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

Date: April 27, 2017	**Amended on 7/19/17 following Informal Conference**
Program Name: Lakeside Village	
Address: 2067 Hwy 4 Panora, IA 50216	
Type of Action: Investigation #67011-I	
Date(s) of Action: 3/29/17 – 4/6/17	

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	**Amended on 7/19/17 following Informal Conference** **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.** Based on observation, interview and record review the Program failed to provide care, treatment and adequate/appropriate services as directed by service plans. This affected 1 of 1 tenant (Tenant #1) reviewed as a result of investigation #67011-I. Finding follows: Record review on 3/29/17 revealed a progress note for Tenant #1 documented Staff A called the nurse at 10:22 a.m. on 3/2/17 to notify that staff found Tenant #1 in between two doors located on the Southwest corner of the building. According to staff, she heard knocking on the door. Staff A notified the manager and nurse clinician of the incident. The nurse arrived and completed a head to toe assessment. Further review revealed Staff B, who worked on the memory care unit, assisted another tenant in the shower and did not hear or feel her pager; but when she came out to the dining room area she heard the alarm sound. She notified Staff A, who worked in the general population Assisted Living. Staff A escorted Tenant #1 back to the memory care unit. When interviewed on 3/29/17 the Manager stated the Program conducted an investigation and concluded Tenant #1 likely rode the elevator down to first floor and left the building via the North door, walked along a sidewalk to the South door where the tenant attempted to re-enter the building at a locked door. Staff A heard the tenant knocking and escorted Tenant #1 back to the memory care unit. When interviewed on 3/29/17 Staff B recalled she saw Tenant #1 at approximately 9:45 a.m. before going to assist another tenant with a shower. Tenant #1 sat at the dining room table in the common area of the memory care unit. She said when she returned to the common area she did not see Tenant #1 and heard the door alarm. She confirmed she did not hear the door alarm on her pager while she showered another tenant. When interviewed on 3/29/17 Staff A reported she worked in the	**$500.00**

	general population part of the building and after administering a tenant's medication she heard someone knocking. She went to the door and found Tenant #1. At the same time, Staff B attempted to contact her on the walkie talkie. When she answered, Staff B told her that she could not find Tenant #1. Observations revealed the Program was located on Highway 4 in a 55 mile an hour speed zone and near Lake Panorama. Observations of the route Tenant #1 likely took revealed a sidewalk near a wooded area with steep hills and the lake approximately 3/4 to 1 mile of a mile cross country. The distance from the North to South door measured approximately 100 yards. According to the state climatologist the closest weather stations were located at the airports in Audubon and Perry. The temperature measured 50 degrees Fahrenheit (F) at the Audubon airport and 56 degrees at the Perry airport. Staff interviews confirmed Tenant #1 wore jeans, long sleeved shirt, jacket, shoes and socks. Tenant #1 resided on the memory care unit and had a Global Deterioration Scale (GDS) of 4 which indicated moderate cognitive decline. At the time of the incident Tenant #1's service plan directed staff to provide 24 hour supervision and hourly visual checks in memory care, initiated on 7/20/16. Tenant #1 wore a Wanderguard bracelet. When interviewed on 3/29/17 Staff A and B said Tenant #1's service plan required hourly checks.	

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69.32(2)	**481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.** **69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.** Based on observations, interviews and record review the Program failed to ensure each exit door for the dementia-specific setting had an operating alarm system attached. This potentially affected 5 of 5 tenants (Tenants #1-5). Finding follows: Observations on 3/29/17 at 12:30 p.m. revealed the alarm on the exit door of the dementia specific part of the building did not function. According to staff present the alarm only sounded when tenants wearing bracelets were close to the door. The Manager pointed out an alarm placed on the door after the elopement incident on 3/20/17. The alarm was unengaged. Record review on 3/29/17 revealed a progress note for Tenant #1 which said Staff A called the nurse at 10:22 a.m. on 3/2/17 to notify that staff found Tenant #1 in between two doors located on the Southwest corner of the building. According to staff she heard knocking on the door. Staff A notified the manager and nurse clinician of the incident. The nurse arrived and completed a head to toe assessment. Further review revealed Staff B, who worked on the memory care unit, assisted another tenant in the shower and did not hear or feel her pager, but when she came out to the dining room area heard the alarm sounding. She notified Staff A, who worked in the general population Assisted Living. Staff A escorted Tenant #1 back to the memory care unit. When interviewed on 3/29/17 the Manager said the Program conducted an investigation and concluded Tenant #1 likely rode the elevator down to first floor and left the building via the North door, walked along a sidewalk to the South door where the tenant attempted to re-enter the building at a locked door. Staff A heard the tenant knocking and escorted Tenant #1 back to the memory care unit. When interviewed on 3/29/17 Staff B said saw Tenant #1 at approximately 9:45 a.m. before going to assist another tenant with a shower. Tenant #1 sat at the dining room table in the common area of the memory care unit. She said when she returned to the common area she did not see Tenant #1 and heard the door alarm. She confirmed she did not hear the door alarm on her pager while she showered another tenant. When interviewed on 3/29/17 Staff A said she worked in the general population part of the building and, after administering a tenant's medication, she heard someone knocking. She went to the door and found Tenant #1. At the same time Staff B attempted to contact her on the walkie talkie. When she answered, Staff B told her that she could not find Tenant #1. Observations revealed the Program was located on Highway 4 in a 55	**$500.00**

	mile an hour speed zone and near Lake Panorama. Observations of the route Tenant #1 likely took revealed a sidewalk near a wooded area with steep hills and the lake approximately 3/4 to 1 mile of a mile cross country. The distance from the North to South door measured approximately 100 yards. According to the state climatologist the closest weather stations were located at the airports in Audubon and Perry. The temperature measured 50 degrees Fahrenheit (f) at the Audubon airport and 56 degrees at the Perry airport. Staff interviews confirmed Tenant #1 wore jeans, long sleeved shirt, jacket, shoes and socks. Tenant #1 resided on the memory care unit and had a Global Deterioration Scale (GDS) of 4 which indicated moderate cognitive decline. At the time of the incident Tenant #1's service plan directed staff to provide 24 hour supervision and hourly visual checks in memory care, initiated on 7/20/16. Tenant #1 wore a Wanderguard bracelet.	