not to complete the investigation and explained only the Associate Director could stop an investigation. When interviewed on 11/15/18 at 8:55 a.m., DSA/CMA E said on 10/19/18 Client #1 had left his facility and went to the adjacent facility where she worked. She stated the staff were not aware Client #1 had left. DSA/CMA E said Client #1 returned to his facility but approximately thirty minutes later, they received two phone calls, initially they could only hear noises and the line disconnected but on the second call they could hear yelling and someone say "Give me the damn phone." before the line disconnected. She said DSA I went to make sure everything was okay and returned with Client #1. DSA/CMA E said Client #1 was shaky, crying, and upset; staff took his vitals and identified his blood pressure was very high. DSA/CMA E said Client #1 reported DSA F had ripped his back pack off and pushed him down to the ground so Client #1 said he bit DSA F and ran out of the facility. She said Client #1 reported DSA F followed him outside and they were fighting, both were yelling, DSA F grabbed	W 153		

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W 153	Continued From page 5 and scratched Client #1 when DSA I brought him into the adjacent facility. She confirmed she did not witness the interaction. DSA/CMA E said the DSS, DSM, and the on-call nurse were notified of the allegation Client #1 made. She said the DSM was on the phone with Client #1 and the DSM told Client #1 he was lying, it didn't happen, and he was just saying this because he didn't like African Americans. DSA/CMA E said she was told to let Client #1 stay until third shift arrived when he could return to his facility. She said she was instructed to complete a statement on the incident and emailed her statement to the Associate Director (AD); she reviewed and confirmed the Surveyor had the statement she provided. When asked, DSA/CMA E confirmed she did not include any information on the allegation of abuse Client #1 made in her written statement. She said she didn't know she was supposed to and then stated there was a lot going on. She reported staff were to provide a detailed statement and complete a GER for allegations of abuse. DSA/CMA E said the DSM instructed her not to because they didn't know if the allegation was true since Client #1 would make stuff up. DSA/CMA E said the DSS instructed the staff to complete the GER as a behavioral issue, not an elopement or allegation of abuse. When interviewed on 11/15/18 at 10:20 a.m., DSA H said on 10/19/18 Client #1 initially eloped to the adjacent facility. She said when he returned to the facility she and Client #1 problem-solved. Client #1 became upset again so DSA F spoke to Client #1 when she went to assist another client. DSA H said within a few minutes DSA F yelled for help and she observed Client #1 hit and grab DSA F. She explained Client #1 ripped DSA F's	W 153		

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W 153	Continued From page 6 shirt, bit DSA F, so she tried to step between them when Client #1 ran outside and she followed. She said she observed Client #1 enter the adjacent facility as he yelled and verbally threatened. DSA H said the staff at the adjacent facility called several times, accused DSA F of physically abusing Client #1, questioned DSA F about what he did to Client #1, and she finally asked them to stop calling. DSA H said Client #1 stayed at the adjacent facility until DSA F's shift was over. DSA H said she was never asked to write a statement and no one had followed up with her on either the elopement or the allegation being made. She stated she asked about any paperwork she needed to complete regarding the allegation or the elopement and was told she didn't need to do anything. Review of facility policies revealed the facility policy titled "Incident Reporting", last revised 1/1/15. The policy instructed a GER was to be completed following any allegation of abuse and was to include the name of the client involved, place of the incident, date and time, if the incident was observed, who was present or responded to the incident, a detailed description and action taken, the person notified and the time of the notification. The policy instructed all allegations of client abuse were to be reported immediately to the administrator and other officials in accordance with state law. When interviewed on 11/15/18 at 11:05 a.m., the AD said she was told Client #1 had said DSA F scratched him, other staff witnessed them outside arguing, and then Client #1 reported DSA F had not scratched him. The AD confirmed the facility failed to report the allegation of abuse to the Department of Inspections and Appeals as	W 153		

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W 153	Continued From page 7 required.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure thorough investigations were completed after a client elopement and an allegation of abuse. This affected 1 of 1 client involved in the investigation of #79615-I. Findings follow: 1. Record review on 11/13/18 revealed a facility General Events Report (GER), dated 10/19/18, completed by Direct Support Associate/Certified Medication Aide (DSA/CMA) D who worked at the adjacent facility. According to the report, on 10/19/18 at 7:15 p.m. Client #1 went to the adjacent facility without his facility staff knowing. The GER noted the adjacent facility staff wanted to wait to see how long it took Client #1's facility staff to notice he left. At 7:29 p.m. DSA/CMA E (adjacent facility staff) notified the on-call supervisor. The GER noted at 7:45 p.m., DSA/CMA E walked to the facility, casually asked about Client #1 and was told he was in his bedroom. DSA/CMA E returned to the adjacent facility and notified the on-call supervisor Client #1's facility staff was unaware he was gone. The GER noted the supervisor instructed DSA/CMA E to call the facility and inform the staff Client #1 was at the adjacent facility. According to the GER, at approximately 7:50 p.m., the adjacent facility notified Client #1's facility staff Client #1	W 154		

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W 154	Continued From page 8 was with them. At 7:53 p.m., a DSA H walked him back to the facility. Additional record review on 11/14/18 revealed statements were taken from DSA I, DSA/CMA E, and Client #1 regarding the elopement on 10/19/18. The record lacked the Internal Inquiry Form, statements from all staff who worked, or any type of conclusion. When interviewed on 11/14/18 at 12:35 p.m., DSA F stated on 10/19/18 he thought Client #1 had left with a peer and DSA/CMA G to go to the store since he walked outside when they were leaving. DSA F said approximately five minutes later, DSA/CMA E came to the facility, casually asked about Client #1, and retrieved some medication cups, then left. He stated DSA/CMA E never said Client #1 was at the adjacent facility. DSA F stated approximately five to ten minutes later, DSA/CMA E called and reported Client #1 was at the adjacent facility and had been there for about an hour. DSA F said DSA H immediately went over and walked him back to the facility. DSA F explained no one had direct accountability for Client #1 as all staff helped all the clients in the facility. DSA F reported no one from the agency followed-up with him or had him write a statement regarding Client #1's elopement. When interviewed on 11/14/18 at 1:20 p.m., DSA/CMA G said after she assisted with the evening medication pass, she provided Client #1 toothpaste and prompted him to brush his teeth. She stated she then left with another client to go to the store and was gone for maybe fifteen minutes. DSA/CMA G reported Client #1 did not walk outside when she and the other client were leaving for the store. DSA/CMA G said on	W 154		

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W 154	Continued From page 9 10/19/18 they (staff) did not clarify who was accountable for which clients at the facility. She stated she had a bracelet for accountability of another client but did not have Client #1's bracelet. She stated she was uncertain if any of the staff had Client #1's bracelet. DSA/CMA G reported no one had interviewed her or had her write a statement regarding the incident. When interviewed on 11/14/18 at 3:05 p.m., DSA/CMA D said she worked at one of the adjacent facilities on 10/19/18 when Client #1 walked in. She said they waited to see if a staff was behind him, no one was, and DSA/CMA E suggested they not call Client #1's facility to see how long it took the staff to realize he was gone. She said she told DSA/CMA E the on-call supervisor needed notified so DSA/CMA E called and reported the incident. DSA/CMA D said after DSA/CMA E spoke to the on-call supervisor DSA/CMA E reported they were instructed to go to the facility to see if staff knew Client #1 had left. DSA/CMA E went to Client #1's facility and when she returned she again called the on-call supervisor and reported the facility was not aware Client #1 was gone and had told her Client #1 was in his bedroom. DSA/CMA D stated she spoke to Client #1 for a while before they called to let the facility know Client #1 had left and was at the adjacent facility. DSA/CMA D reported Client #1 was at the adjacent facility for approximately 24 minutes before they called and informed the facility he was gone. She stated she was instructed to complete a written statement but did not have it completed when her shift ended and the following day all the statements were gone. She confirmed no one had completed any other follow-up with her regarding the elopement.	W 154		

