STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G080	A. BUILDING _____ B. WING _____	C 01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC-SETTLERS	1402 SETTLERS LANE DENISON, IA 51442

(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 Investigation #95026-I completed on 12/31/20 to 1/22/21 resulted in deficiencies written at W102 and W104. On 1/4/21 at 4:11 a.m., Immediate Jeopardy (IJ) was determined based on the facilities failure to ensure clients attended their medical appointments. The facility developed a plan to remove the IJ, which included, "Direct Support Supervisor will assure adequate staffing ratios and the utilization of staff for individualized supports to include the health, and safety for all individuals served." The facility will hold bi-weekly meetings to assure the facility meets the ratios and the facility takes the clients to their medical appointments. On 1/8/21 at 2:45 p.m., the facility had the IJ removed. During the investigation, a focused infection control survey was also completed and resulted in no deficiencies written.	W 000	POC 1/5/21	
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to comply with the Condition of Participation: Governing Body. The facility failed to ensure clients attended their medical appointments. The facility rescheduled a client's medical appointment three times. Before the	W 102		

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

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MOSAIC-SETTLERS	1402 SETTLERS LANE DENISON, IA 51442

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W 102	Continued From page 1 client attended his medical appointment, the client passed away. This affected 1 of 1 client (Client #1) reviewed during investigation #95026-I. Finding follows: Based on interviews and record reviews, the facility failed to provide oversight to ensure clients attended their medical appointments. See W104. On 1/4/21 at 4:11 a.m., Immediate Jeopardy (IJ) was determined based on the facilities failure to ensure clients attended their medical appointments. The facility developed a plan to remove the IJ, which included, "Direct Support Supervisor will assure adequate staffing ratios and the utilization of staff for individualized supports to include the health, and safety for all individuals served." The facility will hold bi-weekly meetings to assure the facility meets the ratios and the facility takes the clients to their medical appointments. On 1/8/21 at 2:45 p.m., the IJ was removed.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide oversight and direction to ensure the health and safety of clients. Specifically, the governing body failed to provide adequate oversight related to attendance of medical appointments. This affected 1 of 1 client (Client #1) reviewed during investigation	W 104		

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W 104	Continued From page 2 #95026-I. Finding follows: Record review revealed the following: a. Investigation Report dated 12/22/20 indicated staff found Client #1 in his bedroom, bleeding from his right fistula. Client #1 passed away at the hospital at 1:51 p.m. b. Client #1's ER (Emergency Room) Evaluation dated 12/22/20 at 1:58 p.m., indicated, "Patient is a 31-year-old mentally challenged male brought to the emergency room by EMS (Emergency Medical Services) in full cardiac arrest. The patient resides at a local facility and apparently has been having issues with his dialysis shunt in the right upper extremity. Nursing staff state that they contacted his dialysis facility about issues with the shunt and were told to bring him to the ER if he began bleeding profusely. According to the nursing staff he does not regularly come out and eat lunch and so had not been seen for an extended period of time. When he was found apparently he had been bleeding from the shunt as there was a large amount of blood on the bed and the floor and the patient was unresponsive. The down time was unknown. CPR (Cardiopulmonary Resuscitation) was initiated and the patient was transferred to the ER and was asystolic throughout the transfer and upon arrival..."CPR was discontinued and patient was pronounced deceased 13:51 (1:51 p.m.)." c. Client #1, 31 years-old, had diagnoses including mild intellectual disability, sacral spina bifida without hydrocephalus, epilepsy, essential hypertension, acute kidney failure, generalized anxiety disorder, and dysthymic disorder (persistent depressive disorder).	W 104		

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W 104	Continued From page 3	W 104		

d. Client #1's Individual Support Plan, approved 6/2/20, indicated he had been diagnosed with renal failure. He received a special diet and fluid restriction to assist with the condition. He received dialysis three times a week. The ISP provided high-risk protocol due to the renal failure and further noted staff should assess for and report signs of impaired renal function, maintain adequate fluid intake, assess for and report signs of acute renal failure, assess for edema each shift, montior intake and output, and consult with the nephrologist as needed.

e. Client #1's ISP further documented he required 15 minute checks from staff. He could be in his room safely with sporadic checks from staff.

When interviewed on 12/31/20 at 12:40 p.m. the Licensed Practical Nurse (LPN) stated Client #1 informed her on 12/17/20 he had a scab on his right fistula. The LPN called dialysis on 12/18/20 and they already made him an appointment to see the vascular surgeon 12/29/20. Dialysis instructed the LPN to monitor the area and go to the ER if it bled.

When interviewed on 12/31/20 at 12:40 p.m. the Program Manager (PM) stated Client #1 knew what to do when he started to bleed. She said he would have yelled out for help if he knew he was bleeding. According to the PM, it would take three to five minutes for Client #1 to bleed out.

When interviewed on 12/31/20 at 5:00 p.m. Direct Support Professional (DSP) A reported Client #1 got up for breakfast and went back to his bedroom. She went grocery shopping and to run errands with DSP C, shortly after breakfast and

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W 104	Continued From page 4	W 104		

returned to the home around 12:30 p.m. They did not take any clients with them. When they got back, staff told them to sit down and eat lunch. Staff informed her DSP B checked on Client #1 at 12:15 p.m. and he refused lunch. After DSP A ate lunch, she went to Client #1's bedroom to help him hook up bluetooth speakers she got for him at the store. When she walked in, she found Client #1 on his bed face down with his feet off the bed. DSP D put pressure on the bleeding and DSP C checked for a pulse. DSP A left the room to help the other clients while other staff assisted Client #1. According to DSP A, Client #1 knew to get help if bleeding.

