

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 01/23/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728</p> <p>Based on interview and record review the facility failed to meet professional standards of practice in provision of providing timely incontinence care for 2 of 3 sampled residents (Resident 1 and 2). This failure placed residents' requiring incontinence care at risk for potential skin injury and decreased quality of life.</p> <p>Findings included:</p> <p><Resident 1></p> <p>Per the assessment dated [DATE], Resident 1 had severe cognitive impairment, was dependent on staff for most activities of daily living such as personal hygiene, toileting, and transferring, was incontinent of bowel and bladder, was at risk of skin injury, and had diagnoses including moderate intellectual disability, hypersomnia (excessive sleepiness) with long sleep times, and ataxia (a condition which causes poor muscle control).</p> <p>The care plan dated 11/22/2024 documented staff was to offer Resident 1 the toilet upon awakening, before & after meals, before bedtime, & prn (as needed), and that Resident 1 used bedside commode for toileting.</p> <p>A skin assessment for resident 1 dated 01-12-2025 showed no documentation of any injury to the skin of the buttocks or perineum (area of skin between the genitals and the anus).</p> <p>A nursing progress note dated 01/14/2025 documented Resident 1 had pink, excoriated skin on their buttocks, and an acute plan of care was initiated.</p> <p>A physician progress note dated 01/15/2025 documented the skin of resident 1's buttocks was red and inflamed.</p> <p>In an interview on 01/15/2025 at 3:31pm Staff H, Attendant Counselor 1 (AC1) stated on 01/13/2025 at approximately 6:30pm Resident 1 complained their buttocks was hurting, and when staff checked, Resident 1's buttocks was red and bleeding.</p> <p>(continued on next page)</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/15/2025 at 4:01pm, Staff D, Attendant Counselor Manager (ACM) stated on 01/13/2025 at approximately 1:20pm they were informed Staff G, AC1 had been floated to a different work site and that the residents Staff G had been caring for, including Resident 1, were wet with urine that had soaked through their clothing.</p> <p>During an interview on 01/16/2025 at 2:07 pm Staff E, AC1 stated they found Resident 1 in urine-soaked clothes and chair pad on 01/13/2025 at 1:00pm when they took over resident care from Staff G, AC1. They stated upon removing Resident 1's wet clothing and brief, the skin on Resident 1's buttock was red and bleeding. When asked how often the residents were checked and changed, Staff E stated it was supposed to be every 2 hours.</p> <p>In an interview on 01/21/2025 at 2:41pm Staff G, AC1 stated they were working with Resident 1 on 01/13/2025 and at approximately 11:00am noticed the resident was wet from urine but did not change them at that time. Staff G stated they were sent to a different work site at 12:00pm that same day and when they left, Resident 1 was still wet and had not been changed. They stated the lead attendant counselor, Staff I Attendant Counselor 2 (AC2) was also aware Resident 1 was wet. When asked if Resident 1 should have been changed, Staff G stated they knew the resident should have been changed and that it was unacceptable to leave a resident wet.</p> <p>During an interview on 01/16/2025 at 1:46pm when asked how often residents are checked and changed, Staff D stated, at least every two hours. When asked if Resident 1 had skin injury on their buttocks prior to being left in a wet brief and clothing on 01/13/2025, Staff D stated the redness was new and was the result of being left wet.</p> <p><Resident 2></p> <p>Per the assessment dated [DATE], Resident 2 had severe cognitive impairment, was dependent on staff for activities of daily living including personal hygiene, toileting, and transferring, was incontinent of bowel and bladder, was at risk of skin injury, and had diagnoses including profound intellectual disabilities, quadriplegia (a type of paralysis that affects all a person's limbs and body from the neck down), and moisture associated skin damage.</p> <p>The care plan dated 11/12/2024 for Resident 2 documented they had no concept of the need to use the restroom and were unable to communicate when they had been incontinent. Staff were to check for incontinence frequently and were to provide all peri-care (cleaning of the private parts area) to reduce risk of skin breakdown.</p> <p>A nursing progress note dated 01/13/2025 documented, Resident 2 had a moisture associated rash, pink in color, with no open areas to bilateral groin, peri area (area of skin between the genitals and the anus), and buttocks. An acute plan of care was initiated to monitor rash.</p> <p>A nursing progress note dated 01/14/2025 documented, Resident 2 continued to have redness to bilateral groin and a pink area on the right buttock.</p> <p>During an interview on 01/15/2025 at 4:01pm, Staff D stated on 01/13/2025 at approximately 1:20pm they were informed Staff G had been floated to a different work site and that the residents Staff G had been caring for, including Resident 2, were wet with urine that had soaked through their clothing and wheelchair pads.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/16/2025 at 2:07pm Staff E stated they arrived at work at 1:00pm on 01/13/2025 and took over the residents that Staff G, AC1 had been caring for that day. Staff E stated shortly after starting their shift they went to check on Resident 2 and found them in urine-soaked clothing and the wheelchair pad also soaked with urine. When asked how often the residents get checked and changed, Staff E stated it was supposed to be every two hours.</p> <p>In an interview on 01/21/2024 at 2:41pm, Staff G stated on day shift, checking and changing residents was supposed to be performed upon the employee's arrival in the morning, after breakfast, after lunch, and right before end of shift. Staff G stated they knew Resident 2 was wet after breakfast at approximately 8:35am and did not change them at that time. Staff G stated they were sent to a different work site at 12:00 that same day and when they left, Resident 2 was still wet and had not been changed. They stated the lead attendant counselor, Staff I Attendant Counselor 2 (AC2) was also aware Resident 2 was wet. When asked if Resident 2 should have been changed, Staff G stated they knew the resident should have been changed and that it was unacceptable to leave a resident in a wet incontinent brief.</p> <p>During an interview on 01/16/2025 at 1:46pm when asked how often residents are checked and changed, Staff D stated, at least every two hours.</p> <p>Reference: WAC: 388-97-1060 (1)</p>		