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W 154	Continued From page 10 When interviewed on 11/14/18 at 3:45 p.m., DSA I explained she worked for a temporary staffing agency and was assigned to work in the facility adjacent to Client #1's facility on 10/19/18. DSA I said Client #1 arrived at the adjacent facility and reported his staff was not aware he had left. DSA I stated Client #1 told her he walked out the back door of his facility. DSA I stated DSA/CMA E wanted to wait to see how long it took Client #1's facility staff to realize he had left but said DSA/CMA E called and informed the on-call supervisor of the incident. DSA I said DSA/CMA E went to Client #1's facility and when she returned she again called the on-call supervisor who instructed them to let Client #1's staff know he was at the adjacent facility. DSA I said DSA H went to the adjacent facility and walked Client #1 back home. DSA I said she let Client #1 know he could return to the adjacent facility if he continued to have issues at his facility. DSA I stated she was instructed to write a statement, which she did, but reported no one from the agency had completed any further follow-up with her regarding the elopement. When interviewed on 11/14/18 at 4:45 p.m., the Direct Support Supervisor (DSS) said she received a call on 10/19/18 from DSA/CMA E who informed her Client #1 had come to the facility adjacent to his but was unsure if the facility staff had knew he was gone. DSS reported DSA/CMA E stated she had already gone to Client #1's facility and was told Client #1 was there. DSS stated she instructed DSA/CMA E to immediately call and let Client #1's staff know he was at the adjacent facility. The DSS confirmed she was aware Client #1 had eloped on 10/19/18 but said she didn't complete the investigation after being told by the DSM they were not doing anything with	W 154		

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W 154	Continued From page 11 it. When interviewed on 11/15/18 at 8:15 a.m., the DSM explained the DSS had called her on 10/19/18, along with several other people. The DSM said she was told DSA/CMA G observed Client #1 leave the facility on 10/19/18 therefore instructed the DSS to follow-up with DSA/CMA G to determine if she actually witnessed Client #1 when he left. The DSM confirmed she did not follow-up with the DSS afterwards to ensure the Inquiry was completed. When interviewed on 11/15/18 at 8:55 a.m., DSA/CMA E reported on 10/19/18 Client #1 showed up at the facility, which is adjacent to his facility, without staff. She said Client #1 had told her he was upset with one of his peers so he left the facility without telling his staff. DSA/CMA E said she wanted to wait to notify his facility to see how long it would take them to notice Client #1 was gone. She said approximately fifteen minutes later she went to Client #1's facility, casually asked about him and was told he was in his bedroom. She reported she called the on-call supervisor to report the incident. DSA/CMA E said she told the on-call supervisor she wanted to see how long it would take the facility staff to notice Client #1 was gone and was told okay. She said approximately fifteen minutes later, she again called the on-call supervisor and was instructed to immediately call and let the facility know Client #1 was gone and at the adjacent facility. She stated she called and informed the facility and approximately ten minutes later DSA H arrived and walked Client #1 back to his facility. DSA/CMA confirmed she completed and e-mailed her statement to the Associate Director but said no one had done any additional follow-up with her	W 154		

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	16G156	A. BUILDING _____ B. WING _____	C 11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 KELLY'S COURT FOREST CITY, IA 50436

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W 154	Continued From page 12 regarding the elopement. When interviewed on 11/15/18 at 10:20 a.m., DSA H explained she worked for the temporary staffing agency and was assigned to work at the facility on 10/19/18. She said after supper, she and DSA F were assisting other clients and Client #1 was in his bedroom. She said DSA/CMA G left with a client to go to the store and Client #1 walked outside with them so she thought Client #1 had gone with DSA/CMA G. DSA H said approximately fifteen minutes later they received a call from the adjacent facility and was informed Client #1 was there. She stated she immediately went to the adjacent facility and walked with Client #1 back to his facility. DSA H stated no one spoke to her about the incident and she was not told to write a statement on the incident. When interviewed on 11/15/18 at 11:05 a.m., the Associate Director (AD) explained on 10/19/18 the DSM informed her Client #1 possibly eloped and an Internal Inquiry was initiated. The AD said the DSM had contacted her over the weekend and informed her DSA/CMA G witnessed Client #1 leave the facility and go to the adjacent facility on 10/19/18. The AD said she did not review the Internal Inquiry after she was told of the results. She confirmed the facility failed to ensure a thorough investigation was completed for the elopement. 2. Record review on 11/14/18 revealed the facility collected statements from DSA I and DSA/CMA E on 10/19/18 and from Client #1 on 10/20/18. The statements all referenced the client elopement incident on 10/19/18. During the course of interviews into the client elopement, staff reported Client #1 also made an allegation of abuse. The	W 154		

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W 154	Continued From page 13 record lacked any documentation or investigation into the allegation of abuse. When interviewed on 11/14/18 at 3:05 p.m., Direct Support Associate/Certified Medication Aide (DSA/CMA) D said on 10/19/18 Client #1 left his facility and arrived at the adjacent facility without his staff knowing. She explained Client #1 had scratches on him and reported DSA F had did it to him. She stated this was reported to both the on-call supervisor and on-call nurse. DSA/CMA D confirmed she had been trained on Mandatory Reporter and the facility abuse reporting procedures. DSA/CMA D confirmed the allegation was not documented on a General Events Report (GER) and was unable to recall if she documented the allegation anywhere else. She stated she was instructed to complete a written statement but did not have it completed when her shift ended and the following day all the statements were gone. She confirmed no one had completed any other follow-up with her regarding the allegation Client #1 made against DSA F until 11/14/18 when she was instructed to finish her statement and to meet with the Surveyor. At the time of the interview, DSA/CMA D had not completed her statement. When interviewed on 11/14/18 at 3:45 p.m., DSA I explained she worked for a temporary staffing agency and was assigned to work in the facility adjacent to Client #1's facility on 10/19/18. DSA I said Client #1 arrived at the adjacent facility and reported his staff was not aware he had left. DSA I said before Client #1 left with his facility staff, she let Client #1 know he could return to the adjacent facility if he continued to have issues at his facility. DSA I said approximately ten minutes later they received a call, the first one initially	W 154		

