

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  07/07/2025
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>Based on interview and record review, the facility failed to protect the residents' right to be free from neglect for 1 of 3 residents (Resident 2). The failure to provide medical care, as ordered by the facility medical provider, resulted in a possible diminished quality of life.</p> <p>Findings include:</p> <p>Record review showed Resident 1 was admitted to the facility in August of 2023 with diagnoses of Moderate Intellectual Disability (characterized by an average mental age of 6 to 9 years old, with adaptive, social and cognitive skills at that level) and dementia (a loss of thinking, remembering and reasoning skills).</p> <p>Review of Resident 2's medical record showed that on 06/02/2025 at 1:34 PM Staff H, Registered Nurse, notified the facility physician, Staff F, that Resident 2's right great toe was discolored and tender to touch. Staff C then wrote in a progress note that they had received a verbal order from Staff F to start Epsom salt soaks for 15 minutes, two times per day, for three days.</p> <p>Further review of Resident 2's medical record showed that on 06/04/2025 at 11:20 AM Staff F, assessed Resident 2's right great toe, continued the foot soaks for another three days, added an antibiotic for treatment of right great toe that was diffusely erythematous (red -indicating possible infection), open drainage from prior wound, serous (clear) fluid.</p> <p>Review of Resident 2's medication administration record showed a treatment order started on 06/04/2025, to begin at 4:00PM the same day, for two times daily for three days beginning 06/04/2025 soak right foot in warm water bath with Epsom salt x 15 min[utes] twice a day: try to gently express any drainage.</p> <p>Review of a facility incident report, dated 06/05/2025, stated that on the evening shift of 06/05/2025, Staff I, Registered Nurse, was told by Staff K, Nursing Assistant, that Staff J, Licensed Practical Nurse was blowing off the foot soak for Resident 2 and that it had not occurred on the evening shift of 06/04/2025.</p> <p>Review of Resident 2's medication administration record showed that the foot soak ordered on 06/04/2025 for 4:00 PM was signed off as completed by Staff J.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 50A263	If continuation sheet Page 1 of 4

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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>Review of the facility investigation into the incident showed a statement from Staff K, on 06/06/2025 at 8:10 PM, stating that they had worked on the evening shift of 06/04/2025 and that Resident 2 had remained near the kitchen to watch them prepare dinner, ate dinner and afterwards they went to the living room area of the building to watch television and that the foot soak had not occurred during that period of time.</p> <p>Review of the facility investigation into the incident showed a statement from Staff L, Nursing Assistant, on 06/06/2025 at 8:25 PM, stating that they had worked on the evening shift of 06/04/2025, had been in the living room area of the building after dinner with another 1:1 resident (staff remains within arm's length distance of a resident for safety), who was watching television, where Resident 2 was also present watching television, and that the foot soak had not occurred.</p> <p>Review of the facility investigation into the incident showed a statement from Staff M, Nursing Assistant on 06/09/2025 at 3:11 PM, stating that they had been assigned to work with Resident 2 on the evening shift of 06/04/2025, had been aware that Resident 2's foot soak had not occurred prior to Resident 2's preferred bedtime. They further stated that Staff J had stopped by Resident 2's bedroom, as they were preparing for bed, and had stated that the foot soak had been completed earlier in the shift, but they needed to change the bandage on Resident 2's right great toe. Staff M stated they thought it was strange that Staff J would need to change the bandage, that appeared used and dry, when the foot soak had occurred earlier in the evening.</p> <p>Review of Resident 2's medical record showed a progress note written by Staff G, Advanced Practice Nurse Practitioner, on 06/05/2025 at 3:57 PM, which stated that they had seen Resident 2's right great toe on the morning of 06/05/2025 and that upon removal of the bandage, purulent (thick, yellow/green - a sign of infection) drainage was noted.</p> <p>Review of the facility investigation showed a statement from Staff J, Licensed Practical Nurse, on 06/11/2025 at 11:15 AM, who stated that the foot soak for Resident 2 had been completed on 06/04/2025, in the kitchen/dining area of the building prior to dinner and that they didn't think any other staff had seen it occur. They further stated that they had changed Resident 2's foot bandage in the bathroom, not in their bedroom, after dinner on 06/04/2025.</p> <p>Review of the facility investigation summary, dated 06/11/2025, stated that it was more likely than not that the foot soak for Resident 2 had not occurred on the evening shift of 06/04/2025.</p> <p>During an Interview with Staff A, Director of Nursing, on 06/16/2025 at 12:45 PM, they stated that they believed that Staff J had neglected to complete the foot soak for Resident 2, and that Staff J remained reassigned from resident care and that they had extensive training planned for Staff J prior to returning to direct resident care, to include completing treatments as ordered by the medical provider.</p> <p>Reference (WAC) 388-97-0640(1)</p>		

