

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Kirkland		STREET ADDRESS, CITY, STATE, ZIP CODE 10101 Northeast 120th Street Kirkland, WA 98034	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47130</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services in a manner that maintained and promoted residents' dignity related to use of urinary catheter (a flexible tube inserted into the bladder, which drains urine into a collection/drainage bag outside the body) for 3 of 4 residents (Residents 4, 5 & 6), reviewed for resident rights. This failure placed the residents at risk for embarrassment, decreased self-worth, and a diminished quality of life.</p> <p>Findings included .</p> <p>RESIDENT 4</p> <p>Resident 4 admitted to the facility on [DATE].</p> <p>Review of Resident 4's physician's order with a start date of 04/08/2024, showed catheter care every shift.</p> <p>Observation on 04/23/2024 at 12:40 PM, showed Resident 4's urinary catheter drainage bag had amber colored urine, and it was visible from the hallway. Further observation showed Resident 4's urinary catheter drainage bag was not covered with a privacy bag.</p> <p>During a joint observation and interview on 04/23/2024 at 12:42 PM with Staff C, Registered Nurse, showed Resident 4's drainage bag did not have a privacy bag. Staff C stated that the drainage bag should be covered.</p> <p>RESIDENT 5</p> <p>Resident 5 admitted to the facility on [DATE].</p> <p>Review of Resident 5's physician's order with a start date of 04/09/2024, showed catheter care every shift.</p> <p>Observation on 04/23/2024 at 12:55 PM, showed Resident 5's urinary catheter drainage bag had amber colored urine, and it was visible from Resident 5's roommate and their visitor. Further observation showed the urinary drainage bag was visible upon entering Resident 5's room, and it had no privacy bag covering the drainage bag.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Joint observation and interview on 04/23/2024 at 12:58 PM with Staff D, Licensed Practical Nurse, showed Resident 5's drainage bag did not have a privacy bag. Staff D stated that Resident 5's catheter drainage bag does not need to be covered.</p> <p>RESIDENT 6</p> <p>Resident 6 admitted to the facility on [DATE].</p> <p>Review of Resident 6's physician's order with a start date of 03/13/2024, showed catheter care every shift.</p> <p>Observation and interview on 04/23/2024 at 1:37 PM, showed Resident 6's urinary catheter drainage bag had amber colored urine. Further observation showed Resident 6's catheter bag was visible from the hallway and it was not covered with a privacy bag. Resident 6 stated that their catheter bag was not covered when they were out of their room on a wheelchair.</p> <p>On 04/23/2024 at 2:00 PM, Staff G, Unit Care Coordinator, stated that catheter drainage bags should be covered for dignity.</p> <p>On 04/23/2024 at 3:15 PM, Staff B, Director of Nursing, stated they expected catheter drainage bags to be covered with a privacy bag.</p> <p>Reference: (WAC) 388-97-0180 (1)(2)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298</p> <p>Based on observation, interview, and record review, the facility failed to ensure allegation of abuse was reported to the State Agency and/or law enforcement for 1 of 3 residents (Resident 1), reviewed for abuse allegations. This failure placed the resident at risk for potential unidentified abuse and lack of protection from abuse.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse-Reporting and Response-No Crime Suspected, revised on 10/13/2023, showed, The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within the prescribed timeframes. Further review of the policy showed, The facility will ensure that all staff are aware of reporting requirements and to support an environment in which staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Staff will be made aware of their rights to report without fear of retaliation.</p> <p>Resident 1 admitted to the facility on [DATE].</p> <p>Review of Resident 1's admission Minimum Data Set (MDS - an assessment tool) dated 03/25/2024, showed Resident 1 was usually understood with moderately impaired cognition.</p> <p>Review of Resident 1's nursing progress notes dated 04/06/2024, showed discovered a skin tear [traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, poor handling, equipment injury or removal of adherent dressings] on their right forearm with a measurement of approximately 8 [eight, 8.0] cm (centimeter-a unit of measurement) in length and 6 [six, 6.0] cm in width.</p> <p>Review of Resident 1's investigative report dated 04/10/2024, showed no documentation that it was reported to the State Agency or Law enforcement.