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	05/01/2026

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Number of residents sampled: Number of residents cited: Based on record review and interview, the facility failed to ensure residents' rights to privacy were protected. Specifically, photographs and videos were taken of residents by an employee and released for public viewing without consent for five (Residents #42, #91, #92, #93, and #94) of five residents reviewed for privacy. The findings include: On 04/30/2026 at 3:26 PM, this surveyor received an email from the complainant which contained photographs and videos of residents who once resided at the facility. The complainant stated the photographs and videos were observed on Certified Nursing Assistant (CNA) #9's social media page. The complainant stated they called the facility after reviewing the photos and videos but could not recall who they spoke with or the date the phone call occurred. Review of CNA #9's employee file revealed a Privacy Training Acknowledgement form with the printed name and signature of CNA #9, dated 07/17/2024. This form also revealed CNA #9 received information on the facility's privacy policies and the privacy standards regarding the Health Insurance Portability and Accountability Act (HIPPA) of 1996 on 07/17/2024. Review of a Termination of Employment form dated 03/18/2025 revealed CNA #9's date of hire was 07/17/2024 and CNA #9 was involuntarily terminated by the facility for violation of policies/procedures. The form also revealed, On 03/18/2025 employee [CNA #9] discharged due to non-compliance with handbook-employee policy and procedures regarding (re:) social media. Review of an Employee Memorandum for CNA #9 dated 03/18/2025, revealed the date of occurrence was non-specific-several days- reported to Admin [Administrator] via [by way of] email on 03/17/2025. The memorandum revealed that a resident from the community reported HIPPA violations by employee (CNA #9) and sent attachments of videos and pictures of residents. The memorandum also revealed that due to the severity of postings and usage of cellphones with resident pictures/videos, the employee was terminated by the Administrator. During an interview on 05/01/2026 at 8:53 AM, the Director of Nursing (DON) was shown the photos and videos of the residents received by email from the complainant. She identified four of the five residents as Residents #47, #91, #92, and #93. She identified CNA #9 as the person who was holding the recording device, as her face was seen on the video when the camera was changed from the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	direction of the residents to CNA #9's face. She identified CNA #10 as the person who was walking to the right of CNA #9, as CNA #9 was recording the residents. The fifth resident was identified as Resident #94 by the Social Services Director. Resident #47 Review of an admission Record revealed the facility admitted Resident #47 on 03/27/2022 with diagnoses which included dementia and adult failure to thrive. The admission Record also revealed Resident #47 discharged from the facility on 04/20/2026. Review of a Patient Choices and Consents-Other form, included in patient information dated 07/21/2020 for Resident #47, revealed Resident #47's resident representative authorized the facility to use photos for educational and promotional material, and/or news releases to the media. This form did not give consent for Resident #47's pictures/video to be shared with people outside of the facility by unauthorized employees or for unauthorized purposes. Resident #91 Review of an admission Record revealed the facility admitted Resident #91 on 01/21/2025 with diagnoses which included dementia. The admission Record also revealed Resident #91 discharged from the facility on 01/29/2025. Review of a Patient Choices and Consents-Other form dated 01/21/2025 revealed Resident #91's resident representative authorized the facility to use photos for educational and promotional material, and/or news releases to the media. This form did not give consent for Resident #91's pictures/video to be shared with people outside of the facility by unauthorized employees or for unauthorized purposes. Resident #92 Review of an admission Record revealed the facility admitted Resident #92 on 10/05/2020 with diagnoses which included senile degeneration of the brain. The admission Record also revealed Resident #92 discharged from the facility on 12/09/2025. Review of a Patient Choices and Consents-Other form, included in the admission paperwork dated 10/05/2020 for Resident #92, revealed Resident #92's resident representative authorized the facility to use photos for educational and promotional material, and/or news releases to the media. This form did not give consent for Resident #92's pictures/video to be shared with people outside of the facility by unauthorized employees or for unauthorized purposes. Resident #93 Review of an admission Record revealed the facility admitted Resident #93 on 09/10/2021 with diagnoses which included senile degeneration of the brain. The admission Record also revealed Resident #93 discharged from the facility on 04/21/2025. Review of a Patient Choices and Consents-Other form, included in the admission paperwork dated 06/15/2023 for Resident #93, revealed Resident #93's resident representative authorized the facility to use photos for educational and promotional