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	12/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to consistently implement interventions to prevent a resident from ingesting an exam glove for 1 of 3 residents (Resident 1) reviewed for accidents and supervision. This failure placed residents at risk for medical complications and decreased quality of life. Findings included .Review of Resident 1's care plan, dated as effective 02/04/2022 to present, showed they had diagnoses which included profound intellectual disability and PICA (an abnormal desire to eat substances not normally eaten), with the following detail, [Resident 1] has severe PICA and can be very sly and will obtain items of [their] choice and they often are not digestible. [Resident 1] has a 1:1 staff to ensure that [they] do not ingest anything that [they] shouldn't. The care plan also showed that Resident 1 had severely impaired cognition and required limited assistance with mobility while in their wheelchair.Review of a facility investigation, dated 12/06/2025, showed that Resident 1 had an ileostomy (an opening in the abdomen that bypasses the intestine, allowing waste (stool and gas) to flow into a pouch that is worn externally). On 12/06/2025 at 2:12 PM Staff D, Nursing Assistant, wrote that while emptying the resident's stool pouch they found a glove inside. Further review of the same investigation showed that Resident 1 was found to have an intact nitrile exam glove in their stool pouch.Further review of the facility investigation found an interview on 12/11/2025 at 2:37 PM, with Staff C, Physical Therapy Supervisor, where they reviewed photos of the resident's room showing placement of nitrile exam gloves in a bathroom storage drawer and a small trash can in the resident's room that staff used to dispose of paper towels and used exam gloves. Staff C stated during the interview that Resident 1 had good hand dexterity and will grab items from staff or within [their] vicinity. Staff C further stated that upon review of the photos they felt that Resident 1 could easily independently access the trash can in their room and the drawer in the bathroom with the gloves.On 12/15/2025 at 2:35 PM, Resident 1 was observed in the hallway of the facility near the central nurses' station, self-propelling in their wheelchair, with a seatbelt fastened at their waist. Their 1:1 staff were observed following behind the resident holding a laptop and typing. The resident was not able to answer any questions, but was observed to self propel in their wheelchair using their feet and interact with the staff present, reaching out and pulling on a staff member's arm and touching another staff on their leg with their foot.During an observation of Resident 1's bedroom, on 12/15/2025 at 2:38 PM, a small metal trash can with a foot pedal to open and close the container, was observed within about 4 feet of the resident's recliner with used paper towels inside. An observation of the resident's bathroom found a wooden bedside table with a drawer, that, when easily slid open, had three boxes of nitrile exam gloves inside. The storage table was of a height made for a seated person to access the drawer and was within 3 to 4 feet of the toilet.During an interview on 12/15/2025 at 2:35 PM, Staff D, Nursing Assistant, stated that they had to always be within arm's reach of Resident 1 and that Resident 1 would reach out and try and grab items and could move very quickly. They further stated that Resident 1 could unbuckle their wheelchair seatbelt and reposition themselves to the floor very quickly. The resident was described as moving fast, especially if there was an item they wanted. Staff D stated they were to never leave the resident's side, and the resident was to be within their constant eyesight. Staff D further stated that on 12/06/2025 they had found an intact blue exam glove in the resident's stool pouch when they emptied it, and that the resident must have, at some point, eaten it.During an interview on 12/15/2025 at 11:34 AM, Staff B, Director of Nursing, stated that changes had not been made to the drawer with gloves in it in the resident bathroom or to the small trash can in the resident room. They further stated that the facility investigation was unable to determine how or when, beyond a general time frame, the resident had ingested the exam glove.During an interview on 12/15/2025 at 2:50 PM, Staff A, Administrator, stated that the facility was aware of the failure as the resident had ingested an exam glove and they had made and were in the process of making changes to prevent the same thing from reoccurring. Reference: (WAC) 388-97-1060 (3)(g)