</p> <p>During an interview and observation on 04/18/2024 at 9:35 AM, Resident 1 stated that a guy grabbed my arm, it hurt. He's a big man and he squeezed my arm. I've never had someone squeeze me like that in my life. Observation showed Resident 1 demonstrated to the surveyor how their right arm was grabbed by the big guy.</p> <p>During an interview on 04/18/2024 at 11:13 AM with Resident 1's Representative (RR1), stated that they sent an email first to the DNS [Director of Nursing Services] to request a copy of the incident report dated 04/08/2024, and a follow-up call on 04/09/2024 with no response. RR1 stated that when they came to visit, Resident 1 had a bandage to their right forearm and that Resident 1 told them about a large man twisted their arm. RR1 stated that they mentioned Resident 1's statement to Staff B, DNS.</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>During an interview on 04/23/2024 at 9:56 AM with Staff C, Registered Nurse (RN), stated that they received a report from Staff H, RN, about Resident 1's right forearm skin tear and that Resident 1 mentioned to Staff H that a big guy grabbed their arm and would not let go causing a skin tear. Staff C stated that Staff I, Certified Nurse Assistant, was assigned to Resident 1 that night [on 04/05/2024] and Staff I fits the physical description of a big guy. Staff C further stated that they informed Staff B about the report they received from Staff H and that Staff B responded, I will take care of it and will investigate it.</p> <p>On 04/23/2024 at 3:38 PM, Staff B stated they received a report from Staff H regarding Resident 1's skin tear incident and that Staff H implied that it was the staff member that did it in a harmful way. Staff B stated that they did not consider the incident as an alleged violation or abuse because of the location of the wound. Staff B further stated that they did not report the abuse allegation/incident to the State.</p> <p>On 04/24/2024 at 11:13 AM, Staff A, Administrator, stated that the incident should have been reported to appropriate agencies.</p> <p>Reference: (WAC) 388-97-0640 (5)(a)</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298</p> <p>Based on observation, interview, and record review, the facility failed to ensure allegation of abuse was thoroughly investigated for 1 of 3 residents (Resident 1), reviewed for abuse investigations. This failure placed the resident at risk for repeated incidents, unidentified abuse, and a diminished quality of life.</p> <p>Findings included .</p> <p>According to the Washington State Reporting Guidelines for Nursing Homes (The Purple Book), dated October 2015, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated.</p> <p>Review of the facility's policy titled, Abuse-Reporting and Response-No Crime Suspected, revised on 10/13/2023, showed An individual who reports an alleged violation to the facility staff does not have to explicitly characterize the situation as abuse, neglect, mistreatment, or exploitation in order to trigger the facility to investigate. Rather, if the facility staff could reasonably conclude that the potential exists related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be reportable and require action.</p> <p>Resident 1 admitted to the facility on [DATE].</p> <p>Review of Resident 1's admission Minimum Data Set (MDS - an assessment tool) dated 03/25/2024, showed Resident 1 was usually understood with moderately impaired cognition.</p> <p>Review of the April 2024 incident reporting log documented that Resident 1 had a type of injury as surface layers of skin [skin tear - traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, poor handling, equipment injury or removal of adherent dressings].</p> <p>Review of Resident 1's nursing progress notes dated 04/06/2024, showed discovered a skin tear [traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, poor handling, equipment injury or removal of adherent dressings] on their right forearm with a measurement of approximately 8 [eight, 8.0] cm (centimeter-a unit of measurement) in length and 6 [six, 6.0] cm in width.</p> <p>Review of Resident 1's investigative report dated 04/10/2024, showed the facility's conclusion was unable to substantiate abuse and neglect per the investigation findings. It's likely that the skin tear occurred during transfer from wheelchair to bed. Staff have been educated on proper transfers when a dementia [memory loss] resident is exhibiting behaviors. Further review of the investigative report showed no documentation that Staff C, Registered Nurse (RN), Staff H, RN, Resident 1's Representative (RR1) were interviewed regarding the alleged incident. In addition, no documentation that staff training was conducted.</p> <p>(continued on next page)</p>

