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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A263 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/11/2024 |
| NAME OF PROVIDER OR SUPPLIER Lakeland Village Nursing Facility | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45433</p> <p>Based on interview and record review, the facility failed to ensure allegations of potential abuse were reported immediately to the State Agency as required, for 1 of 3 sampled residents (Resident 1) reviewed for abuse. This failure placed residents at risk for possible abuse. Findings included .</p> <p>Record review showed that on 08/06/2024 at 7:25 AM, Staff B, Attendant Counselor Manager, received an email from Staff C, Certified Nursing Assistant, that they had overheard Staff D yell at Resident 1 on 08/05/2024 at about 4:30 AM.</p> <p>Further record review found that the facility did not report the incident to the required State Survey Agency until 08/06/2024 at 12:13 PM.</p> <p>In an interview at 12:28 PM on 09/11/2024, Staff A, Director of Nursing, stated that the time frame for reporting abuse allegations to the required State agency is two hours and in this instance, there was a delay in reporting the possible abuse.</p> <p>Reference: (WAC) 388-97-0640 (5)(a)</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>45433</p> <p>Based on interview and record review, the facility failed to protect, assess and monitor 1 of 3 sampled residents (Resident 1) after an allegation of verbal abuse. Failure to immediately protect the resident, failure to immediately assess the resident and failure to start monitoring for any potential harm related to the abuse allegation, placed residents at risk for diminished quality of life, and continued possible abuse. Findings included .</p> <p>Record review showed Resident 1 had a diagnosis of Rapid Cycle Type 2 Bipolar Disorder (frequent changes in mood from very active to almost no activity with marked impairment in social and occupational functioning) and Moderate Intellectual Disability (a condition that affects learning, behavior and adaptive skills).</p> <p>According to a facility incident report, dated 08/06/2024 at 12:13 PM, on night shift (started on 08/04/2024 into 08/05/2024) of 08/05/2024 at about 4:30 AM Staff C, Nursing Assistant, overheard Staff D, Licensed Practical Nurse, yell at Resident 1 to wake up and take their medication after which the resident appeared to be upset. On 08/05/2024 at 7:00 AM Staff C wrote an email to their direct supervisor, Staff B, Attendant Counselor Manager, saying they were concerned that Staff D had yelled at Resident 1 and that the resident appeared agitated after the interaction.</p> <p>Record review showed that Staff D continued to work with Resident 1 on the night of 08/05/2024 into 08/06/2024 and no further action was taken to protect that resident. Further record review showed that Resident 1 was assessed for psychological harm related to this incident on 08/06/2024 at 8:45 AM, had a nursing assessment to look for any physical injury on 08/06/2024 at 10:00 AM during which a care plan update was completed to monitor for any latent injuries (an injury that may appear after the event).</p> <p>In an interview on 09/11/2024 at 12:28 PM Staff A, Director of Nursing, stated that after the allegation of abuse on 08/05/2024 there was a delay in protecting, assessing and monitoring Resident 1.</p> <p>Reference: WAC 388-97-0640 (6)(a)(b)</p> |