STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A263	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Village Nursing Facility	State Highway 902 & Salnave Road Medical Lake, WA 99022

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. 45433 Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 5 residents (Resident 1) reviewed for abuse and/or neglect. The failure to provide incontinence care to a resident who was identified to be incontinent of bladder and required staff assistance for toileting, as well as the failure to provide an adequate morning meal resulted in emotional distress and a diminished quality of life. Findings included . Record review showed Resident 1 had been a long-term resident at the facility and on 03/20/2024 had moved to the nursing facility in response to increased medical and physical needs. Resident 1's diagnoses included moderate intellectual disability (a generalized neurodevelopmental disorder characterized by significant impairment in intellectual and adaptive functioning diagnosed in childhood), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and unstable mood) and bipolar disorder with severe manic episodes and psychotic symptoms (a mental disorder characterized by severe mood swings, hallucinations, delusions, periods of extreme activity and extreme depression). Review of Resident 1's care plan, dated 03/20/2024, showed that Resident 1 was dependent on staff for toileting and setup for meals. Record review of Resident 1's June medication administration record showed they received a medication from 06/04/2024 through 06/06/2024 called Pyridium used to treat pain related to a urinary tract infection (infection in the bladder). A side effect of this medication is the urine passed by the resident would be bright orange or red. Review of an initial facility incident report, dated 06/08/2024, stated that on 06/07/2024 at 7:00 AM Staff E, Nursing Assistant had gone into Resident 1's room to take their daily vital signs. While they were in the room, they noticed that Resident 1 was awake, asking to get out of bed and incontinent of urine and their incontinence brief was soaked and leaking onto the bed. The incident report went on to say that Staff E told Staff D, Assistant Lead Nursing Assistant of their finding Resident 1 incontinent and that Staff D responded that they would get to them. (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	Per a witness statement, dated 06/08/2024 at 2:55 PM, Staff E stated that they had notified Staff D of Resident 1 being incontinent and in need of care at about 7:15 AM. They then noticed about 8:00 AM that Resident 1 was not out of bed and their breakfast meal was sitting on the counter uneaten. At 10:30 AM they noticed Resident 1 was not out of bed and went to check on them and found them soaked in a stained bed. They then wrote that Staff D came in and took over care of resident 1 and threw out their breakfast and gave them a portion of fruit as their breakfast. Per a witness statement, dated 06/13/2024, Staff F, Nursing Assistant stated that at 7:10 AM they were helping to prepare breakfast for the residents and could hear Resident 1 talking in bed and that they were awake and ready to get up. At 9:00 AM Staff D told Staff F they were leaving the building for a break. At about 10:15 AM Staff E asked if they could help get Resident 1 out of bed. At 10:20 AM Staff D returned from their break and took over care of Resident 1. At 10:35 AM Resident 1 was seated at the dining table and Staff D had grabbed a replacement meal but then did not make it and gave Resident 1 some strawberries for breakfast. They stated that Resident 1 appeared very sad and emotional. Per a witness statement, dated 06/13/2024, Staff G, Nursing Assistant wrote that Staff E had asked them to assist to get Resident 1 out of bed at about 10:30 AM. Upon entering Resident 1's room they repeatedly asked to get up and had soaked through their incontinence brief. Staff D then entered the room and told them to leave and Staff D and E assisted to get Resident 1 out of bed. Per a witness statement, dated 06/11/2024, Staff C, Registered Nurse Case Manager, wrote that they saw resident 1 at about 11:30 AM on 06/07/2024, and that they were upset and crying. They then spoke with Staff E who told them that Resident 1 had not gotten out of bed until close to 11:00 AM, that they had been soaked with urine at that time and that they had only fruit for breakfast. They then spoke to Staff F who stated that Resident 1 had not been out of bed until about 11:00 AM, had been soaked in urine, that Staff D was aware Resident 1 needed incontinence care, that Staff D had left the building for over an hour, starting at about 9:00 AM, and that Resident 1 only had fruit for breakfast. Per a witness statement dated 06/11/2024, Staff B, Developmental Disability Administrator, stated that they spoke with Staff D and that Resident 1 had not wanted to get out of bed and that Staff D had given Resident 1 a replacement meal when they did get out of bed around 10:30 AM. Staff F was interviewed on 06/20/2024 at 1:27 PM. They stated that at about 10:15 AM Staff E had come and asked if they could get Resident 1 out of bed. Staff F stated they were surprised Resident 1 was still in bed as this was not usual