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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>Based on interview and record review, the facility failed to ensure timely reporting of an allegation of neglect for 1 of 1 resident (Resident 1). This failure resulted in potential harm and decreased quality of life for the resident.</p> <p>Findings included:</p> <p>Based on the 04/01/2025 assessment, Resident 1 was cognitively impaired and had diagnoses including moderate intellectual disabilities and schizoaffective disorder. They required maximum assistance for activities of daily living such as transferring in and out of bed and wheelchair, standing, toileting, and personal care.</p> <p>In an interview on 06/04/2025 at 1:00PM, Staff B, Attendant Counselor 1 (AC1) stated they witnessed Resident 1 fall out of bed onto the floor. Staff B could not remember the date of the occurrence. Staff B then called out to Staff C, AC1 to get the nurse. While waiting for the nurse Staff E, Attendant counselor Manager (ACM) entered the room and Staff B informed them that the resident had fallen. Staff E then proceeded to pick up the resident and put them on the bed and told Staff B to not complete an incident report because Resident 1 was able to reposition themself from the bed to the floor and it was in the resident's care plan. Staff B stated they told Staff E multiple times the resident had fallen, and Staff E continued to state an incident report was not to be completed. When asked what the usual procedure was for a resident fall, Staff B stated the resident was not supposed to be moved until the licensed nurse has assessed them and given approval, an incident report was supposed to be completed, and the shift lead and/or manager notified. Staff B stated they did not complete an incident report and/or report their concern about Staff E telling them not to do an incident report. When asked, Staff B stated they should have reported it.</p> <p>In an interview on 06/02/2025 at 2:20PM, Staff C, AC1, was unable to recall the exact date Resident 1 fell and stated they were working with another resident, across the hall from Resident 1's room, and heard a loud bang come from Resident 1's room and when they entered Resident 1's room, the resident was lying on the floor beside the bed and complaining about their head hurting and stated they hit their head on the table. Staff C then went to get the nurse, encountered Staff E and told them Resident 1 had fallen. Staff E then entered Resident 1's room, told Staff B and Staff C that Resident 1 had repositioned themself to the floor intentionally. Staff E then picked up Resident 1 and put them on the bed. Staff C told Staff E that Staff B saw Resident 1 fall and hit their head, Staff E continued to instruct them not to complete an incident report. Staff C stated the procedure when a resident had a fall was to get the nurse and to not move the resident until the nurse said it was ok, get a full set of vital signs (measurements of the body's most basic functions, such as temperature, heart rate, breathing rate, and blood pressure), and complete an incident report. Staff C stated they told the nurse that Resident 1 had fallen but the nurse did not assess the resident because Staff E told them not to. Staff C stated they could not remember who the nurse was at the time of the incident. When asked why they did not report the incident, Staff C stated they did not want Staff E mad at them. Staff C stated they should have reported the incident, they said it was their mistake, and they knew they should have reported it.</p> <p>(continued on next page)</p>

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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>In an interview on 06/03/2025 at 949am, Staff D, ACM stated they were not working the day Resident1 fell but when they returned to work, they could not remember the exact date, Staff B told them Resident 1 had fallen, and Staff B stated they wanted to do an incident report at the time, but Staff E told them not to do it. Staff D stated, in their opinion, an incident report should have been done, and they told Staff B they should talk to Staff E about it. When Staff D was asked if they ever considered talking to Staff E's supervisor they replied, no. When asked if they should have reported it, Staff D replied Yes, they should have and will do it in the future.</p> <p>In an interview on 06/18/2025 at 9:04AM, Staff E stated at the time of Resident 1's alleged fall, could not remember the date, either Staff B or Staff C told them Resident 1 was on the floor. Staff E asked if they had heard a klunk and they replied they had not. Staff E stated they then asked the staff member if the resident had said they had fallen and was told the resident didn't say anything. Staff E then went to Resident 1's room and found the resident on the fall mat on the floor beside the bed and the resident was giggling. Staff E asked Resident 1 if they were hurt and the resident laughed. Staff E stated they then assisted Staff C to put the resident back on the bed then did a visual check of Resident 1 for injuries and found none. Staff E stated that neither Staff C nor Staff B told them they saw Resident 1 fall or voiced an opinion that they thought the resident had fallen. Staff E stated they didn't know if the nurse was notified of Resident'1's alleged fall. When asked, Staff E stated when a resident fell they would stay with the resident, call for a nurse to assess the resident, wouldn't move the resident until nurse says ok, complete an incident report, and follow the incident report process. When asked if the occurrence was reportable, Staff E stated No, they did not believe so.</p> <p>Upon review of the record, no documentation was found by nursing staff or attendant counselors between December 2024 and 04/16/2025 regarding Resident 1 falling and /or hitting their head. No incident reports were completed for Resident 1 experiencing a fall.</p> <p>Reference: 483.12(c)(1)(4) -0640(5)(a)</p>		