When interviewed on 12/31/20 at 5:20 p.m. DSP B reported Client #1 got up for breakfast and went back into his bedroom. She checked on him about every 15 to 30 minutes. At approximately 11:30 a.m., DSP B asked Client #1 to eat lunch. Client #1 refused and stated he wanted to take a nap. At approximately 12:00 p.m., DSP B asked Client #1 if he wanted some tea, but he refused. At around 1:00 p.m., DSP B heard screaming and they called 911. DSP B stated Client #1 had two fistulas on each arm. He will pick at them and should have them wrapped. According to DSP B, Client #1 had an appointment that morning, but the facility cancelled the appointment due to a staff Christmas party.

When interviewed on 1/4/21 at 11:10 a.m. DSP C reported between 9:00 a.m. and 9:30 a.m., she ran errands and went grocery shopping with DSP A. They arrived back to the home at approximately 12:30 p.m. and did not take a client with them. At around 1:00 p.m., DSP A went into Client #1's room to talk to him about a bluetooth

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W 104	Continued From page 5	W 104		

speaker and DSP A yelled Client #1 needed help. They applied first aid and called 911. According to DSP C, Client #1 knew how serious it was when he bled. She stated they received training on the fistulas. DSP C reported Client #1 skipped lunch on a regular basis.

When interviewed on 1/4/20 at 11:38 p.m. DSP D reported she worked the morning shift of 12/22/20. She confirmed DSP B completed Client #1's checks every 15 to 30 minutes.

When interviewed on 1/4/20 at 12:32 p.m. Harlen Dialysis Registered Nurse (RN) stated she made Client #1 an appointment at the vascular surgeon on 12/22/20, but the facility changed the appointment because they did not have enough staff. She stated she informed the facility to monitor the scab on the fistula because it could fall off and bleed. She instructed to apply pressure and call 911 if the area bled. The RN stated it could bleed out in a matter of minutes.

When interviewed on 1/4/20 at 1:00 p.m. the LPN reported she could not remember who made the original appointment for Client #1 at the vascular surgeon on 12/22/20. She called Harlen Dialysis on 12/21/20 to inform them she needed to reschedule Client #1's appointment. The LPN stated they did not have enough staff to take Client #1 to his appointment on 12/22/20. She stated the supervisor was off and some of the staff had a funeral. According to the LPN, Harlen Dialysis did not have a problem with Client #1's rescheduled appointment.

When interviewed on 1/4/20 at 1:06 p.m. the PM reported the facility cancelled Client #1's appointment because four staff had a death in the

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W 104	Continued From page 6	W 104		

family and needed bereavement leave. She stated they originally had a Christmas party, but they cancelled the party because of the staff bereavement leave.

When interviewed on 1/5/20 at 4:17 p.m. the Physician Assistant at the vein clinic stated an aneurysm dilates around the fistula and could develop into ulceration. This could be a risk for rupture. She could not say how emergent it was without seeing him, but the area needed to be addressed.

When interviewed on 1/6/20 at 2:32 p.m. the Office Manager at the vein clinic stated Client #1 had an appointment scheduled for 11:00 a.m. on 12/22/20. The facility called on 12/18/20 and rescheduled to 12/23/20 because they did not have transportation. The facility called again on 12/21/20 and rescheduled to 12/29/20 because they did not have transportation.

When interviewed on 1/6/20 at 3:36 p.m. the LPN confirmed the facility rescheduled Client #1's appointment two times. She stated her boss told her to keep that information from the surveyor. The LPN stated on 12/18/20 she called and rescheduled Client #1's appointment to 12/23/20. The facility had a staff Christmas party on 12/22/20 and nobody wanted to take him to the appointment. The LPN stated staff wanted to prepare that day for the Christmas party that afternoon. On 12/21/20, facility staff had a grandfather pass away. The LPN did not know if they would have enough staff to take Client #1 to his appointment on 12/23/20 or have enough time after dialysis to take him so she rescheduled his appointment to 12/29/20. She stated she tried to get the appointment back to the original date, but

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W 104	Continued From page 7 the clinic was already full. Nobody told her it was urgent for Client #1's appointment.	W 104		

ok
3/1/21

Plan of Corrections

February 23, 2021

Mosaic – ICF/ID
1402 Settlers Lane
Denison, IA 51442

Mosaic Settlers Focused Infection Control Survey, Investigation #95026-I

Provider #16G080

102- Governing Body see W104

W104
Direct Support Supervisor will assure adequate staffing ratios, and the utilization of staff for individualized supports to include the health, and safety for all individuals served.
In the event that staffing ratios would change the Direct Support Supervisor, Facility Nurse, Program Manager, or designated employee will be responsible to take the individual served to the scheduled medical appointment.
This will be quality assured by the Program Manager giving a final staffing schedule approval bi-weekly. The Program Manager, Facility Nurse, and Direct Support Supervisor will hold weekly team meetings to review the upcoming week's medical appointments/ staffing ratios, to assure all medical needs are met started 01/05/2021and are ongoing.