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
	170023H	A. BUILDING: _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCYONE NORTH IOWA MEDICAL CENTER	1000 FOURTH STREET SW MASON CITY, IA 50401

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T 000	Initial Comments The State Survey Agency (SA) conducted an on-site investigation into Complaint 118689-I that ended 7/18/24. The investigation related to the Iowa Hospital Licensure rules regarding abuse (IA-481.51.7) with the following state-level deficiencies identified.	T 000		
T 149	51.7(2) Abuse 51.7(2) Abuse prohibited. Each patient shall receive kind and considerate care at all times and shall be free from all forms of abuse or harassment. This REQUIREMENT is not met as evidenced by: Based on document review, policy review, and staff interviews, the Hospital Administrative staff failed to separate an alleged abuser from all patients after a witnessed incident of abuse for 1 of 22 patients (Patient #13). Failure to remove an alleged abuser from all patients resulted in the alleged abuser continuing to have access to all other Emergency Department (ED) patients seeking care after the allegation of abuse. This placed vulnerable patients at risk for further incidents of abuse. Findings include: Review of a hospital policy titled " Adult Dependent Abuse", reviewed 5/2024, revealed in part "...The facility will take all steps indicated to prevent any further potential abuse, neglect, or exploitation while the investigation is in process,	T 149		

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T 149	Continued From page 1 including possible suspension of the alleged staff member ...". A review of documentation of the Hospital ' s abuse investigation revealed, on 1/28/24 at 1:03 AM, Patient #13 threatened hospital staff, which resulted in a security call. Patient #13 returned to Room 5 but ran out again and attacked Staff HH (ED RN) behind the nurse's station. In an effort to control Patient #13 ' s behavior, Staff KK placed hands on the patient ' s neck. Review of Patient #13 ' s medical record revealed admission to the ED occurred on 1/27/24 at 11:08 AM ,and transfer to the Behavioral Health Unit (BHU) occurred on 1/28/24 at 2:22 PM. A summary of entries by staff are as follows: Staff JJ (ED Physician Assistant) documented on 1/27/24 at 12:10 PM, Patient #13 presented with a staff member from their group home due to increased agitation, anger, paranoia, and aggression in the preceding week. Staff JJ completed an Medical Screening Exam (MSE) with no remarkable findings. Staff JJ consulted Staff SS (Telehealth RN) who performed the telehealth behavioral health assessment and recommended admission. Staff H (Psychiatrist) accepted the admission and Patient #13 signed a voluntary admission agreement to the BHU. Due to no bed availability in the BHU, hospital staff boarded Patient #13 in the ED awaiting a bed. Staff J (ED Physician) documented at 1/28/24 at 7:29 AM, Patient #13 behaved calmly and cooperatively when they assumed care of the patient on 1/27/24 at 11:00 PM; however, the patient subsequently became severely agitated and combative. On 1/28/24 at 1:04 AM, Staff J	T 149		

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T 149	Continued From page 2 initiated a 12-hour hold due to Patient #13 attempting to fight ED staff and security officers. Staff J ordered restraints and an intramuscular injection of Versed and Cogentin (combination of medications used to relax an agitated patient) which nursing staff administered. Due to no bed availability in the BHU, Patient #13 remained boarded in the ED awaiting a bed. Staff M (ED Physician) documented on 1/28/24 at 10:56 AM they obtained a court order for a 48-hour involuntary hold from Staff SS (Judicial Hospitalization Referee) for Patient #13 after multiple "code whites" called for the patient ' s acute agitation and threatening of violence. During an interview on 7/18/24 at 8:18 AM, Staff A (Director of Accreditation and Regulatory Support Services) confirmed hospital policy does not require administrative staff to remove a staff member suspected of abuse of a patient for the remainder of the shift; however, Staff A reported all staff in leadership roles recognize this as the hospital ' s standard practice. Staff A explained Staff BB (Vice President, Patient Services/Chief Nursing Officer (CNO)) notified them of the alleged abuse on 1/28/24. Staff A confirmed Staff KK ceased contact with the patient but confirmed Staff KK finished the shift, which ended at 7:00 AM on 1/28/24. Per Staff A, Staff KK had not worked or been scheduled in the ER since then. Staff A explained Staff BB placed Staff KK on administrative leave on 1/30/24, and Staff BB notified Staff KK of the termination of their contract on 2/2/24 at 3:28 PM. During an interview on 7/11/24 at 9:45 PM, Staff HH (ED RN) recalled they did not have direct care of Patient #13 that shift but recalled multiple	T 149		

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attempts to redirect the patient. Staff HH explained they had called security because Patient #13 had chased a doctor down, was spitting, and would not return to Room 5. Staff HH recalled they had turned away from Patient #13 to call security again and the patient came toward Staff HH. Staff HH explained when they were attempting to move away from Patient #13, Staff KK moved behind the desk toward the patient and placed their hand on Patient #13 ' s shoulder and neck and tipped the patient back in an attempt to keep the patient from spitting on them. Staff HH reported when they turned back, Staff KK and Patient #13 were on the floor. Staff HH reported they had stepped away from the situation when BHU staff arrived and they were unsure who returned Patient #13 to Room 5.

During an interview on 7/10/24 at 1:45 PM, Staff J (ED Physician) revealed Patient #13 remained calm and cooperative on the evening of 1/27/24 when their night shift started. Staff J reported Patient #13 did become agitated, and hospital staff placed the patient in restraints on that shift.

