STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505261	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Ridge Center	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)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure orders given by a urologist [a doctor who specializes in the urinary system (the body's drainage system for filtering waste and excess fluid to produce and expel urine) and male reproductive system] were completed and reviewed, in a manner that met professional standards of practice, for 1 of 3 residents (Resident 1) reviewed for change in condition related to the urinary system. Resident 1 experienced harm when they were hospitalized for sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection causing widespread inflammation and injury to organs) related to an untreated urinary tract infection [(UTI) an infection in any part of the urinary system--the kidneys, ureters, bladder and urethra].Findings included .Review of Lippincott Manual of Nursing Practice, 11th edition, showed a cystoscopy [procedure where the physician inserts a thin tube with a camera into the urethra (tube that carries urine out of the body) and bladder] was not recommended for patients with a known UTI. Nursing considerations for cystoscopy aftercare included monitoring for burning with urination, frequency (frequent sensation to urinate) due to trauma to the lining of the urethra and signs of infection in the bladder.Review of the facility policy, Physician/Advanced Practice Provider (APP) Notification, revised on [DATE], showed the nurse must promptly notify the provider of laboratory or diagnostic test results that fall outside of clinical reference ranges and will compare them with the previous results.Resident 1Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses of diabetes (a disease that impacts how the body process sugar), obstructive uropathy (a condition where a blockage prevents urine from flowing out of the body, causing it to back up and potentially damage the kidneys), and dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving). Review of the comprehensive assessment, dated [DATE], showed Resident 1 had severe cognitive impairment, was frequently incontinent of urine and bowel, and required the assistance of one person for personal hygiene, dressing, toileting, transfers, and incontinent care.Review of the medical record showed a Situation, Background, Assessment, and Recommendation [(SBAR) a tool used to communicate a change in condition], dated [DATE] at 6:53 PM, documenting Resident 1 experiencing painful urination and blood in urine. The SBAR showed new orders from the medical provider to obtain a urinalysis (UA) with culture and sensitivity [(C & S) a laboratory test to show the specific bacteria present and which antibiotics work to treat it], Comprehensive Metabolic Panel [(CMP) laboratory blood test to show electrolyte levels and kidney function], and Complete Blood Count [(CBC) a laboratory blood test to show the levels of white and red blood cells in the body].Review of the medical record showed a urine sample for Resident 1 was obtained on [DATE] at 7:50 PM, and the UA laboratory test results were reported to the facility by fax on [DATE] at 10:01 PM.Review of the nursing Progress Note (PN), dated [DATE] at 5:20 PM, showed Resident 1 was sent to the local hospital for evaluation and treatment for the continued hematuria (blood in the urine) per the family's request.Review of the hospital emergency room documents, dated [DATE] at 12:37 AM, showed Resident 1's UA did not show indications of infection. Resident 1 had their bladder irrigated (a process of inserting a catheter through urethra and into the bladder and flushing with sterile solution), removing multiple blood clots. The urinary catheter was left in place to monitor for continued bleeding, and a follow-up appointment was scheduled with the urologist for [DATE].Review of the urologist visit note, dated [DATE] at 10:52 AM, showed Resident 1 had no further hematuria, the catheter was removed, cystoscopy was scheduled for [DATE], and a UA was to be completed prior to the procedure. Review of Resident 1's Medication Administration Record (MAR) for [DATE], showed an order, dated [DATE], to obtain a UA with C & S and the results to be faxed to the urologist's office. Further review of the MAR showed no documentation indicating the UA was completed.Review of the urologist visit note, dated [DATE] at 1:09 PM, showed Resident 1 had a cystoscopy completed with no worrisome findings, and a UA was needed as Resident 1 was unable to provide a urine sample prior to leaving the office.Review of Resident 1's MARs for [DATE], showed an order, dated [DATE], to obtain a UA.Review of the medical record showed a urine sample was obtained from Resident 1 on [DATE] at 2:08 PM. The UA laboratory results were reviewed by the facility's medical provider on [DATE] with the notation no symptoms (sx). Await C & S. Review of the nursing PN, dated [DATE] at 1:24 PM, showed Resident 1 had increased behaviors this shift, hitting, kicking, punching staff. Attempts to bite staff.Review of the medical provider note, dated [DATE], showed Resident 1 was evaluated for follow-up regarding behaviors, functional decline, cognition decline