material, and/or news releases to the media. This form (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not give consent for Resident #93's pictures/video to be shared with people outside of the facility by unauthorized employees or for unauthorized purposes. Resident #94 Review of an admission Record revealed the facility admitted Resident #94 on 06/19/2023 with diagnoses which included malignant neoplasm of the prostate. The admission Record also revealed Resident #94 discharged from the facility on 04/22/2025. Review of a Patient Choices and Consents-Other form dated 06/19/2023 revealed Resident #94's resident representative authorized the facility to use photos for educational and promotional material, and/or news releases to the media. This form did not give consent for Resident #94's pictures/video to be shared with people outside of the facility by unauthorized employees or for unauthorized purposes. During an interview on 05/01/2026 at 11:32 AM, CNA #10 stated she had worked with CNA #9 in the past at the facility. She stated she had never observed CNA #9 taking videos or pictures of residents at the facility. However, she stated she had observed CNA #9 with her cellphone out while residents were in the dining room at the facility, but she could not give an exact date. During an interview on 05/01/2026 at 12:00 PM, the DON stated she saw a video posted on social media from inside the facility by CNA #9, but the video did not show any residents. She stated CNA #9 had made videos of herself, but she did not give a date when this occurred. She stated the employee was terminated after the incident of posting videos of herself to social media from inside the facility. During an interview on 05/01/2026 at 12:10 PM, the Administrator stated no recordings or pictures of any residents were allowed on an employee's social media. She stated her expectation of posting residents' pictures/videos on an employee's social media page should not happen unless the residents gave their consent. She stated the facility performs in-services on HIPPA and resident rights and does not allow cell phones to be used in resident care areas. On 05/01/2026 at 12:12 PM, this surveyor un-successfully attempted to reach Administrator (Admin) #11 via telephone. A voicemail was left with a request for a return call and contact number was provided. As of 05/01/2026 at 2:25 PM, Admin #11 had not returned this surveyor's call. Review of a facility policy titled, Confidentiality of Information and Personal Privacy policy, revised in February 2021, revealed the facility will protect and safeguard resident confidentiality and personal privacy. This policy also revealed, release of resident information, including video, audio, or computer stored information, will be handled in accordance with resident rights and privacy policies. Review of a facility policy titled, Resident Rights policy, revised in February 2021, revealed federal and state laws guaranteed certain basic rights to all residents of the facility. These rights included privacy and confidentiality.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Number of residents sampled: Number of residents cited: Based on record review and interviews, the facility failed to report to the State Survey Agency an allegation of abuse in a timely manner for one (Resident #81) of two residents reviewed for abuse. The findings include: Review of an admission Record revealed the facility admitted Resident #81 on 10/13/2025 and re-admitted Resident #81 on 12/16/2025 with diagnoses that included depression, and anxiety disorder. Review of a significant Change Minimum Data Set (MDS) with an Assessment Reference Date of 12/22/2025 revealed Resident #81 had a Brief Interview of Mental Status score of 15 which indicated Resident #81 was cognitively intact. The MDS also revealed Resident #81 was dependent on one staff for chair to bed transfers. Review of a Care Plan initiated on 11/04/2025 revealed Resident #81 required assistance by one staff to transfer between surfaces. Review of a Grievance Form dated 02/14/2026, signed by the Administrator revealed that Resident #81 stated that Certified Nursing Assistant (CNA) #3 spoke to Resident #81 in a disrespectful and demeaning manner. The Administrator documented that Resident #81 was upset, and the resident reported that they felt CNA #3 was going to hit them. Review of an Office of Long-Term Care (OLTC) Incident and Accident Report dated 02/15/2026 revealed that emotional/mental abuse was discovered on 02/14/2026 at 2:30 PM and was submitted to the OLTC on 02/15/2026 at 4:45 PM. The incident report revealed that the Administrator was notified that Resident #81 reported that CNA #3 was rude, had yelled, and was verbally aggressive. The incident report also revealed that Resident #81 stated, CNA #3's body actions made Resident #81 feel afraid and uncomfortable. During a phone interview on 04/29/2026 at 4:35 PM, CNA #3 indicated that Resident #81 told the Social Service Director/Assistant Director of Nursing (ADON) #2 that she was verbally abusive to Resident #81. CNA #3 indicated that the incident happened at approximately 6:45 AM before breakfast was served on 02/14/2026. During an interview on 04/29/2026 at 5:24 PM, Social Service Director/ADON #2 indicated that she was on-call the morning of 02/14/2026 when she received a call from RN #4, who reported that CNA #3 had a disagreement with Resident #81 that had occurred