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W 154	Continued From page 14 disconnected, but received another call. She said she heard crying and stated if it was Client #1 he come back to the adjacent facility, then she heard someone in the background say something like "hang up the damn phone" or "give me the phone." DSA I said she went outside and observed Client #1 screaming at DSA F who was following Client #1. DSA I said DSA F told her he had it but DSA I again told Client #1 he could go with her to the adjacent facility. DSA I said once inside, Client #1 was visibly upset, was shaky, pale, and unsteady, so staff took his blood pressure and it was very high. DSA I said Client #1 reported DSA F had took his suitcase, hit him in the face, pushed him, and held him down. She stated Client #1 had scratches and red marks on his face, chest, and hands. DSA I said she never spoke to anyone but heard DSA/CMA D and DSA/CMA E report the allegation to the on-call supervisor, the on-call nurse, and they also called the Direct Support Manager (DSM) and reported. DSA I confirmed she was a Mandatory Reporter and had been trained on the facility abuse reporting procedures. She stated she was instructed to write a statement, which she did. When asked about her statement not including anything regarding an allegation of abuse, only about Client #1 eloping, DSA I reviewed her statement and stated "I guess I did leave a lot of it out." DSA I confirmed no one from the agency had completed any further follow-up with her regarding the allegation of abuse. When interviewed on 11/14/18 at 4:45 p.m., the Direct Support Supervisor (DSS) said she received a call on 10/19/18 from DSA/CMA E who informed her Client #1 had come to the facility adjacent to his but was unsure if the facility staff knew he was gone. DSS reported DSA/CMA E	W 154		

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W 154	Continued From page 15 stated she had already gone to Client #1's facility and was told Client #1 was there. DSS stated she instructed DSA/CMA E to immediately call and let Client #1's staff know he was at the adjacent facility. DSS said she was called again after Client #1 had run back to the adjacent facility and was visibly upset, shaking, crying, and his blood pressure was elevated. DSS stated she was told DSA I had witnessed DSA F grab Client #1 as he was running toward the adjacent facility. DSS said she instructed all staff at the adjacent facility to write statements, or e-mail a statement to her. She stated she was then informed Client #1 had a scratch on his neck and redness on his hands. The DSS stated DSA/CMA E took pictures of Client #1's injuries and sent them to her but said she didn't print them out. DSS said she instructed staff to also call the on-call nurse. DSS said she told DSA/CMA E Client #1 could stay at the adjacent facility if he was still upset. DSS said Client #1 fell asleep and was assisted back to his facility after 9:00 p.m. when DSA F's shift ended. DSS stated she called the DSM and informed her of the incident and made a plan to investigate further on 10/20/18. The DSS said on 10/20/18 she went into the facility, the DSM was on speakerphone, while they interviewed Client #1. The DSS reported Client #1 had said he was upset, didn't want DSA F there, and he had lied when he said DSA F had abused him. The DSS stated at this time she stopped the investigation after the DSM told her to since Client #1 was lying. When interviewed on 11/15/18 at 8:15 a.m., the DSM explained the DSS had called her on 10/19/18, along with several other people. She said she recalled one of the staff had called her with Client #1 on speakerphone. She said she	W 154		

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W 154	Continued From page 16 could hear the staff tell Client #1 several times to tell her about DSA F and what he had done; she said she immediately instructed the staff to stop and decided to speak to Client #1 on 10/20/18 without staff present. The DSM said Client #1 would commonly say an African American staff hit him in the face, knocked him down, and either hit or put their knee in his back. The DSM said on 10/20/18 Client #1 immediately started to say these things so she stopped him and reminded him to tell her the truth. The DSM said Client #1 reported DSA F reminded him not to leave without talking to staff and he (Client #1) physically aggressed DSA F, left the facility, and ran to the adjacent facility while DSA F followed him. The DSM said Client #1 then reported DSA F never knocked him down. The DSM explained once Client #1 rescinded the allegation, the Associate Director (AD), herself, and the DSS talked as a group and felt it was a false allegation. The DSM stated she never instructed the DSS not to complete the investigation and explained only the Associate Director could stop an investigation. The DSM confirmed she never followed up with the DSS regarding the internal investigation. When interviewed on 11/15/18 at 8:55 a.m., DSA/CMA E said on 10/19/18 Client #1 left his facility and went to the adjacent facility where she worked. She stated the staff were not aware Client #1 left. DSA/CMA E said Client #1 returned to his facility but approximately thirty minutes later, they received two phone calls, initially they could only hear noises and the line disconnected but on the second call they could hear yelling and someone say "give me the damn phone" before the line disconnected. She said DSA I went to make sure everything was okay and returned with	W 154		

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W 154	Continued From page 17 Client #1. DSA/CMA E said Client #1 was shaky, crying, and upset; staff took his vitals and identified his blood pressure was very high. DSA/CMA E said Client #1 reported DSA F ripped his back pack off and pushed him down to the ground so Client #1 said he bit DSA F and ran out of the facility. She said Client #1 reported DSA F followed him outside and they were fighting, both were yelling, DSA F was grabbing and scratching Client #1 when DSA I brought him into the adjacent facility. She confirmed she did not witness the interaction. DSA/CMA E said the DSS, DSM, and the on-call nurse were notified of the allegation Client #1 made. She said the DSM was on the phone with Client #1 and the DSM told Client #1 he was lying, it didn't happen, and he was just saying this because he didn't like African Americans. DSA/CMA E said she was told to let Client #1 stay until third shift arrived when he could return to his facility. She said she was instructed to complete a statement on the incident and had emailed her statement to the Associate Director (AD); she reviewed and confirmed the Surveyor had the statement she provided. When asked, DSA/CMA E confirmed she did not include any information on the allegation of abuse Client #1 made in her written statement. She said she didn't know she was supposed to and then stated there was a lot going on. She reported staff were to provide a detailed statement and complete a GER for allegations of abuse. DSA/CMA E said the DSM instructed her not to because they didn't know if the allegation was true since Client #1 would make stuff up. DSA/CMA E said the DSS instructed the staff to complete the GER as a behavioral issue, not an elopement or allegation of abuse. DSA/CMA E said no one from the facility talked to her or completed any additional	W 154		

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W 154	Continued From page 18 follow-up with her after she verbally reported the allegation to the DSS and DSM. When interviewed on 11/15/18 at 10:20 a.m., DSA H said on 10/19/18 Client #1 had initially eloped to the adjacent facility. She said when he returned to the facility she and Client #1 problem-solved. Client #1 became upset again so DSA F was speaking to Client #1 when she went to assist another client. DSA H said within a few minutes DSA F yelled for help and she observed Client #1 was hitting and grabbing DSA F. She explained Client #1 had ripped DSA F's shirt, bit DSA F, so she tried to step between them when Client #1 ran outside and she followed. She said she observed Client #1 enter the adjacent facility as he was yelling and verbally threatening. DSA H said the staff at the adjacent facility called several times, accused DSA F of physically abusing Client #1, questioned DSA F about what he did to Client #1, and she finally asked them to stop calling. DSA H said Client #1 stayed at the adjacent facility until DSA F's shift was over. DSA H said she was never asked to write a statement and no one had followed up with her on either the elopement or the allegation made. She stated she asked about any paperwork she needed to complete and was told she didn't need to do anything. Review of facility policies revealed the policy "Incident Reporting", last revised 1/1/15. The policy instructed investigations were to be thorough and completed within five business days. When interviewed on 11/15/18 at 11:05 a.m., the AD confirmed the facility failed to complete a thorough investigation into the allegation of abuse	W 154		

