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	04/17/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff implemented interventions to prevent resident to resident altercations involving 4 of 7 Residents (12, 24, 40 and 39) reviewed for abuse. This failed practice placed residents at risk for physical harm, mental anguish, and a diminished quality of life.Findings included . Resident 12Review of the resident's medical record showed they were admitted with diagnoses which included dementia (a decline in mental ability), stroke (blood flow is cut-off from the brain causing tissue damage) and enchalomalcia (a softening or loss of brain tissue following a stroke). Review of the comprehensive assessment dated [DATE] showed the resident had severe cognitive impairment and required substantial assistance for daily activities such as dressing, showering, personal hygiene and using the bathroom. The residents were independent with walking and mobility requiring no assistance from staff. Resident 24Review of the resident's medical record showed they were admitted with diagnoses which included dementia and diabetes (high blood sugar levels). Review of the comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and required moderate assistance for showering and using the bathroom. Supervision for dressing and was independent with transfers and mobility. Review of a nursing progress note (PN) dated 04/03/2026 at 10:54 AM, Staff J, Licensed Practical Nurse (LPN), documented that Resident 12 and Resident 24 were both in the hallway, and as Resident 24 walked by Resident 12 pushed Resident 24 into the wall. The PN further showed the incident was not provoked and was difficult to anticipate or prevent at the time of the occurrence. During an interview on 04/14/2026 at 11:03 AM, Staff B, Director of Nursing Services (DNS), stated that Resident 12 gets aggressive at times and acknowledged the incident involving Residents 12 and 24 did fit the definition of abuse. Resident 40Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dementia (a group of symptoms that affect memory, thinking and social abilities, severely enough to interfere with daily life), depression and difficulty sleeping. Review of the 03/04/2026 care plan showed the resident was rarely (verbally) understood but could reply yes or no. The resident did experience short and long-term memory loss. Resident 40 was dependent on staff for transfers to and from their bed to the resident's tilt in space wheelchair (a wheelchair designed to tilt the seat, the back of the wheelchair and leg rests as a single unit to redistribute weight and improve positioning). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 39Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dementia with agitation and restlessness and seizures (a sudden surge of abnormal electrical activity in the brain which causes changes in awareness and muscle control). Review of the 04/06/2026 care plan showed Resident 39 was cognitively impaired, verbal, independent with walking and had poor impulse control. Resident 39 had a history of getting into other residents spaces which staff were to redirect Resident 39 and provide constant oversight when these behaviors occurred. Review of the 03/31/2026 incident investigation showed Resident 40 was up in of the in their tilt in space wheelchair in the C hallway when Resident 39 came up behind Resident 40's wheelchair when Resident 39 (another resident) pushed Resident 40's wheelchair and forced the resident forward where Resident 40 slid to the floor from their wheelchair and landed on their bottom. There were no injuries sustained for Resident 40. Resident 39, who was also demented staff stated Resident 39 was trying to push Resident 40 in their wheelchair into the Hall C dining room. The nursing staff were to redirect Resident 39 when they wheel residents' wheelchairs. Residents 39 and 40 could not recall the 03/31/2026 incident. During an interview on 04/16/2026 at 2:00 PM, Staff B, DNS, stated Resident 40's incident was an isolated event. Staff B stated Resident 39 was confused and demented and tried to help staff at times and had in the past assisted by wheeling other residents in wheelchairs. The interventions were to redirect the resident to another area or activity. Resident 40 did not sustain any injury from the incident. Staff B stated Resident 39 was observed and had walked quickly and grabbed Resident 40's wheelchair and started walking quickly pushing Resident 40's tilted wheelchair when the incident occurred. Reference: WAC 388-97-0640(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure identification and evaluation of accident (any unexpected or unintentional incident, which results or may result in injury or illness to a resident) risk/hazards (elements of a residents environment that have the potential to cause injury or illness) regarding residents spilling hot liquids on themselves, nor implementation of an individualized, resident-centered care plan to reduce the risk/hazards related to the spilling of hot liquids for 2 of 3 residents (Resident 48 and 51) reviewed for accident/hazards. This failure placed residents at an increased risk for avoidable accidents, significant injury, and unmet care needs.Findings included.Review of the facility's guidelines titled, Food and Nutrition Services Guideline for Hot Beverages, dated 07/15/2025, showed that hot beverages such as coffee, tea and hot chocolate, held at high temperatures and posed a risk of injury/burns to residents. The