

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Lake Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 817 East Plum Street Moses Lake, WA 98837	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939</p> <p>Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse by staff for 1 of 5 residents (Resident 1) reviewed for abuse. This deficient practice placed residents at risk for further abuse and potential injuries.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Abuse Prohibition, revised 05/01/2022, showed the facility prohibited the abuse and/or mistreatment of all residents.</p> <p><Resident 1></p> <p>Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses Alzheimer's Disease (a progressive brain disease that causes memory loss and other cognitive decline), depression (a mental health condition that involves persistent sadness, loss of interest, and difficulty functioning), and anxiety (a feeling of fear, dread, or uneasiness that can be a normal reaction to stress). Review of the comprehensive assessment, dated 01/23/2025, showed Resident 1 had severe cognitive impairment, required the assistance of one to two people with dressing, personal cares, toileting, and bathing, and was independent with ambulation.</p> <p>Review of the care plan, dated 11/07/2022, showed Resident 1 .exhibits or is at risk for distressed/fluctuating mood symptoms related to depression and anxiety disorders. Further review of the care plan showed interventions to include observing for signs or symptoms of worsening depression, anxiety, anger and agitation and to all Resident 1 time to express their feelings, provide empathy, encouragement and reassurance.</p> <p>Review of the facility investigation log, on 02/27/2025, showed an abuse allegation investigation was initiated on 02/23/2025 involving Resident 1 and a staff member.</p> <p>Review of the facility investigation, dated 02/27/2025, showed Resident 1 had .numerous days of multiple episodes of negative and intrusive behaviors placing him at risk for harm ., and a staff member reported observing Resident 1 attempt to kick the identified staff member, Staff E, Registered Nurse (RN), and Staff E responded by kicking Resident 1 in the left lower leg area. The facility's investigation conclusion substantiated abuse of Resident 1 by Staff E, and Staff E's employment was terminated.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 02/27/2025 at 2:10 PM, Staff F, Nursing Assistant (NA), stated they witnessed Staff E kick Resident 1 in the left lower leg a total of four times in response to Resident 1's agitated and aggressive behavior. Staff E stated they were able to redirect Resident 1 away from the situation, checked for injuries, and then reported the incident to nursing management.</p> <p>During an interview, on 02/27/2025 at 4:05 PM, Staff A, Director of Nursing, stated they removed Staff E from the floor immediately and initiated the investigation. Staff A stated they completed a skin assessment for Resident 1 and found no indication of injuries. Staff A stated upon completion of the investigation it was determined Staff E's employment would be terminated as physical abuse was substantiated.</p> <p>During an interview, on 03/03/2025 at 8:45 AM, a Resident Representative (RR) stated they were aware Resident 1 could display aggressive behaviors at times, but did not feel those behaviors warranted the response of physical abuse from the staff.</p> <p>Reference: WAC 388-97-0640 (1)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939</p> <p>Based on interview and record review, the facility failed to ensure that a compromised resident who experienced a decline in condition with multiple falls and injury was seen timely by the physician when returned from a hospital stay for 1 of 3 residents (Resident 2) reviewed for change in condition. This deficient practice placed the resident at risk for further complications and decline in health status.</p> <p>Findings included .</p> <p>Review of Davis' Drug Guide 2024, showed the therapeutic level for Phenytoin (medication taken to treat seizure disorders) was 10 to 20 milligrams [(mg) unit of measure] per liter [(L) unit of volume].</p> <p><Resident 2></p> <p>Review of the medical record showed Resident 2 admitted to the facility on [DATE] with diagnoses of epilepsy (a brain disorder that causes seizures, which are abnormal electrical surges in the brain) and dementia (a decline in mental abilities that impacts a person's daily life). Review of the comprehensive assessment, dated 01/28/2025, showed Resident 2 had severely impaired cognition and was independent with ambulating, dressing, toileting, and hygiene tasks.</p> <p>Review of the nursing progress note, dated 01/24/2025 at 10:54 AM, showed the previous shift Nursing Aide (NA) reported Resident 2 .was experiencing seizures, was incontinent of urine and seemed 'out of it.'</p> <p>Review of the facility incident log showed Resident 2 experienced falls, some with head injuries, on 01/27/2025, 02/07/2025, 02/09/2025, 02/10/2025, and 02/12/2025.</p> <p>Review of the nursing progress note, dated 01/27/2025 at 9:17 PM, showed Resident 2 was found sitting in their recliner with visible blood on their shirt and right hand. Further assessment of Resident 2 showed they had a laceration to the right side of the back of the head measuring one inch (unit of measure) in length.</p> <p>Review of the after-hours telehealth provider note, dated 01/27/2025 at 10:00 PM, showed Resident 2 was evaluated due to falls with head injury and facility staff reported Resident 2 had .dizziness throughout the day, drowsiness, increased confusion, and not at their baseline .</p> <p>Review of the nursing progress note, dated 01/28/2025 at 9:30 AM, showed Resident 2 .continued to have signs/symptoms of decline and change in condition . and required assistance with bathing and dressing due to poor balance.