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
	S0244	A. BUILDING: _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THALMAN SQUARE DEMENTIA SPECIFIC AL	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(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	Initial Comments 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. 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 The following regulatory insufficiencies were cited during the investigations of Incidents 78544-I, 78555-I and the recertification visit conducted to determine compliance with certification rules for a Dedicated Dementia Specific Assisted Living Program.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by:	A 003	Policy and procedure in regards to checks-service plans will be updated to state, "staff supervision with routine checks to determine needs." Clinical service plan coordinator and/or Director of Thalman Square and/or designee will ensure that service plans are updated. Policy and procedure related to incident reports- Director will review incident report policy with staff to initiate incident reports with accidents and/or incidents r/t behaviors and take corrective action. Plan of correction initiated immediately and will be completed by 11/16/2018.	

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

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A 003	Continued From page 1 Based on interview and record review the Program failed to ensure staff followed the policy and procedure regarding the provision of checks per tenants' service plans for 2 of 5 tenants reviewed (Tenants #1 and #3). The Program also failed to ensure incident reports were completed related to tenant behaviors per policy for 3 of 5 tenants reviewed (Tenants #1, #3 and #4). Findings follow: 1. Review of Incident Reports dated 9/4/18 at 1:30 AM for Tenants #1 and #3 respectively revealed Tenant #1 was found sleeping in Tenant #3's apartment. Tenant #1 was unaware of Tenant #3's presence in the bed. There were no indications of mental, emotional or physical injury. An environmental factor was Tenant #3's door was left unlocked. Staff was educated to lock tenant apartment doors at night. An Interview Statement of Witness for Staff A dated 9-4-18 at 3:30 p.m. indicated at 10:15 p.m. the previous night, she had completed rounds with second shift staff and Tenant #1 was asleep in bed. Second shift staff reported he had been sleeping most of the evening. When completing rounds at 1:20 a.m. she noted Tenant #1 was not in his bed so she checked surrounding apartments. She found Tenant #1 sleeping against the wall at the head of Tenant #3's bed with no blanket. Tenant #1 was not wearing any pants or undergarments and had on a shirt. Tenant #1's pajama bottoms were soiled with urine and were in front of Tenant #3's dresser. Tenant #3 was lying awake further down in the bed under the blankets. Tenant #3's hand was on Tenant #1's hip. Tenant #3 was not wearing any pants; however, it was noted Tenant #3 routinely slept without undergarments. Tenant #3	A 003		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 2 was wearing a shirt. Staff A woke Tenant #1 up and attempted to assist him back to his apartment and he became agitated. Staff A told Tenant #1 he was in bed with Tenant #3 as he was unaware that anyone else was in the bed. Staff A called another staff for assistance. When interviewed on 10-1-18 at 3:10 p.m. Staff A stated she worked 10:20 p.m. to 2:00 a.m. on the night of the incident between Tenant #1 and #3. She checked on the tenants at the start of her shift at 10:20 p.m. and both Tenants #1 and #3 were asleep in their apartments at that time. At 1:20 a.m. she knocked on Tenant #1's door but he was not in the apartment. She described finding the tenants as documented in her Interview Statement. She woke Tenant #1 up and told him he was in the wrong apartment. Staff A said there was a misunderstanding of the frequency of rounds for these tenants. When interviewed on 10-3-18 at 10:07 a.m. the Director of Assisted Living (AL) revealed she received a telephone call from staff regarding finding Tenant #1 in Tenant #3's apartment on rounds. No injuries were noted to either tenant. Tenant #1 and Tenant #3 were checked at 10:15 p.m. and at 1:20 a.m. Staff were to complete rounds every one and half to two hours, depending on individual service plans. Re-education was provided to Staff A regarding the frequency of the rounds and education on the locking the apartment doors at night (doors were to be locked from the exterior which still allowed tenants to exit from the interior). Staff were trained on the expectation of rounds during the delegation process. Frequency of rounds was also documented in service plans.	A 003		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 3 Review of the Staffing Policy revealed there would be one or more staff onsite 24 hours a day. Staff would check on tenants as indicated in their service plans. Review of Tenant #1's and Tenant #3's service plans revealed they were both to be checked on every 2 hours. Review of Staff A's training file revealed a Resident Assistant Orientation and Demonstration Checklist signed by Staff A. The document included training on rounds. 