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W 154	Continued From page 19 Client #1 made on 10/19/18 against DSA F.	W 154		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to maintain minimal compliance with the condition of participation (CoP) - Facility staffing. See W159: Based on interviews and record reviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate, integrate, and monitor client services and supports in place; as evidenced by failure to update client Individual Support Plans (ISPs) and Behavior Support Plans (BSPs) with current supports and services, ensure consistent information was provided to staff, failure to review the Comprehensive Assessment, failure to ensure staff had access to the information, and failed to ensure all supports were accessible. See W 193: Based on interviews and record review, the facility failed to ensure staff were trained on client Individual Support Plans (ISPs) or Behavior Support Plans (BSPs) and how to correctly implement the interventions within the plans. These findings resulted in a determination of an Immediate Jeopardy on 11/13/18 at 2:50 p.m. The facility provided a plan which included updating of ISPs and training of staff. The Immediate Jeopardy was abated on 11/20/18 at	W 158		

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W 158	Continued From page 20 4:18 p.m.	W 158		
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 interviews and record reviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate, integrate, and monitor client services and supports in place; as evidenced by failure to update client Individual Support Plans (ISPs) and Behavior Support Plans (BSPs) with current supports and services, ensure consistent information was provided to staff, failure to review the Comprehensive Assessment, failure to ensure staff had access to the information, and failed to ensure all supports were accessible. This affected 1 of 1 Client (Client #1) involved in the investigation of #79615-I. Finding follows: Record review on 11/13/18 revealed facility Inquiry Report form, dated 10/4/18. The document noted on 10/4/18 Client #1 left the facility without staff knowledge. According to the document, the Home and Community Based Services Program Manager (HCBS PM) observed Client #1 riding his bike past one of the waiver homes, several blocks away from the facility, without staff. The HCBS PM got Client #1's attention, had him go into the waiver home with her until the facility staff picked him up. According to Google Maps, the client traveled approximately 0.2 miles from his home to where he was seen by staff.	W 159		

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W 159	Continued From page 21 When interviewed, the State Climatologist identified the weather in Forest City on 10/4/18 at approximately 11:15 a.m. was 46 degrees Fahrenheit (F) with wind chill of 41 degrees F. Continued record review revealed Client #1's Individual Data form, last updated 9/26/18. According to the Individual Data form, Client #1 was 29 years old and resided at the facility since 8/31/18 and resided within the agency since 6/1/17. Client #1 had diagnoses including, but not limited to: moderate intellectual disabilities, insomnia, major depressive disorder, impulse control disorder, autistic disorder, attention-deficit hyperactivity disorder, and epilepsy. The document supervision requirements noted staff were to know Client #1's whereabouts at all times. The document failed to include staff were to complete twenty minute checks on Client #1 when he was in his bedroom or the bathroom, staff were to monitor the exit doors, staff accountable for Client #1 was to wear a bracelet, or Client #1 was allowed fifteen minutes per shift to go outside by himself. Client #1's Comprehensive Functional Assessment (CFA), dated 6/4/18, identified the following needs: providing name, address, and phone number, using caution with strangers, using sidewalks/crosswalks, using traffic/pedestrian signals. Additional record review revealed Client #1 had an Individual Support Plan (ISP), last updated 8/10/18, when he resided at another facility within the agency. The ISP noted Client #1 resided at 825 South 7th Street, a previous facility within the agency he resided at. The ISP continued to note Client #1 wanted to leave the house by himself	W 159		

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W 159	Continued From page 22 and he had run off without staff knowledge but instructed Client #1 was allowed fifteen minutes per shift. The ISP failed to note any further instructions regarding supervision requirements for Client #1. Further record review revealed Client #1's Behavior Support Plan (BSP), approved on 9/30/18. The BSP noted target behaviors of verbal aggression (yelling, arguing, threatening), physical aggression (hitting, kicking, pushing), property destruction (kicking items, throwing items, slamming doors, punching walls), and exiting the home. Restrictive measures included the use of behavior modifying medications (Clonidine, Geodon, Diazepam, and Sertraline), no hand held electronics, supervised phone calls and visits with his family, and his bicycle was to be locked in a shed with specified times to ride it. The BSP instructed staff to watch the exit doors at 835 (a previous facility), know Client #1's whereabouts at all times, staff accountable for Client #1 was to wear a bracelet to ensure his supervision, and when in his bedroom or bathroom staff were to complete checks every 20 minutes. The BSP instructed Client #1 was not to go outside by himself but did not mention Client #1 was allowed fifteen minutes per shift to be by himself as instructed in the ISP. The QIDP failed to ensure the Individual Data form, ISP and BSP provided consistent instruction on what level of supervision Client #1 required. The QIDP failed to ensure a shed was available to lock his bike in, to ensure specified times were set up for Client #1 to ride his bike, or to ensure bracelets were available for staff to use. When interviewed on 11/13/18 at 12:35 p.m., the QIDP confirmed she was unsure who was	W 159		

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W 159	Continued From page 23 accountable for Client #1 on 10/4/18. She explained staff were not wearing bracelets and confirmed no bracelets were available to the staff. She confirmed the facility did not have a shed available to lock Client #1's bike in and there were no specified times identified for Client #1 to ride his bike. She confirmed facility staff were not monitoring the exit doors or completing checks on Client #1 as instructed in the BSP. During an follow-up interview on 11/13/18 at 2:05 p.m., the QIDP confirmed staff were not trained on Client #1's level of supervision or BSP until after Client #1 eloped on 10/4/18. She confirmed staff had not been trained on Client #1's ISP prior to Client #1 moving to another facility on 10/27/18. 2. Record review on 11/13/18 revealed Client #1's Comprehensive Functional Assessment (CFA), signed 6/4/18 while Client #1 resided in another agency facility. The section of the CFA titled "Social Skills" under subtitle "Maladaptive Behaviors" noted Client #1 did not leave without notifying others/elope. When interviewed on 11/13/18 at 2:05 p.m., the QIDP said Client #1 did exhibit elopement behaviors and should have been reflected on the CFA. She confirmed she did not review or update Client #1's CFA after he moved into the facility. During a follow-up interview on 11/14/18 at 8:50 a.m. the QIDP explained she had forgot to transfer Client #1's ISP and BSP to the current facility until 9/30/18. She said she did not complete a 30-day meeting and just continued the same services and supports Client #1 had in place at the previous facility.	W 159		

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W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff were trained on client Individual Support Plans (ISPs) or Behavior Support Plans (BSPs) and how to correctly implement the interventions within the plans. This affected 1 of 1 client (Client #1) involved in the investigation of #79615-I. Findings follow: Record review on 11/13/18 revealed a facility Inquiry Report form, dated 10/4/18. The document noted on 10/4/18 Client #1 left the facility without staff knowledge. According to the document, the Home and Community Based Services Program Manager (HCBS PM) observed Client #1 riding his bike past one of the waiver homes, several blocks away from the facility, without staff. The HCBS PM got Client #1's attention, had him go into the waiver home with her until the facility staff picked him up. According to Google Maps, the client traveled approximately 0.2 miles from his home to where he was seen by staff. When interviewed, the State Climatologist identified the weather in Forest City on 10/4/18 at approximately 11:15 a.m. was 46 degrees Fahrenheit (F) with wind chill of 41 degrees F. Continued record review revealed Client #1's Behavior Support Plan (BSP), approved on	W 193		

