STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045315	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health and Rehab	1207 Willow Run Road Lake City, AR 72437

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, document review, and facility policy review, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 (Resident #1) of 3 sampled residents reviewed for accidents/supervision. The lack of an effective monitoring plan resulted in Resident #1 eloping from the facility and being found outside of the facility by a passerby on 7/14/2025. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to the State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on 7/14/2025 at 11:45 AM, when Resident #1 exited the facility without staff knowledge via a bedroom window. The Administrator and the Director of Nursing Services were notified of the IJ [immediate jeopardy] on 7/23/2025 at 3:59 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 7/23/2025 at 4:51 PM. The IJ was removed on 7/25/2025 at 12:45 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Based on observations, interviews, record review, document review, and facility policy review, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 (Resident #1) of 3 sampled residents reviewed for accidents/supervision. The lack of an effective monitoring plan resulted in Resident #1 eloping from the facility and being found outside of the facility by a passerby on 7/14/2025. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to the State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on 7/14/2025 at 11:45 AM, when Resident #1 exited the facility without staff knowledge via a bedroom window. The Administrator and the Director of Nursing Services were notified of the IJ [immediate jeopardy] on 7/23/2025 at 3:59 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 7/23/2025 at 4:51 PM. The IJ was removed on 7/25/2025 at 12:45 PM after the survey team performed onsite verification that the Removal Plan had been implemented. The findings include: (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The “Wandering and Elopements” policy was reviewed and revealed the facility will identify resident who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. A review of an Office of Long-Term Care incident document, submission date of 7/15/2025 at 11:42 AM, revealed that on 7/14/2025 at 11:40 PM Resident #1 was observed walking into the resident’s room. At 12:00 PM the investigation review indicated the Director of Nursing (DON) received a phone call from the City Mayor, asking if the facility had a resident by the name of [Resident #1]. The DON confirmed that they had a resident by that name. The DON was informed the resident had been picked up by a third party near the facility and brought to city hall. The DON, Licensed Practical Nurse (LPN) #2, and Assistant Director of Nursing (ADON) then drove to the city hall, located 0.7 miles east of the facility. At approximately 12:07 PM, the ADON drove Resident #1 back to the facility. At 12:30 PM, the DON conducted an incident and accident report and performed a body audit on Resident #1. A small skin tear to the left wrist measuring 0.25 x 0.25 x 0.1 centimeters was found. The facility investigation revealed the resident was able to manipulate a window in a different room on the secure unit out of its frame and exit through the window. Review of an admission Record revealed Resident #1 had a diagnosis that included Alzheimer's disease, unspecified dementia, unspecified severity, without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety. Review of a discharge Minimum Data Set with an Assessment Reference Date of 7/14/2025 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 06, which indicated the resident was severely cognitively impaired. Review of an undated Care Plan Report indicated Resident #1 exhibited behavioral indicators of cursing, yelling, verbally threatening staff, yelling, and screaming rude offensive behavior, wandering, and exit seeking behavior. Resident #1 was an elopement risk/wanderer related to history of attempts to leave the facility unattended, had impaired safety awareness, and resident wandered aimlessly. The Resident was a high risk for falls related to Alzheimer’s confusion, impulsivity, and poor safety awareness. Resident #1 needed a secured/special care neighborhood due to Alzheimer’s disease and exit seeking. Review of Nursing Progress Notes dated 6/26/2025 at 1:39 PM revealed Resident #1 attempted to exit seek by pulling on every exit door in the unit getting verbally aggressive with staff and stated, “I want to see a doctor right now.” Review of Nursing Progress Notes dated 6/27/2025 at 12:57 PM revealed Resident #1 stated, “I am so tired of this place. I’m about to grab something and break this window.” Resident was talking on the phone with a family member when the resident stated, “I want to kill myself.” Psychiatric Advanced Placement Registered Nurse (APRN) was notified, suicide precautions in place. Resident continued to wander, and exit seek, and stated, “Get the doctor up here now” and “I want to talk to my attorney.” