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
	S0264	A. BUILDING: _____ B. WING _____	C 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE VILLAGE	2067 HWY 4 PANORA, IA 50216

(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. Tenants without cognitive impairment: 31 Tenants with cognitive impairment: 7 Total census: 38 No regulatory insufficiencies were cited during the investigation of Incident #127321-I. The following regulatory insufficiencies were cited during the investigation of Incident #129917-I.	A 000	See attached POC 12/11/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the Program failed to implement and follow policies and procedures regarding staff response to door alarms. This pertained to 1 of 1 tenant (Tenant #1) reviewed as a result of self-reported incident 129917-I. Finding follows: Record review on 9/4/25 revealed an internal investigation, dated 6/28/25, documented Staff A reported over Zello (push-to-talk-walkie-talkie application) he could not locate Tenant #1 at 8:04 p.m. on 6/28/25. Staff A initiated a room to room search as directed. Staff B began a search	A 150		

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A 150	Continued From page 1	A 150		

outside the building including the parking lot and garden areas. The Director notified law enforcement who located Tenant #1 and returned her to the building.

Further review revealed the memory care parking lot exit door alarmed sending alerts at 7:43 p.m. Tenant #1 left through the egress door. A secondary alarm attached by a magnet failed to alert.

When interviewed on 9/3/25 at 12:05 p.m. Staff A said he did not hear the alarm and/or the alert on the tablet while he vacuumed the living room area of memory care unit. He said as he moved to the dining room area he heard the alarm. When he checked the door alarm he noticed the secondary alarm had not triggered. At 8:04 p.m. he notified other staff via Zello Tenant #1 could not be located.

When interviewed on 9/3/25 at 11:30 a.m. Staff B reported they worked on the assisted living side of the building on 6/28/25. She saw an alert for the memory care parking lot door while administering medication. She attempted to contact Staff A via Zello to see if he had checked the door. Staff A did not respond. Staff B finished medication administration and went to the memory care unit to check with Staff A. As she entered the memory care unit she heard Staff A's alert via Zello. She assisted to with room to room check as well as checking outside parking lot and garden area.

When interviewed on 9/2/25 at 10:15 a.m. the Healthcare Coordinator (HC) reported, while not on premises, she heard a call on Zello stating Staff A could not locate Tenant #1. She

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A 150	Continued From page 2	A 150		

messaged Community Director (CD) and informed her that an elopement had occurred. She said the CD contacted law enforcement who informed her law enforcement had already made contact with Tenant #1 and were returning her to the Program. The officers reported at 8:01 p.m. a passerby on highway 4 reported Tenant #1 walked along the highway and spoke to the homeowners approximately 150 yards from the Program. She said she completed a head to toe assessment and noted no injuries. Tenant #1 became emotional and stating she wanted to see her mother and father.

When interviewed on 9/2/25 at 10:30 a.m. and 9/8/25 at 10:45 a.m. the CD said the HC messaged her regarding the elopement of Tenant #1 on 6/28/25. The CD confirmed the above information relayed by the HC. She also said it appeared Tenant #1 went out the alarmed egress parking lot door at 7:43 p.m. while Staff A vacuumed the living room area of the memory care unit. She said Tenant #1 wore clothes appropriate to the weather conditions.

Record review on 9/8/25 revealed Staff A's door alarm training and competency checklists, signed 2/20/25 instructed staff to immediately respond to the door that alarmed and check inside and outside the door to determine who exited.

Record review on 9/4/25 revealed Tenant #1's pertinent diagnosis included dementia, adjustment disorder with depressed mood. Her Global Deterioration Scale (GDS) score, dated 5/20/25, measured 6 which indicated severe cognitive decline (moderately severe dementia). The Program admitted Tenant #1 on 4/16/25.

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A 150	Continued From page 3 Record review on 9/8/25 revealed Tenant #1's Service Plan dated 5/20/25 revealed Tenant #1 had a history of wandering. The plan specified Tenant #1 may wander outside; health and safety may be jeopardized. Tenant #1 will try doors to test if locked. Tenant may be outside only with direct supervision. She has poor judgement and may place self into unsafe situations. Review of weather underground history for 6/28/25 at approximately 7:45 p.m. - 8:04 p.m. revealed the temperature measured 87 degrees Fahrenheit (F). Observations on 9/8/25 at 12:12 p.m. revealed the driveway where law enforcement located Tenant #1 was approximately .1 mile from the Program across Highway 4, a 55-mile per hour (MPH) Tenant #1 would have crossed Highway 4 to reach the identified driveway. During the exit on 9/8/25 at 11:45 a.m. the administrative team confirmed staff failed to respond to the door alarm immediately as required by policy and training.	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: The Lakeside Village	DATE SURVEY COMPLETED: 9/2/2025-9/8/2025

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** 481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the program failed to ensure the door alarm response policy was followed at all times, including staff being unable to hear the door alarms effectively.	**Tag # 10977**	**What initial correction was made?** The Arial system alerts staff via their I-Pads when the door is opened (when the magnet detaches), the alerts continue every 2 minutes until the alarm has been reset (when the magnet is re-attached). Re-Delegation of all staff on the Door Alarm Policy and Procedure will be completed by 12/31/2025 by Executive Director and the RN, Healthcare Coordinator	**How will we ensure and maintain compliance going forward?** Upon hire, all staff will receive education related to door alarm policy and procedures during the delegation process. New door alarms will be installed that will be louder and increase the likelihood of staff hearing alarm throughout the Memory Care area. Completed on 10/1/2025 Discontinue everyday use of parking lot exit door by family, staff, visitors to decrease the likelihood of members seeking exit to that door. Reset door code to only be utilized by staff and members in an extreme emergency. Completed on 10/1/2025 Daily, Weekly, Monthly, as needed, as determined by the director or designee audits of the door alarm response times	**Implementation Date: 12/31/2025** **Completion Date:** Ongoing **Responsible Party: Director or designee**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

				and compliance with Community policy will be completed to ensure compliance.	

Compliance Date: ____12/11/2025_____

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