2. Review of Tenant #1's Progress Notes revealed the following: a. On 8-14-18 staff escorted Tenant #1 outside. The tenant hit staff and attempted to kick. He told staff to move their arms or he would break them. The tenant continued with violent behavior for approximately 15 minutes. Supervisors attempted to redirect with a cold drink and administered a scheduled dose of Seroquel. It was recommended that Tenant #1 be a one to one for the rest of the evening. Staff accompanied Tenant #1 outside for a hour and half and successfully escorted him back inside. b. On 9-5-18 it was noted Tenant #1 entered/exited other tenant apartments while also grabbing his spouse's and staffs' arms/hands. Tenant #1 made verbal threats to dump water on staff and pull off jewelry. - No incident reports for these behaviors could be located. Review of Tenant #3's file revealed Monitoring Notes initiated on 8-16-18 to document inappropriate sexual behavior revealed the following: a. On 8-18-18 it was noted Tenant #3 walked	A 003		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 4 inside from the patio and attempted to grope a staff member. b. On 8-19-18 it was noted Tenant #3 was seated on the bench outside of the nurse's station stroking a female tenant's upper thigh. Staff told him it was inappropriate and he got up and sat by a different female tenant. Shortly after, the tenants were observed holding hands and attempted to go to the female tenant's apartment alone. The tenants were separated. c. On 8-20-18 it was noted Tenant #3 was seated on a bench outside of the nurse's station. Tenant #3 rubbed another tenant's abdomen and stuck his hand down her pants. d. On 8-23-18 it was noted Tenant #3 was lying in bed under the covers when staff entered the apartment Tenant #3 removed the blanket, revealed himself to staff and asked "do you like what you see?" e. On 8-23-18 it was noted Tenant #3 rubbed another tenant's upper thigh and was told to stop the behavior as it was inappropriate. Tenant #3 said "You're no fun, I got caught." f. On 8-23-18 it was noted Tenant #3 was observed in a bedroom with a female tenant (both seated on the bed). When asked what was going on, Tenant #3 responded "nothing, let us have fun." Staff escorted the female tenant out of the room. g. On 8-26-18 it was noted Tenant #3 was observed in a room with a female tenant with his genitals exposed. Both tenants were separated and redirected. h. On 8-27-18 it was noted Tenant #3 was observed holding a female tenant's hand and taking her to an apartment. Staff separated the two and directed him to the dining room for lunch. Review of Tenants #3's Progress Notes revealed:	A 003		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 5 a. On 8-1-18 it was noted staff went to Tenant #3's apartment to set up cares and when staff turned around he took off his pants and exposed himself. Another staff went to the apartment to ensure cares were completed and Tenant #3 had not yet changed into pajamas. When the staff encouraged him to change Tenant #3 grabbed staff's shoulders and said "Do you want to help me?" b. On 8-5-18 it was noted a female tenant was seated on Tenant #3's lap. Staff redirected and took the female tenant back to her apartment. c. On 8-5-18 it was noted a female tenant was standing next to Tenant #3 and he rubbed the female tenant's bottom and front genital area over the top of her clothing. The female tenant was removed. Tenant #3 was very upset after she was moved away from him. d. On 8-23-18 it was noted Tenant #3 was observed in a room with a female tenant, both fully clothed. The female tenant was escorted out of the room. - No incident reports for these behaviors could be located. Review of Tenant #4's Progress Notes revealed the following: a. On 9-17-18 it was noted Tenant #4 left by ambulance at 4:35 p.m. to go the hospital for a psych evaluation. Tenant #4 hit and kicked staff/paramedics and refused to get on the gurney. Staff/paramedics were able to lift Tenant #4 onto a gurney using a blanket. Tenant #4 continued with violent behaviors toward paramedics while leaving the Program. b. On 9-27-18 it was noted Tenant #4 was disruptive at dinner. She threw silverware on the floor and towards other tenants, yelled and	A 003		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 003	Continued From page 6 refused medication. Tenant #4's spouse left the dining room due to behaviors. Tenant #4 attempted to throw a spoon at another tenant and was removed from the dining room. - No incident reports for these behaviors could be located. The Program's Incident/Accident Reports policy indicated the purpose of the reports was to provide documentation of events in order to study the cause of an accident or incident and to take corrective action. When interviewed on 10-4-18 at 11:15 a.m. the Director of AL confirmed there were no incident reports for Tenants #1, #3 and #4 related to the behaviors noted above	A 003		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected identified needs for 5 of 5 tenants reviewed (Tenants #1, #2, #3, #4 and #5). Findings follow: 1. Review on 10-2-18 of Tenant #1's file revealed	A 089	Service plans to reflect identified needs-Clinical Service Coordinator and/or Director of Thalman Square or designee will ensure service plans reflect tenant needs with initial assessment, 30 day review, quarterly, and annual reviews, and all significant changes. Plan of correction initiated immediately and will be completed by 11/16/18.	