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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>During an interview and observation on 04/18/2024 at 9:35 AM, Resident 1 stated that a guy grabbed my arm, it hurt. He's a big man and he squeezed my arm. I've never had someone squeeze me like that in my life. Observation showed Resident 1 demonstrated to the surveyor how their right arm [with foam dressing] was grabbed by the big guy.</p> <p>During an interview on 04/18/2024 at 11:13 AM with RR1, stated that they sent an email first to the DNS [Director of Nursing Services] to request a copy of the incident report dated 04/08/2024, and a follow-up call on 04/09/2024 with no response. RR1 stated that when they came to visit [on Wednesday 04/10/2024], Resident 1 had a bandage to their right forearm and that Resident 1 told them about a large man twisted their arm. RR1 stated that they mentioned Resident 1's statement to Staff B, DNS.</p> <p>During an interview on 04/23/2024 at 9:56 AM with Staff C, stated that they received a report from Staff H about Resident 1's right forearm skin tear and that Resident 1 mentioned to Staff H that a big guy grabbed their arm and would not let go causing a skin tear. Staff C stated that Staff I was assigned to Resident 1 that night [on 04/05/2024] and Staff I fits the physical description of a big guy. Staff C further stated that they informed Staff B about the report they received from Staff H and that Staff B responded, I will take care of it and will investigate it.</p> <p>On 04/23/2024 at 3:38 PM, Staff B stated they received a report from Staff H regarding Resident 1's skin tear incident and that Staff H implied that it was the staff member that did it in a harmful way. Staff B stated that they did not consider the incident as an alleged violation or abuse because of the location of the wound. Staff B stated that they did not report the abuse allegation to the State and did not conduct a thorough investigation. When asked if Staff C and Staff H reported to them about Resident 1's allegation that a big guy grabbed their arm, Staff B stated that Staff C and Staff H did not mention about a big guy grabbing Resident 1's arm. When asked about staff training for proper transfer as indicated on the investigative report, Staff B stated that they did not do staff education on proper transfer and that there was no documentation for it.</p> <p>On 04/24/2024 at 11:13 AM, Staff A, Administrator, stated that the incident should have been reported to the state and investigated by the facility.</p> <p>Reference: (WAC) 388-97-0640 (6)a</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>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** 47130</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received skin care and treatments in accordance with professional standards of practice for 3 of 4 residents (Residents 1, 2 & 3), reviewed for skin conditions. This failure placed the residents at risk for not receiving the necessary skin care treatment, unmet care needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Documentation & Assessment of Wounds, reviewed on 03/31/2023, showed that the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>RESIDENT 1</p> <p>Resident 1 admitted to the facility on [DATE].</p> <p>Review of Resident 1's skin assessment dated [DATE], showed right forearm skin tear [traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, poor handling, equipment injury or removal of adherent dressings] covered with dressing CDI (Clean, Dry, Intact).</p> <p>Review of Resident 1's nursing progress notes dated 04/06/2024, showed discovered a skin tear on their right forearm with a measurement of approximately 8 [eight, 8.0] cm (centimeter-a unit of measurement) in length and 6 [six, 6.0] cm in width.</p> <p>Review of the physician's order printed on 04/18/2024 did not show treatment for the right forearm skin tear.</p> <p>Observation and interview on 04/23/2024 at 9:56 AM, showed Resident 1 had a pink foam dressing on their right forearm. Resident 1 stated that their dressing was just changed by a girl [unknown licensed nurse]. Resident 1 further stated, It doesn't hurt anymore when touching their right forearm dressing.</p> <p>During a joint record review and interview on 04/24/2024 at 2:08 PM with Staff E, Unit Care Coordinator, showed a skin tear on Resident 1's right forearm that was documented in the skin assessment dated [DATE]. Review of the April 2024 physician's order showed no treatment order written for the right forearm skin tear. Staff E stated that Resident 1's right forearm skin tear should have had measurements on the skin assessment and have had physician's treatment orders.</p> <p>48298</p> <p>RESIDENT 2</p> <p>Resident 2 admitted to the facility on [DATE].</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>Review of a skin assessment dated [DATE], showed Resident 2 had a skin tear on their right knee, cleansed with NS [Normal Saline - wound irrigation solution], apply skin prep [liquid film-forming dressing that served as a protective barrier] and dressing [on it].