

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Lakeside Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1207 Willow Run Road Lake City, AR 72437	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50923</p> <p>Based on observations, interviews, facility document review, and record review, the facility failed to ensure staff provided supervision for 1 (Resident #66) of 1 sampled resident reviewed for elopement. The lack of supervision resulted in Resident #66 eloping from the facility and facility staff being unaware of the whereabouts of the resident for approximately three hours and twenty minutes. Resident #66 was found inside an event center approximately 900 feet from the facility.</p> <p>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 State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J.</p> <p>The findings are:</p> <p>Upon review of the Admission Record, the facility admitted Resident #66 on 07/22/2024 with a diagnosis of previous cerebral infarction (disrupted blood flow to the brain).</p> <p>Upon review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/29/2024, Resident #66 was assessed with a Brief Interview for Mental Status (BIMS) score of 9, (BIMS score 8-12 indicates moderate cognitive impairment for decision making). Per section GG of this MDS, and Resident #66's Care Plan dated 7/22/2024, the resident required the assistance of a rolling walker for ambulation. The care plan indicated Resident #66 had limited physical mobility related to dementia and impaired balance. Resident #66 did not have the rolling walker or any other assistive devices at the time of the elopement.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The IJ began on 08/23/2024 at approximately 8:20 PM. Resident #66 was in the lobby and approached Laundry Aide #2, who was standing at the front door. Resident #66 asked Laundry Aide #2, Can I go outside? Laundry Aide #2 was opening the door to allow another resident back into the facility, and Resident #66 went out the front door. Laundry Aide #2 asked CNA #1 if this resident could go outside by herself, and CNA #1 confirmed the resident could go outside. Resident #66 was outside, unattended by staff, on the front grounds of the facility. (An internet search showed the sunset on 08/23/2024 was 7:41 PM and the temperature was approximately 80 degrees Fahrenheit.) Resident #66 then went to the gazebo, to the right near the willow tree. The facility had a smoke break at approximately 8:25 PM, where staff were in front of the facility under the canopy with other residents. The staff were unaware Resident #66 was outside at the time. Staff went back into the facility at the end of the smoke break, at approximately 8:40 PM. It is unknown what time Resident #66 left the facility grounds and began walking down the street. Staff noticed Resident #66 was not in their room at approximately 8:45 PM. At this time, staff began to search the building. The Director of Nursing (DON) was notified at approximately 9:00 PM of the missing resident. The Administrator was notified shortly after 9:00 PM, and the facility implemented an expanded search outside the facility. Family members were notified. The local police and fire department were notified, and they joined the search. The resident was located, by the Social Services employee, at the event center (301 Cobean Boulevard, Lake City, Arkansas, approximately 900 feet from the facility) at approximately 11:50 PM. Family was notified. Resident #66 was taken back to the facility where First Responder #3 evaluated the resident with no injuries noted. A skin assessment was performed by the DON with no injuries noted. After discussing the incident with the resident's family, Resident #66 was moved to a secured unit upon return to the facility as part of the plan of correction.</p> <p>During an interview on 10/22/2024 at 11:40 PM, First Responder #3 confirmed no injuries were noted on Resident #66's head-to-toe assessment he completed.</p> <p>During an interview with Resident #66 on 10/22/2024 at 1:10 PM, Resident #66 stated, I saw a light in the white building (event center where resident was later found) down the street and I was curious what was inside. I don't know what possessed me to start walking there, but I did. On my way, a guy in a car stopped and asked if I was okay. I told him I was okay, and he left. When I got to the building, the front door was locked, but the side doors were open. I went inside, and got a little turned around, but then I found some candy. I ate that and laid down and went to sleep. The next thing I knew, the people came in and woke me up. They told me I was lost, and no one knew where I was at. The girl that let me out worked there, and the guy she asked if I could go outside did too, so I thought they knew where I was. I feel bad I caused so much trouble.</p> <p>During an interview with CNA #1 on 10/22/2024 at 3:13 PM, CNA #1 confirmed Laundry Aide #2 did ask him if Resident #66 could go outside without staff supervision. And he confirmed he advised Laundry Aide #2 yes; the resident can go outside. When asked if he was familiar with Resident #66 and their care plan, he stated I didn't know exactly which resident it was but had seen that resident outside before and had seen [Resident #66] in the facility walking around, so I thought it was okay. When asked if any staff members were outside at the time Resident #66 went out the front door, CNA #1 stated, Not at that time, but they went out on a smoke break with other residents about 5-10 minutes later. When asked what an appropriate action would be to take before advising the other staff member, he stated, Know the resident and check the care plan. Ask the nurse if I don't know. Also, make sure staff is supervising residents that need it. CNA #1 confirmed, he was present for the in-service completed on 8/24/2024 on Wandering and Elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Laundry Aide #2 on 10/22/2024 at 4:00 PM, she confirmed the resident was in the lobby and approached her at about 8:15 PM. She stated, I was standing there about to open the front door for another resident coming back into the facility. [Resident #66] wanted to know if it was okay for them to go outside. I wasn't sure so I asked [CNA #1] which was walking by at that time. As I was asking, [Resident #66] went through the door as the other resident was coming in. [CNA #1] said it was okay, so I left. When asked if there were staff members outside at the time Resident #66 went through the doors, she stated, Not that I know of. I didn't see any.</p> <p>During an interview with the DON on 10/23/2024 at 10:45 AM, she confirmed she performed a skin assessment upon return of Resident #66, and no injuries were noted. The DON also confirmed the decision to place Resident #66 on the secured unit was part of their plan of correction but, was previously discussed with the POA for Resident #66 to ensure he agreed with the plan. She also confirmed staff members were in-serviced with an in-depth discussion and re-training related to wandering and elopements, and ways to help prevent future elopements.</p> <p>During an interview with the Administrator regarding Resident #66, she confirmed the facility changed the area designated for smoking from the front entry area under the canopy to a covered area that has a locked gate. In addition, she confirmed that staff are to supervise the residents while outside.</p> <p>During an interview on 10/23/2024 at 1:30 PM, Resident #66's family member, which was the resident's Power of Attorney (POA), confirmed the resident was not able to make appropriate decisions for themselves due to cognition impairment. He confirmed there was a history of Resident #66 not making safe, or sound decisions for themselves. He stated he was in the process of obtaining guardianship over Resident #66, to ensure he can make all decisions for the resident in the future. He confirmed the facility notified him of the elopement.</p> <p>A review of a Wandering and Elopement Discussion In-Service, dated 8/24/2024, revealed a facility policy titled Wandering and Elopements with a revision date of March 2019, that revealed: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain resident's safety. This in-service was signed by forty-nine staff members.</p> <p>The Administrator was notified of the past noncompliance immediate jeopardy (IJ) on 10/23/2024 at 5:50 PM. The facility implemented corrective actions which were completed prior to the State Agency 's survey completion; thus, it was determined to be a past noncompliance citation. The facility initiated a plan of correction was completed on 08/24/2024.</p> <p>Removal Plan:</p> <ol style="list-style-type: none"> <li>1. On 8/24/24, Resident #66 was placed on the secured unit at approximately 12:15 AM.</li> <li>2. On 8/24/24 Elopement assessments were completed for all residents including Resident #66. The care plan for each resident identified at high risk of elopement was reviewed and updated as necessary.</li> </ol> <p>(continued on next page)</p>		

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