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A 089	Continued From page 7 the following Progress Notes: a. On 7-27-18 it was noted Tenant #2 was yelling "no, no" and staff observed Tenant #1 with his arms and hands around Tenant #2's neck. Assistance of three staff was used to free Tenant #2. Tenant #1 began going after staff by pulling hair and trying to hit their faces. Tenant #1 started kicking at doors and yelled profanity. An ambulance and police were called and Tenant #1 was transferred to a behavioral health unit. b. On 8-6-18 Tenant #1 was re-admitted to the program and moved to an apartment near the nurse's station. His spouse reported prior to hospitalization, Tenant #1 had been sexually aggressive towards her. c. On 8-14-18 staff escorted Tenant #1 outside. The tenant hit staff and attempted to kick. He told staff to move their arms or he would break them. The tenant continued with violent behavior for approximately 15 minutes. Supervisors attempted to redirect with a cold drink and administered a scheduled dose of Seroquel. It was recommended that Tenant #1 be a one to one for the rest of the evening. Staff accompanied Tenant #1 outside for a hour and half and successfully escorted him back inside. . d. On 9-5-18 it was noted Tenant #1 entered/exited other tenant apartments while also grabbing his spouse's and staff arms/hands. Tenant #1 made verbal threats to dump water on staff and pull off jewelry. Continued record review revealed a Nursing Facility Visit Progress Note dated 8-15-18 indicating Tenant #1 was seen for a one week post hospitalization visit. Staff reported increased agitation and physical aggression towards others. New orders were received to add Lexapro 10 milligram (mg), orally, daily and to	A 089		

