

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/06/2024
NAME OF PROVIDER OR SUPPLIER  Northern Mahaska Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  2401 Crestview Drive Oskaloosa, IA 52577	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26529</p> <p>Based on observations, record review, and staff, resident and resident responsible party interviews, the facility failed to ensure the environment remained free of hazards, and failed to ensure employees reported hazards that posed an immediate threat to the safety of all residents when at least 3 employees failed to report an employee had a loaded handgun in her purse that she brought into the facility stored at the Nurse's Station, unsecured, where a cognitively impaired resident gained access to the purse (Resident #1). The facility reported a census of 79 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/3/24 at 1:15 p.m. The IJ began on May 5, 2024. Facility staff removed the Immediate Jeopardy on 7/6/24 by implementing the following actions;</p> <p>a. All Nursing Staff educated between 6/26/24 and 7/6/24 on:</p> <ol style="list-style-type: none"> <li>1.) Firearms and weapons are not allowed on the premises, this includes in a vehicle in the parking lot.</li> <li>2.) If you see or hear of a firearm or weapon being on property.</li> <li>3.) Keep your personal belongings in your vehicle or the breakroom, not in public areas accessible to residents.</li> <li>4.) If the person being reported is your supervisor, please go to the next person in charge.</li> <li>5.) If a person or staff member enters facility carrying a weapon, who is not required to carry a weapon (i.e., a law enforcement officer) they will be asked to remove the weapon from the premises. If they refuse to do so, police will be contacted. Staff will move residents and other staff away from situation. Staff will notify manager on duty.</li> <li>6.) Education will be completed with new staff or contracted staff prior to the start of their next shift.</li> </ol> <p>Based on the corrective measures taken by the facility, the scope and severity was from a J level to a G level.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165274
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Findings include:</p> <p>The Annual Minimum Data Set (MDS) for Resident#1 dated 4/18/24 documented the resident had diagnoses including non-Alzheimer's Dementia, altered mental status, right hip pain. The MDS revealed that the resident scored a 4 out 15 for Brief Interview of Mental Status (BIMS), which indicated severe cognitive loss. The MDS documented that the resident used a manual wheelchair for mobility.</p> <p>The Residents Care Plan identified a focus area as follows; the resident had impaired cognitive function or impaired thought processes related to dementia. Resident continues to fidget with things and seeks things out activities to occupy her time, and sometimes this causes her to get into others things an invade other peoples personal space.</p> <p>The facility's self-reported incident dated 6/27/24 stated:</p> <p>Management notified of potential staff member with concealed carry within facility. Employee suspended pending investigation. Police notified. Further Investigation to follow. The facility's investigative summary completed by the Administrator stated she received a phone call around 7 p.m. on 6/26/24 from an employee (Staff D, Licensed Practical Nurse, LPN) who informed her that Staff B, Registered Nurse (RN) had just told her that a while back, Staff A, LPN, told Staff B that she forgot to take her gun out of her purse, brought it into the facility, and Resident #1 got a hold of it, Staff A was able to get it away from the resident and there were no injuries. The facility's investigation estimated the alleged incident occurred on May 5, 2024.</p> <p>The facility's daily nursing schedule/assignments revealed Staff A, Licensed Practical Nurse (LPN) was assigned to the 200 and 300 halls on the day shift (6 a.m. to 2 p.m.), and the first half of the evening shift (2 p.m. to 6 p.m.)</p> <p>The facility's Violence in the Workplace policy, dated effective 3/2015, directed that guns were prohibited from the premises, anyone that had a gun that was not someone that required it for their job, such as a law enforcement officer, was to be asked to remove the gun from the premises, and if the gun was not removed, staff were directed to call the police. The policy also directed if staff believed someone had brought a gun to work they were to notify the Administrator or immediate supervisor immediately.</p> <p>Observation at the Nurse's Station on 7/3/24 at 9:40 a.m. revealed the desk surfaces at the Nurse's Station were 60 inches wide, with open area under them, and the medication/treatment carts were 33 inches wide at the widest portion that included a waste receptacle.