STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165492	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Lutheran Home	301 North Lawler Street Emmetsburg, IA 50536

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents who used psychotropic drugs received a Gradual Dose Reduction (GDR), unless clinically contraindicated, 2 times the first year, in 2 separate quarters (with at least one month between the attempts) unless the provider documented the rationale for 1 of 5 residents (Resident #5) and once a year after for 1 of 5 residents (Resident #1). The facility reported a census of 39 residents.Findings include:1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 12 on the Brief interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included anxiety disorder. The resident received multiple high risk medications including an antianxiety.The Care Plan revised 7/19/25 identified Resident #1 used anti-anxiety medication related to anxiety disorder. The interventions included giving anti-anxiety medications ordered by the physician and monitoring/documenting side effects and effectiveness. The February 2026 Medication Administration Record (MAR) showed Resident #1 received Buspirone (antianxiety) 10 mg at noon, afternoon, and bedtime every day with a start date of 8/5/24 A letter to the Physician from the Pharmacist dated 7/3/25 documented the use of central nervous system medications was always a potential area of concern to state regulators. The letter asked the physician to please review Resident #1's medications to determine future use. It was recommended to only make one major medication change at a time so they knew the effect of each medication change.The letter inquired about GDR for Buspirone 10 mg 3 times a day, Melatonin (hormone affecting sleep) 10 mg every day, and Olanzapine (antipsychotic) 10 mg every day. A check marked GDR to decrease melatonin to 5 mg at bedtime. A check also marked under a GDR not being indicated due to other medication being changed. The clinical record lacked a rationale why a GDR would be contraindicated for the psychotropic medications. On 2/24/26 at 4:27 p.m. the Director of Nursing (DON) stated she saw the provider had decreased melatonin but not the psychotropics. She talked to the pharmacist about not putting the melatonin with the psychotropic medications. Resident #1 did have one of his psychotropic medications decreased after a hospitalization. The antianxiety had not been addressed. On 2/26/26 at 12:15 p.m. the DON verified they did not have a policy regarding psychotropic medications. They followed the regulation. 2) According to the MDS assessment dated [DATE], Resident #5 scored 14 on the BIMS indicating no cognitive impairment. The resident's diagnoses included anxiety disorder, bipolar disorder, and post traumatic stress disorder. The resident received multiple high risk medications including antipsychotic, antianxiety, and antidepressant medication. The Care Plan dated 4/13/25 identified Resident #5 used antidepressant medication related to Bipolar disorder, and borderline personality. The Care Plan identified the resident anti-anxiety medications related to anxiety disorder. Interventions included giving anti-anxiety medications ordered by the physician, monitoring/documenting side effects and effectiveness. Antianxiety side effects included drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Paradoxical side effects included mania, hostility (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165492	A. Building B. Wing	02/26/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and rage, aggressive or impulsive behavior, and hallucinations. The Care Plan identified the resident used psychotropic medications, antipsychotic related to behavior management. Interventions included consulting with pharmacy, and physician to consider dosage reduction when clinically appropriate. The Physician's Orders printed 2/26/26 included:Perphenazine 4 mg, 2 tabs 4 times a day dated 4/9/25.Trazadone 50 mg, give 1/2 tab at bedtime dated 4/8/25.Risperidone 0.5 mg, give 1/2 tab 3 times a day. dated 4/8/25.Divalproex 500 mg, give 2 tabs 3 times a day. dated 4/8/25. The Medication Administration Record for October 2025 showed the resident received Quetiapine 400 mg, 2 tablets in the evening initiated 4/8/25 and continued 10/29/25, after receiving Quetiapine 400 mg 1 time on 10/28/25. A letter to the Physician from the Pharmacist dated 10/31/25 documented the use of central nervous system medications was always a potential area of concern to state regulators. The letter asked the physician to please review Resident #1's medications to determine future use. It was recommended to only make one major medication change at a time so they knew the effect of each med change. The letter inquired about GDR for Quetiapine (antipsychotic), Trazadone (antidepressant), Divalproex (anticonvulsant), Risperidone (antipsychotic), and Perphenazine (antipsychotic). The provider responded no changes, with no rationale given. On 2/25/26 the DON confirmed the provider did not give a rationale for no GDR on for the psychotropic medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to complete the Minimum Data Set (MDS) assessment accurately for 2 of 13 residents reviewed (Resident #19 and #31). The facility reported a census of 39 residents.Findings include:1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #19 scored 6 on the Brief interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included heart failure, renal insufficiency, and chronic respiratory failure. The MDS documented the resident had an indwelling urinary catheter.On 2/23/26 at 3:30 p.m. Resident #19 sat in her recliner and had no catheter.The Care Plan dated 2/23/26 identified Resident #19 had mixed bladder incontinence related to diuretic therapy. Interventions included the resident used disposable briefs.The Care Plan lacked documentation the resident had a catheter.The Progress Notes dated 9/12/25 documented Resident #19 admitted skilled after right hip fracture repair, with a catheter. The Progress Notes dated 9/15/25 at 12:37 p.m. documented receipt of an order to discontinue the urinary catheter. At 12:50 p.m. a nurse removed the resident's urinary catheter.The Progress Notes dated 9/16/25 at 3:36 p.m. documented the resident voiding without concerns after the was catheter removal.On 2/25/26 at 1 p.m. the MDS Coordinator stated she marked the MDS incorrectly (regarding the catheter). On 2/25/26 at 5 p.m. the Administrator stated the MDS should be coded accurately. They did not have a policy for coding them accurately. 2) According to the MDS assessment dated [DATE], the facility marked no to question A1500 indicating Resident #31 was not considered by the state level 2 Preadmission Screening and Resident Review (PASRR) process to have serious mental illness. A Notice of PASRR Level 1 Screen Outcome dated 11/8/23 documented Resident #31 Level 1 positive, with no status change. The PASRR .showed the resident had evidence of a serious mental illness. The services identified in the previous PASRR remained appropriate. Since the evaluation determined the resident the resident had a PASRR condition, the facility should mark yes to question A1500 on the MDS. On 2/24/26 at 1:10 p.m. the Social Services Supervisor stated they coded Resident #31's MDS incorrectly regarding PASRR.