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A 089	Continued From page 8 increase Seroquel to 75 mg, orally, three times daily. Tenant #1's service plan dated 8-13-18 reflected Tenant #1 was in Tenant #2's apartment and became agitated when Tenant #2 entered the room and when staff attempted to redirect him. Tenant #1 was transferred to the emergency room (ER) and admitted to a behavioral health unit. The service plan reflected Tenant #1 could become belligerent at times when redirected and was to be provided a safe area and one to one conversation or activity at those times. The service plan did not reflect Tenant #1's physical aggression or interventions to decrease aggressive episodes. 2. Review on 10-2-18 of Tenant #2's file revealed an Incident Report dated 7-27-18 at 12:30 a.m. indicating staff heard Tenant #2 yelling "no, no" and observed Tenant #1 with his hands and arms around Tenant #2's neck. A one to one staff was provided to Tenant #2 to calm her. Tenant #2 denied any pain or discomfort and no marks were noted to the neck area. Tenant #2 continued her "nightly activity of wandering the halls with walker." The incident occurred in Tenant #2's apartment. Prior to the incident it was noted on video footage she was wandering throughout the Program. When interviewed on 10-2-18 at 2:36 p.m. Staff B revealed Tenant #2 liked to walk the hallways at night and she usually kept her door open. When interviewed on 10-3-18 at 10:07 a.m. the Director of Assisted Living (AL) revealed Tenant #2 walked around the Program during the night and left her door open.	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 089	Continued From page 9 Tenant #2's service plan dated 8-21-18 reflected in the Activities section that she could often be found on walks around the Program or socializing with others. The service plan did not address Tenant #2's walking/wandering around the Program during the night as indicated in staff interview and in the incident that occurred between Tenant #1 and Tenant #3 on 7-27-18. 3. Review of Tenant #3's file on 10-2-18 revealed Monitoring Notes initiated on 8-16-18 to document inappropriate sexual behavior. The notes documented the following: a. On 8-18-18 it was noted Tenant #3 walked inside from the patio and attempted to grope a staff member. b. On 8-19-18 it was noted Tenant #3 was seated on the bench outside of the nurse's station stroking a female tenant's upper thigh. Staff told him it was inappropriate and he got up and sat by a different female tenant. Shortly after, the tenants were observed holding hands and attempted to go to the female tenant's apartment alone. The tenants were separated. c. On 8-20-18 it was noted Tenant #3 was seated on a bench outside of the nurse's station. Tenant #3 rubbed another tenant's abdomen and stuck his hand down her pants. d. On 8-23-18 it was noted Tenant #3 was lying in bed under the covers when staff entered the apartment Tenant #3 removed the blanket, revealed himself to staff and asked "do you like what you see?" e. On 8-23-18 it was noted Tenant #3 rubbed another tenant's upper thigh and was told to stop the behavior as it was inappropriate. Tenant #3 said "You're no fun, I got caught." f. On 8-23-18 it was noted Tenant #3 was	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 089	Continued From page 10	A 089		

observed in a bedroom with a female tenant (both seated on the bed). When asked what was going on, Tenant #3 responded "nothing, let us have fun." Staff escorted the female tenant out of the room.

g. On 8-26-18 it was noted Tenant #3 was observed in a room with a female tenant with his genitals exposed. Both tenants were separated and redirected.

h. On 8-27-18 it was noted Tenant #3 was observed holding a female tenant's hand and taking her to an apartment. Staff separated the two and directed him to the dining room for lunch.

Review of Tenants #3's Progress Notes revealed:

a. On 8-1-18 it was noted staff went to Tenant #3's apartment to set up cares and when staff turned around he took off his pants and exposed himself. Another staff went to the apartment to ensure cares were completed and Tenant #3 had not yet changed into pajamas. When the staff encouraged him to change Tenant #3 grabbed staff's shoulders and said "Do you want to help me?"

b. On 8-5-18 it was noted a female tenant was seated on Tenant #3's lap. Staff redirected and took the female tenant back to her apartment.

c. On 8-5-18 it was noted a female tenant was standing next to Tenant #3 and he rubbed the female tenant's bottom and front genital area over the top of her clothing. The female tenant was removed. Tenant #3 was very upset after she was moved away from him.

d. On 8-16-18 it was noted an order was received to document inappropriate behaviors and to show family the log to start the conversation regarding medication management.

e. On 8-23-18 it was noted Tenant #3 was observed in a room with a female tenant, both

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 089	Continued From page 11	A 089		

fully clothed. The female tenant was escorted out of the room.

f. On 8-29-18 it was noted an order was received to start Estradiol 0.5 mg patch (one patch to skin once weekly, alternate sites).