During an interview on 7/10/24 at 8:30 PM, Staff L (Security officer) explained Patient #13 was attempting to get through two security officers who held onto the patient ' s arms. Staff L recalled Staff KK grabbed Patient #13 by the neck, pushing the patient backward. Staff L reported Patient #13 kneed Staff KK in the groin and Staff KK placed the patient in a choke hold and went to the ground. Staff L explained they secured Patient 13 ' s right arm and two other security officers had secured the left arm and one leg. Staff L reported they told Staff KK four times the security officers had the patient under control. Staff L explained, when they stood the patient up,

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T 149	Continued From page 4 Staff KK grasped Patient #13 by the back of the neck and guided the patient to Room 5. Staff L explained Staff KK left the room and BHU staff assisted in placing the patient in restraints. Staff L recalled, when they spoke to Staff F (Manager of Security), the two other security officers had already notified them. During an interview on 7/10/24 at 6:15 AM, Staff O (Security officer) explained Patient #13 had left Room 5 multiple times going after Staff HH. Staff O recalled they had placed the patient back into Room 5 and turned their back when Patient #13 quickly ran to the nurse ' s station toward Staff HH. Staff O reported Staff KK grabbed Patient #13 around the neck and took them to the ground. Staff O explained, along with the other two officers, they had control of the situation and walked Patient #13 back to Room 5 where they placed restraints on the patient. Staff O recalled Patient #13 behaving erratically for the majority of their ED and inpatient stay. During an interview on 7/11/24 at 12:37 PM, Staff P (RN House Supervisor) recalled a colleague informing them Patient #13 went after an ED RN with a weapon and Staff KK and stopped the patient. Staff P explained no one reported the situation as abuse until the next day when the Staff BB reviewed the video. During an interview on 7/11/24 at 8:30 AM, Staff F (Manager of Security) reported Staff O informed them of the situation on 1/28/24 at 7:00 AM during a briefing, and Staff F explained they reported it to the Staff PP (House Supervisor). Staff F confirmed hospital staff did not train employees to put hands around a person ' s neck in a hold.	T 149		

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T 149	Continued From page 5 During an interview on 7/10/24 at 3:49 PM, Staff G (RN ED Nurse Manager) recalled a colleague informing them on 1/29/24 that Patient #13 had gotten out of control and ran to the nurse ' s station threatening staff with dangerous items on the desk. Staff G (RN ED Nurse Manager) reported security officers became concerned with the rough handling of the patient and reported it to Staff F (Manager of Security). During an interview on 7/16/24 at 9:45 AM, Staff A (Director of Accreditation and Regulatory Support Services) confirmed that Staff KK (ED RN) remained working in the ED on 1/28/24 until 7:00 AM-after the alleged abuse with Patient #13. The census for the ED on 1/28/24 was 63 patients.	T 149		
T 162	51.7(5) Abuse 481-51.7(135B) Abuse. 51.7(5) Mandatory reporting of child abuse and dependent adult abuse. Each hospital shall ensure that written policies and procedures cover all requirements for the mandatory reporting of abuse pursuant to the Iowa Code. Each hospital shall provide that the treatment records of victims of child abuse or dependent adult abuse include a statement that the department of human services ' protective services was contacted. This REQUIREMENT is not met as evidenced by: Based on policy review, document review and	T 162		

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T 162	Continued From page 6 staff interviews, the Hospital ' s administrative staff failed to report a potential allegation of abuse, related to 1 of 22 patients (Patient #13), to the Department of Inspections, Appeals and Licensure (DIAL) within 24 hours. Failure to identify and immediately report adult abuse could potentially result in further abuse of hospital patients. Findings include: Review of a hospital policy titled "Abuse of Patient- Allegations Involving Staff", reviewed 1/2023, revealed in part "... Allegations must be reported to the applicable Federal/State agencies ... The Iowa Department of Inspections and Appeals (DIA) is responsible for the evaluation and disposition of dependent adult abuse reports concerning patient in hospitals were hospital staff are the alleged perpetrators. Call the DIA Hotline #515-281-7102 or 1-877-686-0027 within 24 hours ...". During an interview on 7/18/24 at 8:18 AM, Staff A (Director of Accreditation and Regulatory Support Services) confirmed hospital policy does not require removal of a staff member suspected of abuse for the remainder of the shift; however, Staff A reported all staff in leadership roles recognize this as the hospital ' s standard practice. Staff A explained Staff BB (Vice President, Patient Services/Chief Nursing Officer (CNO)) notified them of the alleged abuse on 1/28/24. Staff A confirmed Staff KK ceased contact with the patient but confirmed Staff KK finished the shift, which ended at 7:00 AM on 1/28/24. Per Staff A, Staff KK had not worked or been scheduled in the ER since then. Staff A	T 162		

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T 162	Continued From page 7 explained Staff BB placed Staff KK on administrative leave on 1/30/24, and Staff BB notified Staff KK of the termination of their contract on 2/2/24 at 3:28 PM. During an interview on 7/16/24 at 10:00 AM, Staff BB (Vice President, Patient Services/Chief Nursing Officer) acknowledged they did not report the allegation of abuse to DIAL because the hospital filed the Incident Report on 1/28/24 as an alleged abuse of hospital staff by a patient. Staff QQ conveyed the concern of the alleged abuse to Staff BB on 1/30/24 and at that time Staff BB escalated the situation to Staff A who self-reported to the SA.	T 162		