and told Staff E to get them up. Staff E then returned and asked Staff F to come look at Resident 1 and both staff went back to Resident 1's room where they both observed Resident 1 laying on two pink pads (disposable pads meant to catch and hold urine) both soaked in urine, the bed sheet was wet with urine top to bottom and Resident 1's cotton t-shirt was also soaked with urine. They stated that Resident 1 did often have to have bed changes, but this situation was not typical, it was usually just a small area around their incontinence brief. They further stated that Staff G then came to assist Staff E and they left the area. They stated that they witnessed Staff D only give Resident 1 strawberries for breakfast and that no replacement meal was given to the resident and that resident 1 was crying and appeared sad. They further stated that Staff B did come to the building but did not talk to them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E was interviewed on 06/20/2024 at 1:46 PM. They stated that they had gone in to do vitals on Resident 1 at about 7:15 AM on 06/07/2024. They stated that they could smell urine strongly and pulled back the sheet to check and found Resident 1's incontinence brief was soaked, there was urine on the sheet around their brief and the urine was easy to see because it was orange. They stated that the resident was wearing a cotton t-shirt, and it was not wet. They stated that they then told Staff D that Resident 1 was awake, incontinent of urine and ready to get up. Staff D responded that they would get to them. They further stated they went back to that area of the building about 8:30 AM and noticed Resident 1 was not out of bed and thought it was strange as they were always up for breakfast. At about 10:15 AM they heard Resident 1 yelling help me, I'm wet repeatedly, and went and asked Staff F if it was okay to get them out of bed. Staff F told them to go ahead as Staff D had been gone for over an hour and had not returned. Staff E then found Resident 1 in bed soaked with urine from head to foot and the sheet was stained orange. They then asked Staff F to witness the situation and asked Staff G to help get Resident 1 out of bed as Staff F was not able to assist. Staff E and G then started to get resident 1 out of bed when Staff D returned and told them to leave. Staff E then stated they saw Resident 1 at the dining table, and they only had strawberries and were crying. They stated that they were working on the side of the building with the microwave and that no one had heated up a replacement meal for Resident 1. They further stated that they saw Staff B come onto the building and talk to Staff D, but that they did not ask them any questions or talk to them. Staff A, Administrator, was interviewed on 06/20/2024 at 2:40 PM. They stated that Staff B had made them aware of the situation with Resident 1 and they had asked them to go to the building and find out what was happening. Upon their return Staff B told them that Resident 1 had been offered additional food items by Staff D and that they had also been changed several times. At that point they did not feel an abusive act had occurred and nothing more was done that day. They stated that they knew it would have to be investigated further and on 06/10/2024 after more statements from staff had been collected, they realized that the situation should have been looked into more at the time it occurred. They stated that typically the witnesses would be interviewed at the time of the event and not just the alleged perpetrator. Refer to WAC 388-97-0640 (5)(a) and WAC 388-97-0640 (6)(a)(b) for 06/20/2024. Reference (WAC) 388-97-0640(1)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45433 Based on interview and record review, the facility failed to ensure allegations of potential abuse and/or neglect were reported immediately to the State Survey Agency, as required, for 1 of 5 sample residents (Resident 1). This failure placed residents at risk for abuse and/or neglect. Findings included . Record review showed Resident 1 had been a long-term resident at this facility and on 03/20/2024 had moved to the nursing facility portion of the facility in response to increased medical and physical needs. Resident 1's diagnoses included moderate intellectual disability (a generalized neurodevelopmental disorder characterized by significant impairment in intellectual and adaptive functioning diagnosed in childhood), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and unstable mood) and bipolar disorder with severe manic episodes and psychotic symptoms (a mental disorder characterized by severe mood swings, hallucinations, delusions, periods of extreme activity and extreme depression). According to a facility incident report, dated 06/08/2024, about 7:00 AM on 06/07/2024, Resident 1 had been alleged, by three Nursing Assistants (Staff E, F and G), to have been neglected by Staff D, lead Nursing Assistant. Staff E and F told Staff C, Registered Nurse Case Manager about their concerns around 11:30 AM who then told Staff B, Developmental Disability Administrator who went and spoke to Staff D about that same time. According to the facility intake the allegation of neglect was not called in to the State Agency until 06/07/2024 at 5:46 PM, well beyond the