Tenant #3's service plan dated 7-26-18 was updated on 8-16-18 to reflect the documentation of inappropriate behaviors and on 8-29-18 and 8-30-18 regarding the application of the Estradiol patch. The service plan reflected Tenant #3 had inappropriate behaviors if initiated by a specified female tenant. Staff were to monitor relations between the two tenants and separate as needed. However, the service plan did not address the extent of the sexual behaviors, including behaviors towards staff. The service plan did not provide interventions for the behaviors noted above, with the exception of separating the tenants.

4. Review of Tenant #4's Progress Notes on 10-2-18 revealed the following:

a. On 8-31-18 it was noted Tenant #4 was assessed status post hospital admission and two ER visits. Tenant #4 returned to the Program with care from an outside agency related to history of agitation with yelling and verbal threats to spouse and staff.

b. On 9-11-18 it was noted Tenant #4 was very rude to staff and other tenants, including making some tenants cry.

c. On 9-12-18 it was noted Tenant #4 refused to leave her spouse's apartment when he did not want her in there due to trying to sleep. Tenant #4 slapped staff across the face, hit and attempted to bite staff. Tenant #4 "continues violent behaviors with staff."

d. On 9-13-18 it was noted Tenant #4 was

DEPARTMENT OF INSPECTIONS AND APPEALS

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THALMAN SQUARE DEMENTIA SPECIFIC AL	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(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 089	Continued From page 12 extremely rude to tenants and staff throughout the shift. Tenant #4 interrupted others' conversations to insult them. e. On 9-15-18 it was noted Tenant #4 came down the hallway with no pants on and was re-directed back to her apartment. She refused to put on pants and come out for breakfast. f. On 9-15-18 it was noted Tenant #4 was seated on the bench outside of the nurse's station with no pants on. She was redirected to apartment to attempt morning cares again. When staff turned around she was seated on the floor. Staff assisted Tenant #4 off of the floor and she began to pull staff's hair. It was noted Tenant #4 refused medications over the past week. A one to one was not effective in calming Tenant #4. An ambulance was called to transport to the ER for a psych evaluation. g. On 9-17-18 it was noted Tenant #4 left by ambulance at 4:35 p.m. to go the hospital for a psych evaluation. Tenant #4 was hitting and kicking staff/paramedics and refused to get on the gurney. Staff/paramedics were able to lift Tenant #4 onto a gurney using a blanket under Tenant #4. Tenant #4 continued with violent behaviors with paramedics while leaving the Program. h. On 9-27-18 it was noted Tenant #4 was disruptive at dinner. She threw silverware on the floor and towards other tenants, yelled and refused medication. Tenant #4's spouse left the dining room due to behaviors. Tenant #4 attempted to throw a spoon at another tenant and was removed from the dining room. i. On 9-28-18 it was noted Tenant #4 refused medications at lunch, threw a glass of juice at staff and yelled at her spouse. Tenant #4 refused to eat and went back to her room. j. On 9-28-18 it was noted Tenant #4 was	A 089		

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
	S0244	A. BUILDING: _____ B. WING _____	C 10/04/2018

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A 089	Continued From page 13 placed on a list for a higher level of care. Family was in agreement with the plan of care. k. On 9-29-18 it was noted Tenant #4 displayed disruptive behaviors at lunch. She made fun of other tenants, was rude to her spouse and tried to get other tenants to refuse medications. Tenant #4's service plan dated 9-12-18 and updated on 9-26-18 did not reflect these behaviors or interventions. 5. Review of Tenant #5's file revealed on 10-2-18 file revealed Tenant #5 received hospice services. The Program had applied for a Waiver of Administrative Rule from the Department dated 9-28-18 regarding Tenant #5's level of care. A Progress Note dated 9-24-18 revealed Tenant #5 required complete assistance with bathing and staff provided bed baths. She no longer used the toilet and utilized a commode in the bedroom due to less difficulty with transfers. The tenant's service plan dated 7-11-18 and updated on 9-26-18 did not reflect the use of the commode or bed baths provided by staff. 6. When interviewed on 10-4-18 at 11:15 a.m. the Director of AL confirmed all current service plan documents for the tenants listed above were provided.	A 089		