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W 193	Continued From page 25 9/30/18. The BSP noted target behaviors of verbal aggression (yelling, arguing, threatening), physical aggression (hitting, kicking, pushing), property destruction (kicking items, throwing items, slamming doors, punching walls), and exiting the home. Restrictive measures included the use of behavior modifying medications (Clonidine, Geodon, Diazepam, and Sertraline), no hand held electronics, supervised phone calls and visits with his family, and his bicycle was to be locked in a shed with specified times to ride it. The BSP instructed staff to watch the exit doors at 835 (a previous facility), know Client #1's whereabouts at all times, staff accountable for Client #1 was to wear a bracelet to ensure his supervision, and when in his bedroom or bathroom staff were to complete checks every 20 minutes. The BSP instructed Client #1 was not to go outside by himself. Client #1's Comprehensive Functional Assessment (CFA), dated 6/4/18, identified the following needs: providing name, address, and phone number, using caution with strangers, using sidewalks/crosswalks, using traffic/pedestrian signals. Additional record review revealed the Therap (facility electronic record) BSP and ISP acknowledgment reports of staff training completed. The report revealed DSA/CMA A was trained on Client #1's BSP on 10/8/18, after the incident; she had not acknowledged any training on Client #1's ISP before Client #1 moved to a different facility within the agency on 10/27/18. A temporary staff acknowledged training on Client #1's BSP on 10/10/18 but there was no name associated with this acknowledgment. No temporary staff had acknowledged any training	W 193		

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W 193	Continued From page 26 completed on Client #1's ISP. When interviewed on 11/13/18 at 1:20 p.m., Direct Support Associate/Certified Medication Aide (DSA/CMA) A stated she worked at the facility on 10/4/18. She stated Client #1 had been upset off and on and had gone to his bedroom at approximately 10:45 a.m. when she last saw him, prior to her going to the kitchen to make lunch. She stated the HCBS PM called the facility before lunch to let the facility know Client #1 was at one of the waiver houses. DSA/CMA A reported she was unaware Client #1 had left. DSA/CMA A explained no one had direct accountability for Client #1 as all staff working would assist all the clients. She said she was not aware Client #1's staff was to wear a bracelet and explained there were no bracelets available for staff. DSA/CMA A said no staff were assigned to watch the exit doors but explained whoever was working in the front of the facility would keep an eye on the doors. DSA/CMA A said on 10/4/18 Client #1's bike sat in the front yard of the facility prior to him leaving on it. She said the facility did not have a shed to keep the bike locked in but said on 10/5/18 a bike lock was placed on Client #1's bike. DSA/CMA A stated she was not aware of Client #1 having specified times to ride his bike. DSA/CMA A reported she was not trained on Client #1's BSP until after the incident. When interviewed on 11/13/18 at 3:30 p.m., DSA B explained she was not an agency employee but worked for a temporary staffing agency. She stated she worked at the facility on 10/4/18. DSA B said as she was assisting another client in the facility she would look in on Client #1 when she walked past his bedroom; the last time she observed Client #1 was between 10:30 a.m. and	W 193		

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W 193	Continued From page 27 10:45 a.m. and he was playing video games in his bedroom. DSA B said she found out Client #1 had left the facility after the facility received a phone call at approximately 11:20 a.m. from the HCBS PM who reported Client #1 was at one of the waiver houses after he had been observed riding his bike without staff. DSA B said she did not recall any bracelets in the facility on 10/4/18. She reported she assisted another client all day and was unsure who had accountability for Client #1. She stated Client #1's bike was not locked up on 10/4/18 and was not aware Client #1's bike was to be locked in a shed. DSA B said she was not aware exit doors were to be watched or that a bracelet was to be used to ensure supervision of Client #1. DSA B said she was not trained on Client #1's ISP or BSP prior to the incident. DSA B explained she worked for the temporary staffing agency and did not receive much, if any, training on client specifics. She said temporary staff received initial 30-minute training on various facility policies and some basic client information for the initial facility worked in but explained temporary staff worked in all the different agency facilities. She stated she had to seek out client information from other staff when she worked in a facility and was normally told the basic information such as possible behaviors, client diets, and just enough information to get through the shift. DSA B explained temporary staff were not to address client behaviors except to step in between clients, if needed, and a facility staff was to implement any further interventions since temporary staff were not trained in Mandt, the facility behavior management system. She stated she had found client books in the facility but explained the books were kept in various locations and the information was not always current depending on what facility she worked in	W 193		

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for the agency. DSA B stated she was not aware client ISPs and client programming information was available on Therap (electronic record). She explained each facility provided temporary staff with a single log-in for Therap to be used for all temporary staff who worked in the facility.

When interviewed on 11/13/18 at 5:00 p.m., Client #1 said he left the facility on his bike because he was mad at a peer. He said the HCBS PM saw him and had him wait with her at the waiver house until he was picked up by the facility. He said it was easy to leave because staff had not checked on him and he left when all the staff were busy.

When interviewed on 11/14/18 at 9:30 a.m., DSA C explained she worked through a temporary staffing agency and was not employed through the facility. DSA C said she worked at the facility on 10/4/18 but had not worked there since around the beginning of summer, before Client #1 moved into the facility. She said DSA B, another temporary staff, gave her a brief rundown of the clients and then she started to help clients get up for the day. DSA C said between 9:45 a.m. - 10:00 a.m. she observed Client #1 had a bike helmet on and was upset about a peer's behavior. She stated she reminded Client #1 not to leave without staff and Client #1 returned to his bedroom. DSA C said before lunch, the facility received a phone call and was informed Client #1 had left the facility and was at one of the waiver homes. She said she was told Client #1 had ridden his bike past one of the waiver homes when the worker at the home saw and stopped him. She said she was not aware Client #1 was at risk to elope until he eloped. DSA C stated she was not aware Client #1's bike was to be locked

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W 193	Continued From page 29 up, the exit doors were to be monitored, Client #1's staff was to wear a bracelet, or even how frequently Client #1 was to be checked by staff. DSA C was shown a copy of Client #1's ISP and BSP; she stated she had not seen the documents before and had not been trained on the services and supports Client #1 was to receive. She continued to explain temporary staff had a single log-in per facility to use for Therap. She explained if something changed, she wouldn't see the update if another temporary staff had acknowledged it on the Therap. DSA C explained when documenting in Therap, the system would ask if the client completed the task, normally in a yes/no format, but explained the entire program was not shown. She said some facilities provided a paper document, which noted some basic information on each client but said she did not recall any of these available on 10/4/18. She said she was told there are client books within each facility she could read if she would like more detailed information on each client. DSA C said temporary staff did not address client behaviors other than to redirect and keep clients safe. She explained temporary staff were not trained in Mandt, the facility behavior management system, and therefore the facility staff were to intervene during client behaviors. She said she has refused to work at the facility since Client #1 eloped due to a lack of training on how to address client behaviors. When interviewed on 11/13/18 at 2:05 p.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff were not trained on Client #1's BSP until after the incident. She explained all temporary staff were provided the same log-in information for Therap for the facility which did not record anything by the temporary staff's	W 193		