that morning about clothing the resident did not want to wear. Social Service Director/ADON #2 indicated that CNA #3 was sent home, and the Administrator took over the investigation. During a phone interview on 04/29/26 at 7:54 PM, Resident #81's family member indicated that Resident #81 informed them that one of the CNA's had talked mean to the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 04/30/2026 at 11:20 AM, RN #4 indicated having been informed that Resident #81 contacted a family member and reported that CNA #3 was talking down to Resident #81 like a child. Resident #81 reported to the family member that CNA #3 put clothes on Resident #81 that were too big. RN #4 indicated that Resident #81 reported to a family member that the resident felt scared and felt like CNA #3 was going to hit them. RN #4 indicated that Resident #81 reported the incident to her the morning of 02/14/2026. RN #4 indicated that she messaged the Social Service Director/ADON #2 around 12:00 PM on 02/14/2026 and informed her of the incident. RN #4 indicated that she found out about the incident at 11:00 AM. During a second interview on 04/30/2026 at 11:29 AM, Social Service Director/ADON #2 indicated that she was notified of the incident the morning of 02/14/2026 and that she talked to RN #4 about the incident. RN #4 reported to Social Service Director/ADON #2 that she had written a grievance. Social Service Director/ADON #2 indicated that an investigation was started on Saturday 02/14/2026. During a follow up interview on 04/30/2026 3:04 PM, Social Service Director/ADON #2 indicated that an allegation of abuse should be reported as soon as it happens. Social Service Director/ADON #2 indicated that she notified the Administrator of the incident as soon as it happened and that the Administrator was responsible for reporting the incident to the OLTC. During an interview on 04/30/2025 at 3:12 PM, the Administrator confirmed that she was responsible for reporting allegations of abuse. The Administrator indicated that abuse should be reported immediately and as soon as being made aware. The Administrator indicated that she was informed at 4:30 PM on 02/14/26 that Resident #81 had accused CNA #3 of verbal abuse. The Administrator stated that she had 24 hours to report a non-physical accusation of abuse. Review of a facility policy titled, Abuse Prevention revised in April 2021, revealed that verbal abuse is any use of verbal, oral written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of age, ability to comprehend, or disability. The policy revealed that it is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, and volunteers to promptly any incident of suspected neglect or resident abuse to the administrator of his/her designee. The policy also revealed that the administrator or designee will report the incident to the local police department and the state licensing agency not more than 2 hours after the allegation is made if the events that caused the allegation involve abuse.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure a member of the nursing staff operated within their scope of practice for two (Resident #33 and Resident #89) of two residents reviewed. The findings include: Review of a facility document titled [Facility] Steps of Action dated 05/01/2026 revealed a reportable was completed for Medication Aide-Certified (MA-C) #1 allegedly working outside of their scope of practice by obtaining a Urine Analysis (UA) approximately two weeks prior to 04/30/2026, flushing a PICC line with normal saline, obtaining a blood sugar on a resident prior to that being in the scope of practice for a MA-C and allegations of MA-C #1 being in the narcotic draw on the [NAME] Hall in April of 2026. Document signed and dated by the Administrator. Review of a facility document titled Job Description-MA-C undated revealed Assume the authority, responsibility and accountability of MA-C care, services, and scope of work. And Must be knowledgeable of MA-C and medication procedures as appropriate to the MA-C scope of work. Review of the document titled, Signed Job Description Medication Aide-Certified MA-C dated 10/25/2023 and signed by MAC #1 revealed, Responsibilities and task: Administer medications according to state approved procedures and Policy and Procedure. The MA-C is responsible to administer medications, check vital signs, and perform resident personal care and other nursing duties as directed by the DON, ADON and charge nurse. Resident #33 Review of Resident #33's admission Record revealed the facility admitted Resident #33 on 09/11/2024 with diagnoses that included muscle wasting and atrophy, assistance with personal care, urinary tract infection, morbid obesity, swelling of the kidneys with a buildup in urine, kidney failure, kidney stones, retention of urine, blood in urine and urinary tract infections (UTIs). Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/06/2026, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact and was independent for daily decision making. Resident #33's MDS also revealed Resident #33 was always incontinent of bowel and bladder, had an active diagnosis of kidney failure and a blockage in the urinary tract restricting the flow of urine. Review of Resident #33's Care Plan initiated on 09/11/2024, revealed Resident #33 had acute renal failure and swelling of the kidneys due to kidney stones and mixed bladder incontinence. Interventions included to give medications as ordered, monitoring and reporting signs of acute kidney failure, encouraging fluids daily and monitoring for signs and symptoms of a UTI. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33's Lab Report revealed on 04/08/2026 at 4:30 AM a Urinary Analysis (UA) was collected. The results were cloudy urine which contained protein, occult blood, red blood cells, bacteria and white blood cells. Review of Resident #33's Progress Note dated 04/08/2026 at 4:51 AM, revealed Licensed Practical Nurse (LPN) #6 documented UA obtained. Resident tolerated well. No c/o [complaints of] pain or discomfort. POC [plan of care] ongoing. Review of an Office of Long-Term Care (OLTC) Witness Statement Form dated 04/30/2026, signed by LPN #6 revealed LPN #6 stated, While performing an in and out 'cath' of a resident, this nurse was not able to get the 'cath' the first try. Attempting to try again [MA-C #1] took the 'cath' out of my hands and performed the in and out with regular gloves. Resident #89 Review of Resident #89's admission Record revealed the facility admitted Resident #89 on 02/04/2025 with diagnoses that included an acute and subacute infection of the heart, sepsis, stroke, heart failure, low blood pressure, altered mental status and coronary artery disease. Review of an admission MDS, with an ARD of 02/08/2025, revealed Resident #89 had a BIMS score of 13 which indicated the resident was cognitively intact. The MDS also indicated Resident #89 was admitted from the hospital and received intravenous (IV) antibiotics. Review of Resident #89's Clinical Physician Orders revised on 02/04/2025, revealed Resident #89 was admitted to skilled care due to a decline in functional mobility and Activities of Daily Living (ADLs) related to an infection of the valves of the heart. Review of Resident #89's Care Plan initiated on 02/04/2025, revealed Resident #89 required Enhanced Barrier Precautions (EBP) due to a Peripherally Inserted Central Catheter (PICC), altered heart status related to an infection of the heart, and heart failure. Interventions included to wear Personal Protective Equipment (PPE) and administering medications as ordered. Review of a Medication Administration Record (MAR) dated 02/2025, revealed Resident #89 had two antibiotics ordered and administered. The first IV antibiotic was ordered 02/04/2025 through 03/09/2025 to be administered every 12 hours for infection of the heart by IV route at 9:00 AM and 9:00 PM daily. The second antibiotic was ordered 02/04/2025 through 03/09/2025 every four hours for infection of the heart by IV route at 12:00 AM, 4:00 AM, 6:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. Review of MA-C #1's Employee file revealed an Employee Memorandum write up dated 02/23/2025 for flushed IV/turned off IV meds- working out of scope signed by LPN #2. During an interview on 04/29/2026 at 7:26 PM, MA-C #1 indicated she was able to apply oxygen, administer insulin with nursing supervision, pass and administer oral medications, eye drops, nose sprays, inhalers and topical medications. MA-C #1 indicated she was not allowed to do anything with IV medications. MA-C #1 stated, Yes, I have worked outside of my scope of practice. MA-C #1 reported on 02/23/2025 she had disconnected and flushed Resident #89's PICC line with a normal saline flush. MA-C #1 reported she was working the shift as a CNA on 02/23/2025. MA-C #1 stated I have also done a [blood sugar check] once and given insulin way before certified to do them. MA-C#1 denied any interaction with the narcotic medications. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/29/2026 at 7:34 PM, LPN #7 denied ever seeing any MA-C work outside of their scope of practice. LPN #7 indicated MA-Cs were not allowed to pass narcotics or do anything with IV's or catheters. LPN #7 denied ever seeing a MA-C insert a catheter. During an interview on 04/30/2026 at 10:15 AM, LPN #6 indicated MA-Cs were not allowed to do anything with a peg tube, breathing treatments, narcotics, or IVs. LPN #6 indicated she was never trained by the facility to know what a MAC was allowed to do. LPN #6 indicated approximately two weeks ago in April LPN #6 was assisted by LPN # 7 to insert a catheter into Resident #33 to obtain a urine sample. LPN #6 stated MAC #1 was present. LPN #6 indicated she was wearing sterile gloves and was attempting to obtain the sample when MAC #1 reached into the field and took the catheter and inserted the catheter into Resident #33 with regular gloves on. LPN #6 reported neither LPN attempted to stop the MA-C, nor did she inform anyone of the incident. During an interview on 04/30/2026 at 11:19 AM, the Director of Nursing (DON) indicated she was aware MAC #1 administered an IV flush to a resident through an IV in 02/2025. The DON clarified through the electronic system that it was Resident #89, and Resident #89 had a PICC line not just IV access. The DON indicated she verbally counseled MAC #1 and the nursing staff and told them, You cannot let them [MA-Cs] work outside of their scope of practice. The DON indicated MA-C #1 had also been written up for working outside of her scope of practice previously by completing a [blood sugar check] on a resident because the resident asked and was being demanding. The DON stated that the write up would be in MA-C #1's Employee File. The DON was unable to recall the name of the resident. The DON indicated those were the only two times she was made aware