two-hour window for reporting allegations of abuse and/or neglect required by State Law. In an interview on 06/20/2024 at 1:46 PM Staff E stated that they felt Resident 1 had been neglected by Staff D and had relayed their concerns to Staff C around lunch time. Staff E further stated that they were not aware that abuse and/or neglect allegations needed to be reported to the State Agency within two hours of discovery. In an interview on 06/20/2024 at 1:27 PM, Staff F stated that they had been told by Staff E about their concerns and had witnessed what they thought was possible neglect of Resident 1. They stated that they thought Staff E was going to report the situation to the State Agency and that they were not aware of the two-hour reporting timeline for abuse and/or neglect. Refer to WAC 388-97-0640(1) and WAC 388-97-0640 (6)(a)(b) for 06/20/2024 Reference: (WAC) 388-97-0640 (5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45433 Based on interview and record review, the facility failed to complete a thorough investigation into allegations of neglect in a timely manner, for 2 of 5 sample residents (Resident 1 and 2). Failure to recognize allegations as possible neglect, failure to protect the residents and failure to immediately investigate allegations, placed residents at risk for diminished quality of life, and continued possible neglect. Findings include . <Resident 1> Record review showed Resident 1 had been a long-term resident at the facility and on 03/20/2024 had moved to the nursing facility portion of the facility in response to increased medical and physical needs. Resident 1's diagnoses included moderate intellectual disability (a generalized neurodevelopmental disorder characterized by significant impairment in intellectual and adaptive functioning diagnosed in childhood), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and unstable mood) and bipolar disorder with severe manic episodes and psychotic symptoms (a mental disorder characterized by severe mood swings, hallucinations, delusions, periods of extreme activity and extreme depression). The resident was largely wheelchair bound and reliant on staff for all their care. <Resident 2> Record review showed Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included Down Syndrome (a genetic disorder associated with growth delays, characteristic facial features and developmental and intellectual disability), Alzheimer's Disease (a type of dementia that affects memory, thinking and behavior) and Spastic Cerebral Palsy (a developmental disorder caused by damage to the brain that affects coordination and movement). The resident was largely wheelchair bound and reliant on staff for all their care. According to a facility incident report, dated 06/08/2024, on 06/07/2024 Staff E, F and G, all Nursing Assistants, had concerns for possible neglect of Resident 1. Staff E then reported their concerns to Staff C, Registered Nurse Case Manager, who then reported the concerns to Staff B, Developmental Disability Administrator. The incident report went on to describe Staff B going to speak to Staff D, Assistant Lead Nursing Assistant and alleged perpetrator. Staff B did not speak to Staff E, F, or G and no further action was taken to protect Resident 1 or investigate the report until 06/10/2024 when Staff H, Lead Nursing Assistant reported the incident again after overhearing unidentified staff members discussing the incident. On 06/10/2024 Staff H described further concern for Resident 2 also possibly having experienced neglect on 06/07/2024 by Staff D. Record review showed that from 06/07/2024 through 06/11/2024 Staff D continued to work with Residents 1 and 2 and no further action was taken to protect those residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/20/2024 at 1:46 PM, Staff E, stated that they were concerned about the care Residents 1 and 2 had not received on 06/07/2024 and that they had reported the concerns on the evening of 06/07/2024 about Resident 1 to the required State Agency. They stated that they also had concerns at the time for Resident 2 but that they did not report those concerns on 06/07/2024.They stated they didn't think anything had been done until 06/11/2024 when they knew that Staff D was no longer working in the building. In an interview on 06/20/2024 at 2:40 PM Staff A, Administrator stated that Staff B had talked to Staff D on 06/07/2024, around 11:30 AM, after concerns had been brought to them and they had made Staff A aware of the concerns. They further stated that it was not typical to only talk to the alleged perpetrator when trying to determine if a report of abuse or neglect could have happened and needed further investigation and protection of the involved residents. They stated that during the heat of the situation they just wanted to make sure Resident 1 was okay but typically in such a situation the other staff should have been questioned and then the facility investigative team would have taken over. Staff A stated that the investigation into the alleged incident did not begin until 06/10/2024, three days after the incident was first reported and that Staff D was not removed from resident care until 06/11/2024. Refer to WAC 388-97-0640 (5)(a) and WAC 388-97-0640(1) for 06/20/2024 Reference: WAC 388-97-0640 (6)(a)(b)