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W 193	Continued From page 30 name. The QIDP said after one temporary staff acknowledged anything in Therap, the other temporary staff would not be provided the information when they logged in. The QIDP stated she did not know who the temporary staff was that acknowledged Client #1's BSP on 10/10/18. The QIDP reviewed the ISP acknowledgement report and confirmed staff were not trained on Client #1's ISP either. When interviewed on 11/15/18 at 10:45 a.m., the Home and Community Based Services Program Manager (HCBS PM) reported she was working at a waiver house on 10/4/18, several blocks from the facility. She said between 11:10 a.m. and 11:20 a.m. she saw Client #1 riding his bike but didn't see a staff with him. The HCBS PM said she went outside, tried to talk to Client #1 but he continued to ride past the house. The HCBS PM said she yelled his name several times, saw he had headphones on, so she ran up to Client #1 to get his attention. She said Client #1 told her he was mad and going to the previous facility he lived at to talk to a staff; he said his staff was not aware he had left the facility. The HCBS PM said Client #1 went into the waiver house with her. She called the on-call supervisor and reported the incident then called the facility. She stated DSA/CMA A said she thought Client #1 was in his bedroom. The HCBS PM stated Client #1 stayed at the waiver house with her until someone came to pick him up approximately fifteen minutes later. The HCBS PM said Client #1 was casually riding his bike and appeared focused on going forward. She stated there was no traffic at the time and Client #1 was riding on the right side of the road by the curb. 2. Record review on 11/13/18 revealed a facility	W 193		

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W 193	Continued From page 31 General Events Report (GER), dated 10/19/18, which was completed by Direct Support Associate/Certified Medication Aide (DSA/CMA) D who worked at the adjacent facility. According to the report, on 10/19/18 at 7:15 p.m. Client #1 went to the adjacent facility without his facility staff knowing. The GER noted the adjacent facility staff wanted to wait to see how long it took Client #1's facility staff to notice he had left. At 7:29 p.m. DSA/CMA E (adjacent facility staff) notified the on-call supervisor. The GER noted at 7:45 p.m., DSA/CMA E walked to the facility, casually asked about Client #1 and was told he was in his bedroom. DSA/CMA E returned to the adjacent facility and notified the on-call supervisor Client #1's facility staff was unaware he was gone. The GER noted the supervisor instructed DSA/CMA E to call the facility and inform the staff Client #1 was at the adjacent facility. According to the GER, at approximately 7:50 p.m., the adjacent facility notified Client #1's facility staff Client #1 was with them. At 7:53 p.m., a DSA H walked him back to the facility. Continued record review revealed Client #1's Behavior Support Plan (BSP), approved on 9/30/18. The BSP noted target behaviors of verbal aggression (yelling, arguing, threatening), physical aggression (hitting, kicking, pushing), property destruction (kicking items, throwing items, slamming doors, punching walls), and exiting the home. Restrictive measures included the use of behavior modifying medications (Clonidine, Geodon, Diazepam, and Sertraline), no hand held electronics, supervised phone calls and visits with his family, and his bicycle was to be locked in a shed with specified times to ride it. The BSP instructed staff to watch the exit doors at 835 (a previous facility), know Client #1's	W 193		

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W 193	Continued From page 32 whereabouts at all times, staff accountable for Client #1 was to wear a bracelet to ensure his supervision, and when in his bedroom or bathroom staff were to complete checks every 20 minutes. The BSP instructed Client #1 was not to go outside by himself. If Client #1 did leave, one staff was to follow him until he returned to the facility. Additional record review revealed Therap (facility electronic record) acknowledgement report for staff training completed on Client #1's BSP. According to the report, neither DSA F or DSA/CMA G acknowledged they were trained on Client #1's BSP. The report noted on 10/10/18 a temporary staff acknowledged being trained on Client #1's BSP but Therap failed to identify who the staff was by name. Continued record review revealed a facility Supervision Training initiated after Client #1 eloped on 10/4/18. The training provided levels of supervision for each client who resided within the facility. The document instructed staff were to know where the clients were at all times by monitoring their assigned clients, reporting responsibility over to a different staff if unable to provide the required supervision for their assigned clients, and to know the level of supervision for their assigned clients. The document noted Client #1 was to be checked every fifteen minutes in his room, monitor the doors if out of his room, follow him outside, and staff were to be with him in the community. The training did not instruct staff to wear a bracelet to ensure accountability and supervision of Client #1. DSA/CMA G signed the training on 10/12/18, DSA H signed on 10/18/18, and DSA F was trained on 11/1/18. The staff were not able to	W 193		

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W 193	Continued From page 33 demonstrate correct implementation of the interventions identified in Client #1's BSP, or the Supervision Training, as evidenced by failure to ensure a staff was assigned accountability, by wearing a bracelet, of Client #1 on 10/19/18. When interviewed on 11/14/18 at 12:35 p.m., DSA F stated on 10/19/18 he thought Client #1 had left with a peer and DSA/CMA G to go to the store since he walked outside when they were leaving. DSA F said approximately five minutes later, DSA/CMA E came to the facility, casually asked about Client #1, and retrieved some medication cups, then left. He stated DSA/CMA E never said Client #1 was at the adjacent facility. DSA G stated approximately five to ten minutes later, DSA/CMA E called and reported Client #1 was at the adjacent facility and had been there for about an hour. DSA F said DSA H immediately went over and walked him back to the facility. DSA F explained no one had direct accountability for Client #1 as all staff were helping all the clients in the facility. DSA F said he was not aware Client #1's staff was to wear a bracelet. He explained he was not consistently provided updated information prior to working at different facilities therefore he followed what the primary staff instructed. DSA F confirmed he was a primary staff at the adjacent facility but was working overtime at 105 Kelly's Court. DSA F said he was not trained on Client #1's BSP while Client #1 resided at the facility. When interviewed on 11/14/18 at 1:20 p.m., DSA/CMA G said after she assisted with the evening medication pass, she provided Client #1 toothpaste and prompted him to brush his teeth. She stated she then left with another client to go to the store and was gone for maybe fifteen	W 193		

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W 193	Continued From page 34 minutes. DSA/CMA G reported Client #1 did not walk outside when she and the other client were leaving for the store. DSA/CMA G said on 10/19/18 they (staff) did not clarify who was accountable for which clients at the facility. She stated she had a bracelet for accountability of another client but did not have Client #1's bracelet. She stated she was uncertain if any of the staff had Client #1's bracelet. When interviewed on 11/14/18 at 3:05 p.m., DSA/CMA D said she worked at one of the adjacent facilities on 10/19/18 when Client #1 walked in. She said they waited to see if a staff was behind him, no one was, and DSA/CMA E suggested they not call Client #1's facility to see how long it took the staff to realize he was gone. She said she told DSA/CMA E the on-call supervisor needed notified so DSA/CMA E called and reported the incident. DSA/CMA D said after DSA/CMA E spoke to the on-call supervisor DSA/CMA E reported they were instructed to go to the facility to see if staff knew Client #1 had left. DSA/CMA E went to Client #1's facility and when she returned she again called the on-call supervisor and reported the facility was not aware Client #1 was gone and had told her Client #1 was in his bedroom. DSA/CMA D stated she spoke to Client #1 for a while before they called to let the facility know Client #1 had left and was at the adjacent facility. DSA/CMA D reported Client #1 was at the adjacent facility for approximately 24 minutes before they called and informed the facility he was gone. When interviewed on 11/14/18 at 3:45 p.m., DSA I explained she worked for a temporary staffing agency and was assigned to work in the facility adjacent to Client #1's facility on 10/19/18. DSA I	W 193		