guidelines showed that hot liquids would be held at a temperature between 120 to 150 degrees Fahrenheit (F, a unit of measure) before leaving the kitchen to be delivered to residents. The guidelines showed that in order to limit the risk of burns resident's .who may be at greater risk of spilling hot beverages on themselves ., would be identified, which may include, but were not limited to; residents with tremors (an involuntary rhythmic shaking movement of one or more body parts), residents with poor hand control from a stroke (a complication when blood supply to the brain is blocked or reduced which can lead to brain damage and loss of muscle movement of affected arms/legs) or weakness, residents not seated or walking with a hot beverage and resident in a wheelchair traveling with a hot beverage .even a few feet.Review of facility's guidelines presented on survey titled, Hot food and Beverages Can Burn, dated April 2016, showed that hot beverages spilling was a frequent source for scald (an injury that occurs when a portion of skin is exposed to a hot liquid and can damage several layers of skin) injury's. The guidelines showed that vulnerable residents with limited mobility, carrying hot liquids while seated in a wheelchair, were at an increased risk for scalding injuries and that hot liquid temperatures of 155 degrees F, at one second (a unit of measure) or 140 degrees F, at five seconds could cause a serious burn injury.<Resident 48>Review of the medical record showed they were admitted to the facility on [DATE] with diagnosis including stroke, severe dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) with behavioral disturbances (a pattern of disruptive behaviors that can significantly impact an individual's daily life and social interactions), agitation, exit-seeking behavior (a form of wandering where an individual attempts to leave a safe environment, common with dementia residents and can be driven by confusion, distress/anxiety) and generalized muscle weakness. The 04/06/2026 comprehensive assessment showed the resident had a severely impaired cognition, was wheelchair dependent, required substantial/maximal assistance from nursing staff with transfers, had no skin/wound or open sores noted, and had been receiving psychotropic medications (drugs that affect brain activities associated with mental processes, emotions and behavior).Record review of the resident-centered care plan, last revised 04/10/2026, showed Resident 48 did not have an individualized care plan that identified/assessed the residents risks for hazards or accidents regarding the spilling of hot beverages nor specific interventions or assistive devices that might be utilized to mitigate (to make something less severe or harmful) Resident 48's risk for an avoidable accident/injury from the spilling of a hot beverage on themselves. Observations of the A- Hall dining room on 04/13/2026 from 11:50 AM to 12:42 PM showed Resident 48 sitting in their wheelchair, at a table with other residents, drinking hot tea in a mug/cup with a plastic lid. Resident 48 self-propelled in/out of the dining room multiple times, using their feet in conjunction with grabbing at tables/chairs and handrails to maneuver themselves around, waiting for lunch to be served. Confused, Resident 48 maneuvered up to the door that led from the A-hall dining room to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside the facility and proceeded to grab/bang their hands on the door stating, you can't get out of here (exit-seeking behaviors).Record review of an initial incident report/investigation on 04/14/2026 at 2:30 PM, showed Staff I, Licensed Practical Nurse (LPN), was informed that Resident 48 had spilled hot tea on themselves during a group activity. Resident 48 removed the lid from their hot beverage and lost their grip, spilling the beverage into their own lap. The hot water used for the resident's beverage was temped at 146 degrees F, after the resident had the spill incident and per the facility's policy the temperature of hot liquids used for beverages were to be at most 150 degrees F. Additionally, Resident 48 had a history of spilling a hot tea/beverage on themselves.Record review of a progress note, summary to provider, documented by Staff I on 04/14/2026 at 2:30 PM, showed that Resident 48 was very confused and disoriented (a state of mental confusion where a resident is unsure on the time, place, identity or situation). Staff I stated the resident had spilled tea on themselves and when assessing the skin at the site where the resident had spilled, .redness noted with some peel skin to right inner thigh .Record review of the facility's kitchen temperature guidelines and daily logs for hot beverages served out to residents from 03/22/2026 through 04/14/2026, showed when preparing hot beverage like tea or coffee, .hold hot beverage until temperature is in range from 120 degrees F to 150 degrees F before delivering . The temperature logs from 03/22/2026 through 04/14/2026 showed that everyday hot beverages were initially temped at 170 degrees F, then delivered at 150 degrees F, with the 04/14/2026 hot beverages being delivered at 1:40 PM that day.During a concurrent observation and interview on 04/14/2026 at 5:01 PM, Resident 48 was making their way down the hallway in their wheelchair. When asked, the resident could not remember spilling hot tea on themselves earlier in the day and kept looking at the double doors that exited the hallway. Resident 48 was confused by questions about the accident