</p> <p>Observation on 7/6/24 at 1:25 p.m. revealed Resident #1 seated in a wheelchair, inside the Nurse's Station, and held a blood pressure cuff that was in a portable upright cart that staff used to take resident vital signs. A CNA near the resident asked if she could have it and was able to return the blood pressure cuff to the cart.</p> <p>Staff interviews revealed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/2/24 at 2:46 p.m. Staff C, Certified Nursing Assistant (CNA) stated she heard Staff A, LPN, talking out loud about she was happy the resident didn't get into her purse because she would have got a hold of her gun, it wasn't the first time she'd made the comments, she thought it had been discussed before based on how Staff A was talking about it at the time. Staff C didn't know who all might have heard Staff A as she talked about it, but others had to know, and thought she'd heard her talking about it a month or so ago. Staff A always kept her purse at the Nurse's Station, usually on top of the desk and not below it. The resident fidgets, she likes to hold on to things, she gets a hold of things and sometimes it's hard to get them away if she shouldn't have them or they belong to someone else, and is often in the Nurse's Station opening drawers and grabbing papers if she sees them. Staff A said she was glad she got Resident #1 before she got her gun.</p> <p>On 7/2/24 at 4:52 p.m., Staff B, Registered Nurse (RN), stated she was at work one day in May, Staff A said that she forgot her gun was in her purse when she came to work one day, Resident #1 got her purse, but she got to the resident before she got the gun. Staff B stated she told Staff A at that time that she needed to report it to management and she said she was going to. Some time had passed since then and she thought it had been dealt with. When she gave report to Staff D, LPN last week, they started talking about the resident going through purses, the subject of the gun came up and Staff D didn't know anything about it and said she was calling the Administrator, and did. The resident likes to be busy, she likes to rummage through things, will go through drawers at the Nurse's Station, she loves purses and is always looking for her purse.</p> <p>On 7/2/24 at 2:48 p.m. Staff D, LPN, stated on the evening shift on 6/26/24, Staff B told her about an incident where Resident #1 got a gun out of Staff A's purse and she had a gun in her purse. She called the Administrator on the phone and told her about it. Staff D knew staff could not bring a gun to work, and all staff have since been educated that if anyone brought a gun into the facility the were supposed to call the Administrator. There are lockers here for staff to use to store their belongings while they work.</p> <p>On 7/2/24 at 3:01 p.m. Staff A, LPN, stated she'd been out late the day before it happened and didn't think to take the gun out of her purse. She kept her purse under the Nurse's Station, and when she went to the office around 2 p.m. to talk about the scheduler, she blocked the area where her purse was with the treatment cart, she positioned it the long way in front of the desk and locked the wheels. She hadn't been gone even 5 minutes and realized she needed her calendar from her purse, went to the Nurse's Station to get the calendar and the resident had her purse sitting on top of the desk at the Nurse's Station, the resident had moved the treatment cart, with wheels still locked, out of the way and was able to get to her purse. The resident was seated in her wheel chair, she'd been going through the center part of her purse and said she was looking for her hairbrush, she hadn't taken anything out of her purse. She got to the resident as she started to unzip the side pocket, she'd unzipped it about 4 to 5 inches and Staff A was standing above her and could see the case for the gun and that was when she realized the gun was in her purse. She didn't think the resident saw it because she was seated and couldn't see into the purse like Staff A who stood above her. She got the purse away from the resident and normally didn't bring her gun to work. Staff A said nobody else saw or witnessed it, and the resident didn't get a hold of her gun. She didn't want to get in trouble so she didn't tell management. She said something about it to one of the aides around that time, and somebody turned it in quite a bit later. During another interview on 7/8/24 at 9:04 a.m., Staff A stated her gun was a 22 caliber [NAME].</p> <p>(continued on next page)</p>		

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