</p> <p>Review of the physician's order printed on 04/24/2024 did not show Resident 2 had a treatment order for the right knee skin tear.</p> <p>During a joint record review and interview on 04/24/2024 at 2:08 PM with Staff E, showed a skin tear on Resident 2's right knee that was documented in the skin assessment dated [DATE]. Review of the April 2024 physician's order showed no treatment order written for the right skin tear. When asked about the right knee skin tear treatment order, Staff E stated Resident 2's right knee skin tear was resolved but the treatment should have been in place [when the treatment was first initiated].</p> <p>RESIDENT 3</p> <p>Resident 3 admitted to the facility on [DATE].</p> <p>Review of Resident 3's skin assessment dated [DATE], showed a skin tear on left buttock, dressing was applied.</p> <p>Review of the physician's order printed on 04/24/2024 did not show a physician order treatment for Resident 3's left buttock skin tear.</p> <p>During a joint observation and interview on 04/24/2024 at 3:23 PM with Staff F, Registered Nurse, showed Resident 3 had a dressing on their right buttock dated 4/20/24 [04/20/2024]. Staff F removed Resident 3's right buttock dressing, the right buttock had intact skin. Further observation showed Resident 3's skin tear on the left buttock was not covered with a dressing. Staff F stated that the dressing should have been placed on the left buttock and not on the right buttock. Staff F further stated that there was no physician order written for the left buttock skin tear.</p> <p>During a joint record review and interview on 04/24/2024 at 2:08 PM with Staff E, showed a skin tear on Resident 3's left buttock was documented in the skin assessment dated [DATE]. Review of the April 2024 physician's order showed no treatment order written for Resident 3's left buttock skin tear. Staff E stated that there should have been a written physician's order for it.</p> <p>On 04/24/2024 at 3:48 PM, Staff B, Director of Nursing (DNS), stated that when a resident was found to have new skin issues, staff were expected to notify the provider, the DNS, and the resident's representative, complete a thorough skin assessment, which includes the location, measurements, as well as to obtain treatment orders. Staff B further stated that there should have been daily treatment order for Resident 1's right forearm skin tear, Resident 2's right knee skin tear, and an order treatment for Resident 3's skin tear to their left buttock.</p> <p>Reference: WAC 388-97-1060 (3)(b)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47130</p> <p>Based on observation, interview, and record review, the facility failed to ensure urinary catheters (a flexible tube inserted into the bladder, which drains urine into a collection/drainage bag outside the body) were positioned off the floor for 2 of 4 residents (Resident 1 & 2), reviewed for urinary catheter use. This failure placed the residents at risk for urinary tract/bladder infections and related complications.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Indwelling Urinary Catheter (Foley) Management, reviewed on 08/24/2023, showed the general urinary catheter maintenance guidelines were to always keep the collecting bag below the level of the bladder and do not rest the bag on the floor.</p> <p>RESIDENT 4</p> <p>Resident 4 admitted to the facility on [DATE].</p> <p>Review of Resident 4's physician's order with a start date of 04/08/2024, showed urinary catheter care every shift.</p> <p>Observation on 04/23/2024 at 12:40 PM, showed Resident 4 was sitting on the edge of their bed with their urinary drainage bag lying flat on the floor.</p> <p>During a joint observation and interview on 04/23/2024 at 12:42 PM with Staff C, Registered Nurse, showed Resident 4's catheter bag was lying flat on the floor. Staff C stated that Resident 4's drainage bag should be hooked on the bed frame and off the floor.</p> <p>RESIDENT 5</p> <p>Resident 5 admitted to the facility on [DATE].</p> <p>Review of Resident 5's physician's order with a start date of 04/09/2024, showed urinary catheter care every shift.</p> <p>Observation on 04/23/2024 at 12:55 PM, showed Resident 5 was in bed with their drainage bag lying flat on the floor.</p> <p>A joint observation and interview on 04/23/2024 at 12:58 PM with Staff D, Licensed Practical Nurse, showed Resident 5's urinary drainage bag was lying flat on the floor. Staff D stated that Resident 5's drainage bag should be off the floor.</p> <p>On 04/23/2024 at 2:00 PM, Staff G, Unit Care Coordinator, stated that urinary catheter drainage bag should be hooked on the resident's bed frame and off the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/23/2024 at 3:20 PM, Staff B, Director of Nursing Services, stated that urinary catheter drainage bags should be off the floor.</p> <p>Reference: (WAC) 388-97-1060 (3)(c)</p>		