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| 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 07/16/2025 |
| 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.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Resident Representative (RR) and physician were notified of multiple medication refusals that resulted in a change in condition for 1 of 2 residents (Resident 1) reviewed for change in condition. This deficient practice placed residents at risk of a potential delay in medical treatment. Findings included. &lt;Resident 1&gt; Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses of dementia (a decline in mental ability, impacting memory, thinking, and social abilities enough to interfere with daily life) with agitation (feeling restless, uneasy, or disturbed), heart failure (condition where the heart muscle is weakened or stiffened, making it less effective at pumping blood), and diabetes mellitus (a condition where your body has trouble regulating blood sugar levels). Review of the comprehensive assessment dated [DATE] showed Resident 1 had severely impaired cognition and required the assistance of one person for dressing, personal hygiene, toileting, and bathing. Review of the physician's orders for June 2025 showed Resident 1 was prescribed the following medications to treat diabetes mellitus: Glipizide (a medication used to treat high blood sugar levels) 5 milligrams (mg)--take by mouth in the morning. Humalog (fast-acting-within 15-60 minutes) Insulin (man-made form of the hormone needed to manage blood sugar levels) 100 units/milliliter (mL)--inject subcutaneously [SQ (under the skin)] per sliding scale based on blood sugar (BS) value with meals and at bedtime. If BS 150-200=inject zero units; 201-250=inject one unit; 251-300=inject two units; 301-350=inject three units; 351-400=inject four units; 401-500=inject five units and call provider. Lantus (long-acting-works over 24-hours) Insulin 100 units/mL-Inject 30 units SQ in the evening. Review of the Medication Administration Record (MAR) for June 2025 showed Resident 1 had the following documented refusals: Glipizide was refused two out of 25 opportunities. Humalog Insulin was refused two out of 24 opportunities with breakfast, two out of 23 opportunities with lunch, 18 out of 24 opportunities with dinner, and 22 out of 24 opportunities at bedtime. Lantus Insulin was refused 20 out of 25 opportunities. Review of the nursing progress notes from 06/05/2025 to 06/30/2025 showed no documented notifications to Resident 1's Representative or the medical provider regarding their medication refusals. Review of the medical record showed Resident 1 was admitted to the local hospital on [DATE] for hyperglycemia (a condition where there's too much sugar in the blood) and altered mental status. During an interview, on 07/09/2025 at 10:10 AM, a Resident Representative (RR) stated they were unaware of the number of medication refusals by Resident 1 and felt this was the cause of Resident 1's change in condition and hospitalization. During an interview, on 07/09/2025 at 2:40 PM, Staff C, Advanced Registered Nurse Practitioner (ARNP), stated they expected facility nursing staff to notify a medical provider (either in-person while they were at the facility or by phone) within 24 hours of a resident refusing vital medications such as insulin, antibiotics (medicines that fight bacterial infections), blood thinners (medications that prevent blood clots from forming), or antiseizure medications (used to prevent or stop seizures (a sudden, temporary surge of abnormal electrical activity in the brain that can cause changes in behavior, sensations, muscle control, and awareness)). Staff C stated patterns of overall medication refusals or missed doses should be brought to the medical provider's attention regardless of the type of medication within a week's time. Staff C stated they were not aware of the number of medication refusals Resident 1 had since admission. During an interview, on 07/16/2025 at 2:15 PM, Staff D, Licensed Practical Nurse (LPN), stated they were aware Resident 1 refused their medications frequently, especially in the evening. Staff D stated their practice was to notify nursing management and the medical provider when residents refuse their medications on more than one occasion. Staff D stated they were usually successful with medication administration for Resident 1 and did not recall a time when notification was warranted. During an interview, on 07/16/2025 at 2:35 PM, Staff E, LPN, stated Resident 1 was very difficult to administer medications to, and they were usually not successful. Staff E stated their practice was to verbally notify the Director of Nursing Services (DNS), medical provider, and/or the RR of medication refusals when they saw them in person. Staff E stated they try (to remember) to document (the notification) in the medical record. During an interview, on 07/16/2025 at 3:45 PM, Staff B, DNS, stated the expectation was for the nursing staff to notify the nursing managers, medical provider, and the RR when a resident refused to take medication, especially medications that can have negative impacts if missed. Staff B stated notifications for Resident 1's medication refusals should have been made and were not. Reference: WAC 388-07-0320(1)(c)</p> | | |