

**Iowa Department of Inspections, Appeals, and Licensing**  
**Health & Safety Division**  
**Adult Services Civil Penalty Citation**

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| <b>Date:</b> December 1, 2025                    |
| <b>Program Name:</b> Lakeside Village            |
| <b>Address:</b> 2067 Highway 4, Panora, IA 50216 |
| <b>Type of Action:</b> Investigations #129917-I  |
| <b>Date(s) of Action:</b> 9/2/25 – 9/8/25        |
| <b>Citation #</b> 10977                          |

| <b>State Rule #</b>                         | <b>State Rule</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Amount of Civil Penalty</b> |
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| <b>Iowa Administrative Code 481-67.2(3)</b> | <p><b>67.2(3) The program shall follow the policies and procedures established by the program.</b></p> <p>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:</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | <b>\$3000.00</b>               |

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|  | <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> |  |
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|  | <p>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).</p> <p>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.</p> <p>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.</p> |  |
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