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nursing Progress Notes dated 6/29/202025 at 1:24 PM revealed Resident #1 had not had a good day. The resident was mad, upset and crying. The resident cursed a family member out and “fired” their Power of Attorney. Resident #1 was exit seeking and going to all of the doors trying to get out. Resident #1 did not remember that their spouse was also at the facility. Will continue to monitor behaviors. Review of Nursing Progress Notes dated 7/6/2025 at 11:43 AM revealed Resident #1 was found pulling and pushing on an exit door. When asked by the nurse what the resident was doing Resident #1 stated, “I can’t get this open.” The nurse attempted to redirect the resident away from the exit door, but the resident refused and remained standing looking out of the door at that time. Review of Nursing Progress Notes dated 7/7/2025 at 1:00 PM revealed Resident #1 was pulling and pushing on exit doors. Review of Nursing Progress Notes dated 7/13/2025 at 10:36 AM revealed Resident #1 was becoming anxious and was talking about going home. The resident would not accept an available [as needed] sedative medication. Review of Nursing Progress Notes dated 7/13/2025 at 3:40 PM revealed Resident #1 had been very confused, anxious, and tearful that shift. Available [as needed] medication appeared to have helped the anxiety. Review of Nursing Progress Notes dated 7/13/2025 at 10:37 PM revealed Resident #1 was resting in bed. The resident required another [as needed] dose of medication during both day and night shifts. Resident #1 had rested well. Resident #1 had increased crying throughout the day. The resident continued to decline in physical and mental ability, along with increased episodes of incontinence. Review of Nursing Progress Notes dated 7/14/2025 at 12:25 PM revealed Resident #1 was pacing, anxious, verbally disgruntled, and exit seeking. The resident expressed they wants out of this “hell hole. ” The resident went outside of the facility. Upon return, a body audit was completed with noted skin tear to left wrist that measured 0.25x 0.25 centimeters. Review of Nursing Progress Notes dated 7/14/2025 at 1:41 PM revealed the APRN was contacted 7/14/2025 at 1:00 PM. The family was contacted at 1:01 PM. Incident Description: Resident manipulated bedroom window in unit, tore screen, and crawled out of window causing skin tear to left wrist. Resident stated, “I am needing to go home.” Review of Nursing Progress Notes dated 7/14/2025 at 4:51 PM revealed Resident #1 had a history of elopement and wandering aimlessly while at home. The resident’s Elopement Score was 5.0 (Score of 1 or higher indicates risk of elopement). Review of Nursing Progress Notes dated 7/14/2025 at 5:20 PM revealed a call was received from behavioral health. The resident had been accepted. All information was faxed to the facility and bed placement call was being awaited. Review of Nursing Progress Notes dated 7/1420/25 at 7:05 PM revealed the resident left the facility via medical transport company stretcher enroute to behavioral health. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nursing Progress Notes dated 7/17/2025 at 9:31 PM revealed, Long-Term Intervention of Incident and Accident Description on 7/14/2025 included the resident was put on one-on-one line of sight until admit to behavioral health. All windows were secured. Added to the Care Plan: Yes. Ensure MD & Family notification: Yes. Review of Elopement Evaluation dated 04/25/2025, revealed the resident had a history of elopement or an attempted elopement while at home. It also revealed the resident verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door and revealed that the resident did wander and the wandering behavior was goal-directed (i.e. specific destination in mind, going home, etc.). Review of Elopement Evaluation dated 07/14/2025, revealed the resident had a history of elopement or an attempted elopement while at home. It also revealed the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door and revealed that the resident, did wander aimlessly or non-goal-directed (i.e. confused, moves with purpose, may enter