

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 03/14/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728</p> <p>Based on interviews and record review the facility failed to protect 2 of 5 sampled residents (Resident 1, 2) from abuse. These failures resulted in the potential for physical and psychological harm, and decreased quality of life for all residents.</p> <p>Findings included:</p> <p><Resident 1></p> <p>Per record review Resident 1 was cognitively impaired, required assistance for most activities of daily living (ADLs), required one to one direct supervision at all times, and had diagnoses including intellectual disability, and fracture of a finger on the right hand.</p> <p>Per review of a Facility Resident Incident Witness Statement dated 01/15/2025, Staff D, Attendant Counselor (AC) documented they witnessed Staff C, Registered Nurse (RN), on 01/15/2025 at approximately 9:15pm pushing on Resident 1's chest, with their hand, while Resident 1 was lying on their bed, and attempting to put medication into Resident 1's mouth.</p> <p>Per review of the Developmental Disabilities Administration 5-Day Investigation Report an interview was documented on 01/21/2025 at 10:42am with Staff E, AC in which they stated they witnessed on 01/15/2025 at 9:15pm Resident 1 being held down against the bed by Staff C who was attempting to give Resident 1 medication. Staff E stated Resident 1's left arm was pinned against their chest by Staff C's hand, who was leaning over Resident 1. Staff E stated they physically removed Staff C's hand from Resident 1 and that is how Staff E knew Staff C was applying pressure to Resident 1's chest.</p> <p>In review of a nursing assessment dated [DATE], Staff F, RN assessed Resident 1 at 10:15pm and documented observation of a red circular mark on Resident 1's upper right chest.</p> <p>Per review of the Developmental Disabilities Administration 5-Day Investigation Report an interview was documented on 01/22/2025 at 3:25pm with Staff F, RN and they stated the red mark they observed on Resident 1's right upper chest on 01/15/2025 was consistent with pressure being applied to that area.</p> <p>Per review of Resident 1's record, photographic documentation dated 01/16/2025 at 12:44am showed a red area on Resident 1's right upper chest.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per review of the Developmental Disabilities Administration 5-Day Investigation Report an interview was documented on 01/21/2025 at 2:41pm with Staff D who was shown the photograph of Resident 1's chest and confirmed the red mark on Resident 1's chest coincided with where Staff C was holding down Resident 1.</p> <p>Per review of the Developmental Disabilities Administration 5-Day Investigation Report an interview was documented on 01/21/2025 at 10:42am with Staff E who was shown the photograph of Resident 1's chest and confirmed the red mark on Resident 1's chest coincided with where Staff C was holding down Resident 1.</p> <p>In an interview on 2/7/2025 at 12:04pm, Staff C, RN stated Resident 1 was lying on their bed. Staff C stated they were leaning over Resident 1 attempting to give Resident 1 their medication while holding Resident 1's left hand. Staff C denied leaning on Resident 1 or exerting any pressure on Resident 1's body.</p> <p>On 2/19/2025 at 2:00pm attempted to interview Resident 1 but they did not respond.</p> <p>In an interview on 03/11/2025 at 3:58pm Staff B, Attendant counselor manager (ACM) stated she the red area on Resident 1's right upper chest was still present when she looked on 01/16/2025, the day following the alleged abuse.</p> <p><Resident 2></p> <p>According to the 11/25/2024 Assessment, Resident 2, was unable to direct their own care, was dependent on staff for most activities of daily living (ADLs) including moving their wheelchair, and had diagnoses which included, profound intellectual disabilities, cerebral palsy (a brain disorder that permanently affects body movement and muscle coordination), and depression.</p> <p>Per review of RHC Incident Report dated 01/16/2025, Staff J documented they had clocked out for lunch and went into the kitchen in the resident cottage to use the microwave and happened to look down the hall and saw Resident 3 hitting Resident 2 toward their face.</p> <p>Per review of the developmental disability administration 5-day investigation report Staff K stated that on 01/16/2025 at approximately 6:30pm they witnessed Staff J separating Resident 3 and Resident 2. Staff K stated Resident 3 was facing Resident 2 and assaulting Resident 2 with their right hand.</p> <p>Per review of a nursing assessment of Resident 2, Staff K documented on 1/16/2025 at 6:30pm they observed Resident being hit by another resident which resulted in a reddened area and scratches at the base of the left side of Resident 2's neck.</p> <p>In an interview on 03/13/2025 at 2:36:18 PM, Staff I, Attendant Counselor Manager (ACM), stated the expectation for staffing in the cottage where Resident 2 and 3 lived was always at least one staff member on each side of the resident cottage to monitor the residents and keep them within line of sight. This requirement was due to residents, like Resident 3, who needed to be monitored because of their behavior. Staff I stated that the incident would have been avoided if Staff J had not left to take their lunch break without another staff member present to monitor the residents.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 483.12(a)(1)-0640 (1)		