of MA-C #1 working outside of her scope of practice. The DON indicated the danger of Resident #89 developing an infection or having an air embolism was likely with MA-C #1 performing the task outside of her scope of practice and flushing the PICC line of Resident #89. During an interview on 04/30/2026 at 3:11 PM the Medical Director (MD) indicated, I think the nurses, LPN's or higher are supposed to administer IV medications. The MD stated, Medically if they didn't know what they were doing it could cause an infection or an air embolism. IV medications and flushes, that should be done by the LPN. During an interview on 05/01/2026 at 10:43 AM, MAC #8 indicated she had seen MA-C #1 working outside of her scope of practice before. MAC #8 reported that MA-C #1 was in the narcotic drawer on the [NAME] Hall counting narcotics while LPN #7 was present, in April of 2026. MA-C #8 reported she informed the DON immediately. During a second interview with the DON on 05/01/2026 at 12:00 PM, The DON reported that MA-C #1 was reported to have been in the narcotic drawer with LPN #7 present, but the video footage was reviewed, and it was determined MA-C #1 was not in the narcotic drawer. The DON denied any counseling being completed at that time. During an interview on 05/01/2026 at 12:10 PM, the Administrator indicated she was aware of the IV incident for Resident #89 with MAC #1 but that she verbally told MA-C #1 to not work outside of her scope of practice or she would be terminated. The Administer denied any knowledge of MA-C #1 completing a blood sugar or completing a UA by inserting a catheter into Resident #33. The Administrator indicated an action plan had been created. An in-service for all MAC employees and licensed nursing staff to be educated on the scope of practice for a MA-C was initiated and the target date for completion was 05/06/2026. The Administrator stated, He (LPN#7) lied to me. The Administrator then stated, I believe everything happened as LPN #6 says it did in her statement. The (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator indicated MA-C #1 had been terminated as of 05/01/2026. Review of a facility document titled Termination of Employment dated 05/01/2026 for MAC #1 revealed, Do not rehire. Suspended 04/30/2026 pending investigation. Terminated 05/01/2026 for practicing out of her scope of practice. Signed by the Administrator. Review of a facility document titled Action Plan MA-C Scope of practice dated 05/06/2026 presented by the Administrator indicated, All MA-c employees and licensed nurses will have a full understanding of the MA-C scope of practice as defined by the Arkansas State Board of Nursing. There will be a verification of knowledge and MA-C employees will not perform duties outside of the scope of practice. Also stated If another employee witnesses a MA-C performing duties that are not within the scope of practice, that employee will notify the Administrator and the DON immediately. Specific action steps include, DON/ADON immediately initiated in-servicing of all MA-Cs & licensed nurses on the scope of practice. Additionally, a copy of MA-C approved duties will be located at each nurse's work [NAME]. Following re-education of scope of practice, the MA-C's will be tested of their knowledge of scope by verbal return demonstration. Any MA-C determined to perform duties outside their scope of practice will be terminated and reported to the State Board of Nursing. If an employee is found to have witnessed a MA-C performing duties outside of the scope of practice and is known to have failed to report to the administrator/DON, the employee will be subject to disciplinary action up to/including termination. Review of a facility policy titled, Controlled Substances dated 2001, revealed Only authorized licensed nursing and/or pharmacy personnel have access to the Scheduled II controlled substances maintained on the premises. Review of a facility policy titled, Peripheral and Midline IV Catheter Flushing and Locking revised March 2022, revealed Verify with the State Nurse Practice Act the scope of Practice for the RN's and LPN's regarding this procedure. The policy also revealed, The purpose of this procedure are to maintain catheter patency and function: to prevent mixing incompatible medications and solutions; and to ensure entire dose of solution or medication is administered into the venous system. Review of a facility policy titled, Administering Medications revised April 2019, revealed Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. The policy revealed, Medication errors are documented, reported and reviewed by the QAPI committee to inform process changes and the need for additional staff training. The policy also revealed, The individual administering the medications initials the MAR on the appropriate line after giving each medication. Review of a facility policy titled, Catheter Care, Urinary dated 2001, revealed General guidelines: Follow aseptic technique when inserting a urinary catheter. Review of a published document titled ACT 265, completed by the State of Arkansas 95th General Assembly Regular Session, 2025. House [NAME] 1182, set forth the scope of practice for the Certified Medication Assistants. The [NAME] indicated, Certified Medication Assistant shall not: Receive, have access to, or administer any controlled substance, Administer parenteral, enteral or injectable medication except as authorized under this subchapter.