others rooms and explore others belongings) and was likely to affect the privacy of others. During an interview on 7/21/2025 at 5:08 PM, the ADON indicated the facility received a call from the police department, informed the facility Resident #1 was there (at city hall). The ADON reported facility staff brought the resident back to the facility and tried to determine how the elopement happened. The ADON stated that she and the Maintenance Director went to Resident #1’s room and checked the window, and it would not open. The ADON stated they then went into the next room located next to Resident #1’s room on the North side and observed the window had screws out, the window track had been manipulated, and the screen was ripped. The ADON stated the Maintenance Director immediately began working on interventions to secure all windows. The ADON stated that she called in Nursing Assistant (NA) #3, to sit one-on -one with Resident #1. The ADON verified a resident head count was conducted for all residents and everyone was accounted for. The ADON stated elopement assessments and BIMS assessments were conducted on all residents and the elopement book was updated. Staff were also in-serviced on elopement, abuse, and neglect. During an interview on 7/22/20 25 at 8:20 AM, the Maintenance Director stated that 12 years ago, when the secure unit was remodeled, the windows on the unit had two screws inserted on the bottom of the windowpane to keep the window from opening more than 2 to 3 inches. On 7/14/2025, after Resident #1 eloped, he installed a 21-inch, 1x2 inch wooden board that was screwed in all windows in the facility. The 1x2 inch wooden board kept the sliding window in place and did not allow it to be pulled off the track. The opening of each window measured approximately 2 to 3 inches. During an interview on 7/23/2025 at 3:05 PM, NA #3 stated the facility called her into work on 7/14/2025 to sit one-on-one with Resident #1 around 3:30 or 4:00 PM. NA #3 stated she sat with the resident until the ambulance arrived. NA #3 did not recall the time the ambulance arrived. During an interview on 7/23/2025 at 1:00 PM the Administrator revealed Resident #1 was admitted from a behavioral hospital. The Administrator stated she did not have any information of any exit seeking behaviors prior to admission and did not have any information about the resident eloping at home. The Administrator stated that she was not aware of any exit seeking behaviors from Resident #1 the day the resident eloped. The Administrator reported the resident was a little distraught and anxious that day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/23/2025 at 1:00 PM the Social Director revealed that upon admission Resident #1 was assessed for elopement risk, with elopement interventions that included individual activities and redirection for safety reasons. The Administrator confirmed that on 7/14/2025 the facility had all windows modified with a wooden board and screws to prevent opening more than 2 to 3 inches, staff were educated on elopement policies, and care planned interventions were reviewed for residents who were high elopement risks. The Administrator confirmed facility staff were in-serviced upon hire and annually on elopement. During an interview on 7/21/2025 at 4:56 PM Resident #1’s family member confirmed that on 7/14/2025 around 12:45 PM, they received a phone call from the facility informing them the resident had eloped and was back at the facility. The family member stated they did not recall a history of elopement for the resident and then stated, “But I know [Resident #1] has been hell bent on getting home.” On 7/21/2025 the Administrator provided a copy of Facility Action Plan, date of Occurrence 7/14/2025, dated 7/14/2025. 1. Specific Components: Resident left the facility unaccompanied. Specific Action Steps to Prevent any Further Elopements: Resident returned to facility memory care unit for safety and to be monitored by staff and Nurse Manager/Designee. Any negative finding will be address at that time-Person Responsible-Administrator, D.O.N., Social/L.P.N., MDS/Care Plan Coordinator. Head count of all resident in building-Person responsible ADON and Social. Target Date of Completion: #1 and #6, 7/14/2025. 2. All staff [NAME]-serviced on Abuse Prevention Program, Elopement Book and Facility Elopement Policy. Target Date of Completion: #2, Inservice Initiated on 7/14/2025. All resident assessed for elopement via elopement wandering assessment, care plans reviewed and resident who are at risk for elopement had care plan reviewed and updated. 3. All resident [BIMS] eval assessment updated. 