

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2018
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NAME OF PROVIDER OR SUPPLIER THALMAN SQUARE DEMENTIA SPECIFIC AL	STREET ADDRESS, CITY, STATE, ZIP CODE 5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613
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(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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 29 Total Census of Assisted Living Program for People with Dementia: 30</p> <p>No regulatory insufficiencies were cited during the investigation of Incident #79767-1.</p> <p>The following regulatory insufficiency was cited during the investigation of Incident #79442-1.</p>	A 000	<p style="text-align: center;">✓ 11/16/19</p>	
A 013	<p>481-67.3(2) Tenant Rights</p> <p>481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.</p> <p>This REQUIREMENT is not met as evidenced by: 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: Review of an incident report dated 10/9/18 revealed Tenant #1 entered Tenant #2's</p>	A 013	<p>Staff educated regarding notification of nurse with behavioral concerns.</p> <p>Staff educated to escort other residents to a safe area if/when unable to redirect residents with behavioral concerns.</p> <p>Staff in question terminated upon investigation.</p> <p>All staff will be educated upon hire, annually, and PRN.</p> <p>Will be completed within 30 days.</p>	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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DD 11/19

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A 013	<p>Continued From page 1</p> <p>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</p>	A 013		

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A 013	<p>Continued From page 2</p> <p>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> <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</p>	A 013		

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A 013	Continued From page 3 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.	A 013		