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W 193	Continued From page 35 said Client #1 arrived at the adjacent facility and reported his staff was not aware he had left. DSA I stated Client #1 told her he walked out the back door of his facility. DSA I stated DSA/CMA E wanted to wait to see how long it took Client #1's facility staff to realize he had left but said DSA/CMA E called and informed the on-call supervisor of the incident. DSA I said DSA/CMA E went to Client #1's facility and when she returned she again called the on-call supervisor who instructed them to let Client #1's staff know he was at the adjacent facility. DSA I said DSA H went to the adjacent facility and walked Client #1 back home. DSA I said she let Client #1 know he could return to the adjacent facility if he continued to have issues at his facility. When interviewed on 11/14/18 at 4:45 p.m., the Direct Support Supervisor (DSS) said she received a call on 10/19/18 from DSA/CMA E who informed her Client #1 had come to the facility adjacent to his but was unsure if the facility staff had knew he was gone. She reported DSA/CMA E stated she had already gone to Client #1's facility and was told Client #1 was there. The DSS stated she instructed DSA/CMA E to immediately call and let Client #1's staff know he was at the adjacent facility. The DSS confirmed she was aware Client #1 had eloped from the facility on 10/19/18. When interviewed on 11/15/18 at 8:15 a.m., the DSM explained the DSS had called her on 10/19/18, along with several other people. The DSM said she was told DSA/CMA G observed Client #1 leave the facility on 10/19/18 therefore instructed the DSS to follow-up with DSA/CMA G to determine if she actually witnessed Client #1 when he left. The DSM confirmed she did not	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G156	A. BUILDING _____ B. WING _____	C 11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 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 193	Continued From page 36 follow-up with the DSS afterwards. When interviewed on 11/15/18 at 8:55 a.m., DSA/CMA E reported on 10/19/18 Client #1 showed up at the facility, which is adjacent to his facility, without staff. She said Client #1 had told her he was upset with one of his peers so he left the facility without telling his staff. DSA/CMA E said she wanted to wait to notify his facility to see how long it would take them to notice Client #1 was gone. She said approximately fifteen minutes later she went to Client #1's facility, casually asked about him and was told he was in his bedroom. She reported she called the on-call supervisor to report the incident. DSA/CMA E said she told the on-call supervisor she wanted to see how long it would take the facility staff to notice Client #1 was gone and was told okay. She said approximately fifteen minutes later, she again called the on-call supervisor and was instructed to immediately call and let the facility know Client #1 was gone and at the adjacent facility. She stated she called and informed the facility and approximately ten minutes later DSA H arrived and walked Client #1 back to his facility. When interviewed on 11/15/18 at 10:20 a.m., DSA H explained she worked for the temporary staffing agency and was assigned to work at the facility on 10/19/18. She said after supper, she and DSA F were assisting other clients and Client #1 was in his bedroom. She said DSA/CMA G left with a client to go to the store and Client #1 had walked outside with them so she thought Client #1 had gone with DSA/CMA G. DSA H said approximately fifteen minutes later they received a call from the adjacent facility and was informed Client #1 was there. She stated she immediately went to the adjacent facility and walked with	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G156	A. BUILDING _____ B. WING _____	C 11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 KELLY'S COURT FOREST CITY, IA 50436

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W 193	Continued From page 37 Client #1 back to his facility. DSA H explained she had not received any client specific training. She said she sought out information and would ask for client books to review. Review of facility policies revealed the "Mandatory Orientation and Training Policy", last revised 11/1/17. According to the policy, the QIDP/DSM/PM was responsible for training employees when changes were made to a clients ISP and/or BSP. The policy instructed employees who were cross training at other sites were to receive a minimum of two hours of training by the DSS to ensure the staff was trained to support each client's needs and become acclimated to the new environment. The policy continued to instruct, any employee who was scheduled to work at a site they had not previously been trained at were to receive two hours of training. When interviewed on 11/15/18 at 11:05 a.m., the Associate Director (AD) confirmed staff were not consistently trained on client plans prior to working in the facility.	W 193		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	960156	A. BUILDING: _____ B. WING _____	C 11/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-105 KELLY'S COURT	105 KELLY'S COURT FOREST CITY, IA 50436

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C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report client elopement to the Department of Inspections and Appeals (the Department) in accordance with state code. This affected 1 of 1 client (Client #1) involved in the investigation of #79615-I. Finding follows: Record review on 11/13/18 revealed a facility General Events Report (GER), dated 10/19/18, completed by Direct Support Associate/Certified Medication Aide (DSA/CMA) D who worked at the adjacent facility. According to the report, on 10/19/18 at 7:15 p.m. Client #1 went to the adjacent facility without his facility staff's knowledge. The GER noted the adjacent facility's staff wanted to wait to see how long it took Client #1's staff to notice he left. At 7:29 p.m. DSA/CMA E (adjacent facility staff) notified the on-call supervisor. The GER noted at 7:45 p.m., DSA/CMA E walked to the facility, casually asked about Client #1 and was told he was in his bedroom. DSA/CMA E returned to the adjacent facility and notified the on-call supervisor Client #1's facility staff was unaware he was gone. The GER noted the supervisor instructed DSA/CMA E	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOSAIC-105 KELLY'S COURT	105 KELLY'S COURT FOREST CITY, IA 50436