</p> <p>Review of the nursing progress note, dated 01/29/2025 at 8:15 PM, showed Resident 2 experienced a witnessed seizure while in the bathroom and sustained injuries when they fell and hit their head. Further assessment of Resident 2 showed they had a two-inch laceration above their left eye that had extensive bleeding. Resident 2 was transferred to a local hospital for evaluation and treatment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record showed Resident 2 was admitted to a local hospital for treatment from 01/29/2025 to 02/03/2025.</p> <p>Review of the hospital discharge summary, dated 02/03/2025 at 11:03 AM, showed Resident 2's Phenytoin level on 01/29/2025 was 34 mg/L and on 01/31/2025 was 32 mg/L. There were instructions to follow-up with the facility's medical provider.</p> <p>Review of the nursing progress note, dated 02/07/2025 at 8:16 PM, showed Resident 2 experienced two falls within one hour, the after-hours medical provider was contacted, and .patient needs to be seen by facility provider when (they do their) next rounds.</p> <p>Review of the after-hours telehealth provider note, dated 02/07/2025 at 10:00 PM, showed Resident 2 fell twice in the span of one hour and was complaining of chest pain and head pain. Facility staff reported Resident 2 had .increased confusion and behavioral changes similar to pre-seizure state ., was unstable and would not stay in bed. Further review of the provider note showed new orders for laboratory testing of blood and urine were ordered to rule out a urinary tract infection as the cause of Resident 2's decline.</p> <p>Review of the nursing progress note, dated 02/08/2025 at 10:53 AM, showed Resident 2 was transferred to a local hospital for evaluation and treatment for change in condition .blood pressure was low and (Resident 2) was very lethargic. (Resident 2) was unable to transfer or ambulate and was not talking when (they) left the facility.</p> <p>Review of the nursing progress note, dated 02/08/2025 at 7:45 PM, showed Resident 2 had returned to the facility and required three people to assist them to the bathroom due to being .very off balance.</p> <p>Review of the incident investigation, dated 02/09/2025 at 1:55 PM, showed Resident 2 experienced an unwitnessed fall in their room and sustained a one-half inch laceration to the left, back side of head.</p> <p>Review of the nursing progress note, dated 02/10/2025 at 9:00 AM, showed Resident 2 experienced an unwitnessed fall at 2:00 AM and sustained a laceration to the back of their head. Resident 2 was sent to a local hospital for evaluation and treatment, received seven staples to their head laceration, and was diagnosed with aspiration pneumonia and subdural hematoma.</p> <p>Review of the incident investigation, dated 02/10/2025 at 12:49 PM, showed Resident 2 had an unwitnessed fall and re-opened one of their lacerations to their head. The investigation showed Resident 2 stated they had a seizure and fell .</p> <p>Review of the nursing progress note, dated 02/12/2025 at 9:50 AM, Resident 2 alerted facility staff that they experienced a fall and sustained a laceration to their forehead from hitting their head on the sink. Resident 2 was transferred to a local hospital for evaluation and treatment.</p> <p>Review of the local hospital emergency room (ER) notes, dated 02/12/2025 at 12:53 PM, showed Resident 2 needed to be seen by facility medical provider .as soon as possible.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress note, dated 02/12/2025 at 1:30 PM, Resident 2 returned to the facility from the local hospital with new orders .to put Phenytoin on hold until seen by (facility provider) or Neurologist as the level is elevated to 38 mg/L.</p> <p>Review of the nursing progress note, dated 02/16/2025 at 10:02 PM, showed Resident 2 was seen face to face by the facility medical provider (13 days after readmission from the hospital and five transfers to the ER related to seizures, falls, and head injuries) and new orders given to check Resident 2's Phenytoin levels in the morning.</p> <p>Review of the laboratory report, dated 02/18/2025 at 8:02 PM, showed Resident 2's Phenytoin level was 22 mg/L and new orders were given to continue to hold the Phenytoin medication for five days and then re-check the level.</p> <p>During an interview, on 03/03/2025 at 2:30 PM, Staff C, Resident Care Manager (RCM), stated they completed Resident 2's re-admission from the hospital on 02/03/2025. Staff C stated they did not question Resident 2's elevated Phenytoin levels or the order to continue the medication as previously ordered. Staff C stated residents returning from the hospital should be seen by the medical provider within a week, and confirmed they did not specifically request for Resident 2 to be evaluated by the facility medical provider. Staff C stated they were not sure of the facility process to have a resident evaluated by the facility medical provider for acute purposes.</p> <p>During an interview, on 03/03/2025 at 3:05 PM, Staff B, Infection Preventionist, stated they assisted with the risk management and re-admission of Resident 2 from their multiple transfers to the local hospital. Staff B stated they followed the orders provided by the hospital and did not question the elevated Phenytoin levels with orders to continue the medication as previously ordered. Staff B stated residents returning from the hospital should be seen by their medical provider within a week, and the floor nurses notified the facility medical provider of acute concerns with residents either by phone or in person when they were at the facility.</p> <p>During an interview, on 03/03/2025 at 3:15 PM, Staff A, Director of Nursing, stated they expected residents to be seen by the facility medical provider within a week of re-admitting from the hospital or returning from an ER visit and confirmed that was not done for Resident 2.</p> <p>During an interview, on 03/04/2025 at 10:00 AM, Staff D, Medical Director, stated their expectation was for residents to be evaluated by a medical provider within a week of re-admitting from the hospital and confirmed that was not done for Resident 2.</p> <p>Reference: WAC 388-97-1060 (1)</p>		