

**Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation**

Date: December 14, 2018
Program Name: Thalman Square Dementia Specific AL
Address: 5500 South Main St. Cedar Falls, IA 50613
Type of Action: 79442-I
Date(s) of Action: 11/19/18 – 11/21/18

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	<p><u>481—67.3(231B,231C,231D) Tenant rights.</u> All tenants have the following rights: <u>67.3(2)</u> To receive care, treatment and services which are adequate and appropriate.</p> <p>Based on interview and record review the Program failed to consistently provide adequate and appropriate care for 2 of 3 tenants reviewed (Tenant #1 and Tenant #2). Findings follow:</p> <p>Review of an incident report dated 10/9/18 revealed Tenant #1 entered Tenant #2's apartment. According to the incident report Staff A and B, along with Tenant #2, entered the apartment to ask Tenant #1 to leave. Tenant #2 was asked to remove herself for the apartment as she had become agitated as they were talking to Tenant #1. The incident report indicated as Tenant #2 was leaving, Tenant #1 stormed after her. Staff intervened by separating the tenants. Tenant #2 went into her apartment with the door locked, while Tenant #1 proceeded to walk around common areas. Tenant #1 was given Ativan in order to calm down. No injuries were noted but several pieces of ceramics had been broken by Tenant #1. The report was written by a Program nurse.</p> <p>Review of Staff A's Interview Statement of Witness dated 10-10-18 revealed Staff B requested his assistance in Tenant #2's room. Tenant #1 was in Tenant #2's bed and would not get up when asked. Staff A made several attempts to redirect him, but Tenant #1 either ignored him or yelled at him. Later Tenant #1 jumped out of the bed and cursed at them. Staff A stated he ran out of room and down the hall and heard glass breaking. He stated he tried to distract Tenant #1 away from Tenant #2 from down the hall. He then called the nurse after the incident.</p> <p>Review of Staff B's Interview Statement of Witness dated 10-11-18 revealed Tenant #2 approached her and was visibly upset. Tenant #1 was in her room lying on her bed. Staff B stated she called Staff A for assistance as Tenant #1 ignored requests to leave the room. Staff B shook the bed to wake Tenant #1 with no response. She stated after the 4th attempt to get the tenant up, he stood up really fast and grabbed something off of the nightstand. She stated she ran out of the room and down the hall. She checked on Tenant #2 after the incident.</p>	\$2500.00

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	<p>A video recording provided by the Program revealed Tenant #2 standing in the hallway across from her room. Staff A and Staff B ran out of her room followed by Tenant #1. Tenant #1 walked over to Tenant #2 and shoved her into the wall. Tenant #1 walked away followed by Tenant #2.</p> <p>Review of Tenant #1's file revealed diagnoses including early onset dementia, Alzheimer's type with behavioral disturbances, and major depressive disorder. The tenant resided on the memory care unit. Review of his service plan dated 10-1-18 revealed a history of agitation and physical aggression towards staff. During times of increased agitation or belligerence staff were to direct the tenant to a calm, safe area and provide 1:1 supervision. If Tenant #1 displayed physical aggression, staff were to move other tenants to safety and call the nurse for assistance.</p> <p>Review of Tenant #2's file revealed diagnoses including dementia. The tenant resided on the memory care unit. Review of her service plan dated 9-17-18 revealed she required supervision to ensure her safety due to confusion.</p> <p>When interviewed on 11-20-18 at 4:52 p.m. the Director stated she initiated an investigation regarding possible neglect for leaving a dependent adult in harm's way after reviewing video footage of the incident. Both Staff A and Staff B told her Tenant #1 had been agitated for quite awhile. Neither called the nurse because they felt they could handle the situation. Both staff said they attempted to get Tenant #1 to leave Tenant #2's bed by shaking him and the bed until he finally got up and ran after them. She stated both had been trained on behavior management and Tenant #1's service plan. Both staff were terminated for failure to follow code of conduct and leaving a tenant (Tenant #2) in harm's way.</p>	
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