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C 147	Continued From page 1 to call the facility and inform the staff Client #1 was at the adjacent facility. According to the GER, at approximately 7:50 p.m., the adjacent facility notified Client #1's facility staff Client #1 was with them. At 7:53 p.m. DSA H walked him back to the facility. When interviewed on 11/14/18 at 12:35 p.m., DSA F stated on 10/19/18 he thought Client #1 left with a peer and DSA/CMA G to go to the store since he walked outside when they were leaving. DSA F said approximately five minutes later, DSA/CMA E came to the facility, casually asked about Client #1, retrieved some medication cups, then left. He stated DSA/CMA E never said Client #1 was at the adjacent facility. DSA G stated approximately five to ten minutes later, DSA/CMA E called and reported Client #1 was at the adjacent facility and had been there for about an hour. DSA F said DSA H immediately went over and walked him back to the facility. DSA F explained no one had direct accountability for Client #1 as all staff were helping all the clients in the facility. DSA F said he was not aware Client #1's staff was to wear a bracelet. When interviewed on 11/14/18 at 1:20 p.m., DSA/CMA G said after she assisted with the evening medication pass, she provided Client #1 toothpaste and prompted him to brush his teeth. She stated she then left with another client to go to the store and was gone for maybe fifteen minutes. DSA/CMA G reported Client #1 did not walk outside when she and the other client were leaving for the store. DSA/CMA G said on 10/19/18 they (staff) did not clarify who was accountable for which clients at the facility. She stated she had a bracelet for accountability of another client but did not have Client #1's bracelet. She stated she was uncertain if any of	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 147	Continued From page 2 the staff had Client #1's bracelet. When interviewed on 11/14/18 at 3:05 p.m., DSA/CMA D said she worked at one of the adjacent facilities on 10/19/18 when Client #1 walked in. She said they waited to see if a staff was behind him, no one was, and DSA/CMA E suggested they not call Client #1's facility to see how long it took the staff to realize he was gone. She said she told DSA/CMA E the on-call supervisor needed notified so DSA/CMA E called and reported the incident. DSA/CMA D said after DSA/CMA E spoke to the on-call supervisor DSA/CMA E reported they were instructed to go to the facility to see if staff knew Client #1 left. DSA/CMA E went to Client #1's facility and when she returned she again called the on-call supervisor and reported the facility was not aware Client #1 was gone and had told her Client #1 was in his bedroom. DSA/CMA D stated she spoke to Client #1 for a while before they called to let the facility know Client #1 had left and was at the adjacent facility. DSA/CMA D reported Client #1 was at the adjacent facility for approximately 24 minutes before they called and informed the facility he was gone. When interviewed on 11/14/18 at 3:45 p.m., DSA I explained she worked for a temporary staffing agency and was assigned to work in the facility adjacent to Client #1's facility on 10/19/18. DSA I said Client #1 arrived at the adjacent facility and reported his staff was not aware he had left. DSA I stated Client #1 told her he walked out the back door of his facility. DSA I stated DSA/CMA E wanted to wait to see how long it took Client #1's facility staff to realize he had left but said DSA/CMA E called and informed the on-call supervisor of the incident. DSA I said DSA/CMA E went to Client #1's facility and when she returned	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 147	Continued From page 3 she again called the on-call supervisor who instructed them to let Client #1's staff know he was at the adjacent facility. DSA I said DSA H went to the adjacent facility and walked Client #1 back home. When interviewed on 11/14/18 at 4:45 p.m., the Direct Support Supervisor (DSS) said she received a call on 10/19/18 from DSA/CMA E who informed her Client #1 came to the facility adjacent to his but was unsure if the facility staff had knew he was gone. DSS reported DSA/CMA E stated she had already gone to Client #1's facility and was told Client #1 was there. The DSS stated she instructed DSA/CMA E to immediately call and let Client #1's staff know he was at the adjacent facility. The DSS confirmed she was aware Client #1 had eloped on 10/19/18. When interviewed on 11/15/18 at 8:15 a.m., the Direct Support Manager (DSM) explained the DSS had called her on 10/19/18, along with several other people. The DSM said she was told DSA/CMA G observed Client #1 leave the facility on 10/19/18 therefore instructed the DSS to follow-up with DSA/CMA G to determine if she actually witnessed Client #1 when he left. The DSM confirmed she did not follow-up with the DSS afterwards. When interviewed on 11/15/18 at 8:55 a.m., DSA/CMA E reported on 10/19/18 Client #1 showed up at the facility, adjacent to Client #1's facility, without staff. She said Client #1 told her he was upset with one of his peers so he left the facility without telling his staff. DSA/CMA E said she wanted to wait to notify his facility to see how long it would take them to notice Client #1 was gone. She said approximately fifteen minutes later she went to Client #1's facility, casually	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 147	Continued From page 4 asked about him and was told he was in his bedroom. She reported she called the on-call supervisor to report the incident. DSA/CMA E said she told the on-call supervisor she wanted to see how long it would take the facility staff to notice Client #1 was gone and was told okay. She said approximately fifteen minutes later, she again called the on-call supervisor and was instructed to immediately call and let the facility know Client #1 was gone and at the adjacent facility. She stated she called and informed the facility and approximately ten minutes later DSA H arrived and walked Client #1 back to his facility. When interviewed on 11/15/18 at 10:20 a.m., DSA H explained she worked for the temporary staffing agency and was assigned to work at the facility on 10/19/18. She said after supper, she and DSA F assisted other clients and Client #1 was in his bedroom. She said DSA/CMA G left with a client to go to the store and Client #1 walked outside with them so she thought Client #1 went with DSA/CMA G. DSA H said approximately fifteen minutes later they received a call from the adjacent facility and was informed Client #1 was there. She stated she immediately went to the adjacent facility and walked with Client #1 back to his facility. When interviewed on 11/15/18 at 11:05 a.m. the Associate Director (AD) explained on 10/19/18 the DSM informed her Client #1 possibly eloped and an internal inquiry was initiated. The AD said the DSM contacted her over the weekend and informed her DSA/CMA G witnessed Client #1 leave the facility and go to the adjacent facility on 10/19/18. The AD said she did not review the internal inquiry after she was told of the results. The AD confirmed the facility failed to report Client #1's elopement on 10/19/18 to the	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 147	Continued From page 5 Department.	C 147		

OK 1/7/19

1/7/19

MOSAIC Forest City
105 Kelly's Court
Forest City, IA 50436
PLAN OF CORRECTION
Investigation #79615-I

Investigation Date: 11/13/18-11/21/18

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS:
The facility will 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.

1. QIDP will retrain all staff on Mandatory Reporter Policies and Mistreatment/Abuse Procedure.
2. QIDP will retrain all staff on the Elopement Policy.
3. QIDP will retrain all staff on completing a GER.
4. QIDP will retrain all staff on the bracelet supervision procedure.
5. Interim ED will retrain all on-call personnel on expectations of responding to elopement and abuse allegations.
6. The QIDP will complete monthly observations and review GERs regularly to prevent recurrence of this deficiency.
7. Completion Date: 12.4.18

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS:
The facility will have evidence that all alleged violations are thoroughly investigated.

1. QIDP will retrain all staff on Mandatory Reporter Policies and the Mistreatment/Abuse Procedure.
2. QIDP will retrain all staff on the Elopement Policy.
3. QIDP will retrain all staff on completing a GER.
4. QIDP will retrain all staff on the bracelet supervision procedure.
5. Interim ED will retrain all on-call personnel on expectations of responding to elopement and abuse allegations.
6. The QIDP will complete monthly observations and review GERs regularly to prevent recurrence of this deficiency.
7. Completion Date: 12.4.18

W 158 483.430 FACILITY STAFFING:
The facility will ensure that specific facility staffing requirements are met.

1. QIDP will ensure ISPs are current and will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.
2. QIDP will ensure all staff are trained on person's ISPs and/or BSPs.
3. Completion Date: 12.4.18

W 159 483.430(a) QIDP:

Each client's active treatment program will be integrated, coordinated and monitored by a qualified intellectual disability professional.

1. QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.
2. QIDP will ensure all staff are trained on each person's ISP's.
3. QIDP will ensure people's ISP's, BSPs, CFA's and IDF's are up to date and current, including detailed information on monitoring and supervision the person in service.
4. Completion Date: 12.4.18

W 193 483.430(e)(3) STAFF TRAINING PROGRAM:

Staff will be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

1. QIDP will ensure all staff are trained on person's ISPs and/or BSPs and where these are located for reference.
2. QIDP will ensure people's ISP's, BSPs, CFA's and IDF's are up to date and current, including detailed information on monitoring and supervision the person in service.
3. The QIDP will retrain staff on the bracelet supervision procedure.
4. QIDP will monitor compliance with ISPs and health/medical procedures through monthly programming review and observations to prevent recurrence of this deficiency.
5. Completion Date: 12.4.18

C 147 50.7(4) ADDITIONAL NOTIFICATION:

The director or the director's designee will be notified within 24 hours, or the next business day, by the most expeditious means available.

1. Interim ED will retrain all on-call personnel on expectations of responding to elopement and abuse allegations, ensuring allegations are reported to AD and/or ED.
2. Interim ED, QAM, or DSM will ensure that reporting is completed to DIA within 24 hours or next business day when a person in service elopes.
3. Completion Date: 12.4.18