4. Elopement book reviewed and ensured all resident at risk are in place with resident picture, demographics and care plan. 5. Body audit, Incident and Accident, and Elopement form along with [BIMS] assessment completed when resident was found and returned to building. Noted small skin tear on wrist and resident was noted on distress at time of assessment. 6. Documentation supporting approx. time of last seen, when found, notification of family and doctor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Police, family and doctor notified. 8. All windows throughout facility were secured by Maintenance Personnel with modifying windows from being manipulated and moved off track which then opens completely up. Maintenance Personnel to check 5x’s weekly for the next month and monthly for next quarter to ensure all preventive measures are in place and working. Any negative findings will be corrected immediately and reported to QAA committee. Person responsible-Maintenance Personnel. Memory Care Unit completed 7/14/2025. Entire building completed 7/15/2025. 9. Facility Maintenance to obtain estimate for new window replacement for unit if necessary. 7/16/2025 vendor at building for estimate. Target Date of Completion: #3, 4, 5 and 7, 8, 7/15/2025. The Removal Plan: 1. Head count of all resident was performed and all other residents were accounted for on 7/14/2025. 2. On 7/14/2025 Upon return to the facility, resident was returned to the memory care unit and Incident and Accident was completed. Small skin tear on wrist was noted. No active bleeding noted. [NAME] crusted edges on wound. Skin tear cleansed with wound cleanser and applied band aid by D.O.N. on 7/14/2025. 3. On 7/15/2025 Facility initiated and completed skin audits, elopement risk assessments, and [BIMS] score on the resident. 4. On 7/15/2025 resident transferred to St. [NAME] Behavioral Health for evaluation and treatment. 5. On 7/14/2025 initiated staff in-service on abuse, neglect and misappropriation, elopement policy and the facility elopement book completion 7/23/2025. 6. All residents assessed for elopement risk via elopement/wandering assessment. All residents who are at risk for elopement were noted to be residing in Memory Care Unit of facility. Care plans were updated accordingly. Completed 7/23/2025. 7. All residents [evaluation assessments were up BIMS] dated. 7/17/2025. 8. Elopement book reviewed to ensure all resident at risk for elopement were in the facility’s elopement book with resident picture and demographics completed 7/14/20225. 9. Completed on 7/15/2025 all window seals on sliding windows throughout the facility were modified so the windows could not be manipulated to move over the stopper and or come off track. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. On 7/23/2025 facility trained all staff on recognizing key factors, such as cognitive impairments (ie. Dementia) history of wandering or history of elopement through the individualized closet care plan. Also educated staff on established protocols for preventing elopement, including recognizing early warning signs, managing exit seeking behaviors, and responding to potential incidents. All corrections were completed on 7/23/2025 Administrator Signature Date 7/24/2025. Onsite Verification: The IJ was removed on 07/25/2025 at 12:45 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 07/25/2025 at 9:00 AM. A total of 25 staff interviews were conducted with staff from 2 of 3 shifts to verify training had been completed. The staff interviewed included 5 Certified Nursing Assistants, 4 Licensed Practical Nurses, the Administrator, DON, ADON, Social Services Director, Activity Director, 3 Housekeeping, 1 Dietary, maintenance director, nurse practitioner, 3 house keeper, 1 dietary aid, the medical director, 1 maintenance staff, case coordinator. The staff interviewed verified they had been trained in elopement, responding to the overhead announcement and text messages, verification of a resident out of the facility, how they were contacted and when to respond, elopement and care plan interventions. A review of the in-service sheets provided indicated 89 of 89 facility employees had been provided training. The Governing Body/Board of Directors were contacted, and they verified they were notified with emergency information such as elopement and were aware of the elopement of Resident #1. The Medical Director was interviewed and confirmed he was made aware of the elopement of Resident #1 and that the facility keeps him updated with concerns that occur in the facility. The facility assessment dated [DATE] was reviewed and was appropriate for the facility.