but stated no when asked if they had any pain from spilling the hot tea and was redirected by nursing staff as the resident got closer to the hallways exit doors.During an interview on 04/14/2026 at 5:04 PM, Staff I stated the resident was in the dining room for activities when they spilled their hot tea on themselves. Staff I stated that Resident 48 normally dropped things like their drinks and food. Staff I stated they had notified the provider who assessed the resident after the hot tea spilling incident and that it was common for Resident 48 to take the lid off their hot tea beverage.During an interview on 04/14/2026 at 5:29 PM, Staff B, Director of Nursing Services, stated they had just started an investigation into Resident 48's accident involving the spilling of hot tea on themselves and was not aware of the resident having an accidental spill of their hot beverages prior to the incident on 04/14/2026 at 2:30 PM. Staff B stated that Resident 48 would now have to be supervised when drinking their hot tea, that hot beverages from the kitchen should be at a lower temperature than 150 degrees F, and an assisted device cup with a screw top lid.During an interview on 04/14/2026 at 5:40 PM, Staff Q, Activities Director, stated that Resident 48 did have a previous accident where they had spilled their hot tea beverage before, but remembered the resident's tea had been sitting out and that it was at a cooler temperature at that time the resident spilled the beverage. Staff Q stated they conveyed the accidental spill to the nursing staff but were unsure of the date the accident happened, maybe three months ago and did not complete any documentation nor present documentation of it in the resident's record.During an interview on 04/15/2026 at 11:16 AM, Staff J, LPN, stated that within the past couple of months Resident 48 had been more anxious, exit-seeking and just a lot more movement (referring to the residents anxiousness and inability to sit still in one place for too long). Staff J stated they had not completed an evaluation, nor did they know of an assessment regarding Resident 48's risk for spilling their hot beverages or care plan interventions implemented. Additionally, if the resident was at risk of spilling hot beverages, that information would be conveyed to the Resident Care Manager (RCM).During a concurrent interview with facility staff on 04/15/2026 at 11:32 AM, Staff G, RCM, stated they oversaw Resident 48's care. Staff G stated that residents who had tremors, impaired cognition or the inability to understand safe practices regarding handling of hot liquids/drinks would be at an increased risk for accidents/hazards around the spilling of hot beverages. Staff G stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were not aware of Resident 48 spilling their hot tea before. Staff G stated they did not know of a facility process for identifying/assessing residents that were at an increased risk for the spilling of hot beverages and did not identify or complete an evaluation or a resident-centered care plan regarding Resident 48's accidents/hazards with spilling of hot liquids/beverages. Staff L, Physician's Assistant, stated the facility's resident population was at risk for accidents/hazards with the spilling of hot beverages and Resident 48 would be at an increased risk. Staff L stated they were not aware of the resident having an incident with spilling their hot beverages before. Staff L stated that if a resident had a prior incident of spilling their hot liquids, it would be a safety concern and Staff L would expect care plan intervention to be implemented. Staff L stated they were not aware of the facility hot beverage temperature guidelines process or parameters, or that the daily kitchen temperature logs showed resident hot beverage temperatures of 150 degrees F were being served out. Staff L stated that hot beverage temperatures of 150 degrees F placed residents at an increased risk for scalding and would expect the temperature to be 140 degrees F or lower. Staff F stated that if residents, like Resident 48, with an increased risk for accidents/hazards around spilling hot beverages were identified, assessed and interventions care planned/implemented it would mitigate or prevent accidents/injury from the spilling of hot beverages.During an interview on 04/15/2026 at 12:53 PM, Staff B stated the facility did not have a process for identifying or assessing residents at risk for the spilling of hot beverages. Staff B stated residents that walked around with a hot beverage or self-propelled themselves around in a wheelchair with a hot beverage, residents with a diagnosis that may cause tremors and have an impaired cognition would have an increased risk for accidents/hazards of hot beverages spills. Staff B stated that Resident 48 was not at an increased risk of spilling their hot beverages before the incident on 04/14/2026. During an interview on 04/15/2026 at 12:59 PM, Staff S, Activities Assistant, stated they were familiar with Resident 48. Staff S stated they were in the A-hall dining room on 04/14/2026 when they heard Resident 48 state, Ow, it burns and noted the resident had accidentally spilled hot tea on themselves. Staff S stated the resident normally drank the hot tea beverage before activities in the dining area. Staff S stated that Resident 48 was normally confused and would take off the lid to their hot beverages most times, after a few sips. Additionally, Staff S stated that Resident 48 had been known to take their hot beverage with them into the hallways while self-propelling/shuffling in their wheelchair. During a concurrent observation and interview on 04/15/2026 at 3:16 PM, showed A-hall residents gathering in the dining room for tea and coffee before activities started. Staff R, Activities Assistant, stated they were familiar with Resident 48 and worked with the resident during activities in the A-hall dining room area. Staff R stated they had not been informed of any residents having complications with the spilling of their hot beverages or that needed increased supervision during the afternoon hot tea/coffee time before activities. Staff R stated that residents had spilled their hot coffee/tea before but not on themselves. Staff R stated that Resident 48 was a risk for spilling their hot beverage. Staff R stated they had to take the hot tea beverage from the resident sometimes because the resident would fall asleep with the hot beverage in their hands. Staff R stated that sometimes Resident 48 would be in their wheelchair, take their hot beverage, with the lid already off, and attempt to self-propel in the hallway. Staff R stated it was not safe. Staff R stated it was the residents right to take off the hot beverage lid, and the staff member would remind the resident to be careful.During a follow-up interview on 04/15/2026 at 3:36 PM, Staff I stated that residents with tremors, had dementia with confusion or were cognitively impaired, or had behaviors where the resident could not sit still or moved around constantly, were at an increased risk for spilling beverages. Staff I stated that some residents were at a higher risk for spilling their hot beverages and Resident 48 was one of them. Staff I stated there was no formal process for identifying or assessing residents at high risk for spilling hot liquids/beverages. Staff I stated that measure or intervention for Resident 48 should have been put in place to help prevent or mitigate accidents/hazards for spilling of hot beverages.<Resident 51>Review of the medical record showed they were admitted to the facility on [DATE] with diagnosis (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including stroke, Alzheimer's disease (a progressive disease that destroys memory and cognitive functioning, thinking, remembering, and reasoning) with other behavioral disturbances, anxiety, depression and generalized muscle weakness. The 02/06/2026 comprehensive assessment showed the resident had a severely impaired cognition and had active diagnosis of a cognitive communication deficit (a condition where cognitive impairments disrupt an individual's ability to communicate effectively, despite intact language and speech abilities).Record review of a Licensed Nurse (LN) progress note dated 05/12/2025 at 10:21 AM, showed that Resident 51, .spilled hot coffee on (Resident 51's) right thigh during today's activity . The LN documented that Resident 51 refused an assessment, but the resident pushed up their pant leg and the LN observed a light pink discoloration.Record review of the resident-centered care plan, last revised 02/23/2026, showed Resident 51 did not have an individualized care plan that identified/assessed the residents risks for hazards or accidents regarding the spilling of hot beverages nor specific interventions or assistive devices that might be utilized to mitigate risk for an avoidable accident/injury from the spilling of hot beverage on themselves.During a concurrent observation and interview on 04/16/2026 at 11:06 AM, showed activities staff finishing tea and coffee time with the residents in the dining room along with Resident 51. Staff T, Medication Assistant Certified/Nursing Assistant, stated they knew all the residents and had been working with Resident 51 for many years. Staff T stated the resident did like to have coffee during activities. Staff T stated Resident 51 was confused at times, with short term memory loss and would have behaviors of expressed frustration when confused or if Resident 51 did not understand what another resident was saying. Staff T stated that due to Resident 51 and other residents with impaired cogitation and behaviors, many of the residents within the C-hall dining area were at a higher risk for spilling their hot beverages. Staff T stated they were not aware of Resident 51 ever spilling their hot beverage on themselves. Staff T stated, we have had accidents with spilling of hot liquids but nothing that has caused injury.During an interview on 04/16/2026 at 11:31 PM, Staff B stated they had not been informed of an incident where Resident 51 had spilled hot coffee on themselves. Staff B stated they had not completed an investigation into the accident. When surveyor inquired on identifying the resident risk/hazards of spilling hot beverages, Staff B stated, I do not think (Resident 51) is a risk if (the resident) only spilled the hot coffee that one time. Staff B stated that no care plan intervention or changes were completed regarding the Resident 51's spilling of hot coffee on themselves.During an interview on 04/16/2026 at 11:45 AM, Staff U, Regional Clinical Resource Nurse Manager, stated they were unaware of Resident 51's accident regarding spilling hot coffee on themselves. Staff U stated that residents should have been identified/assessed on the risk/hazards regarding the spilling of hot beverages and that none of the facility residents had a resident-centered care plan implemented to reduce the risk/hazards towards the spilling of hot beverages.Reference: WAC 388-97-1060(3)(g)