

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  11/07/2024
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619</b></p> <p>Based on interview and record review, the facility failed to ensure timely reporting of an allegation of neglect to the State Agency for 1 of 3 resident (Resident 1), reviewed for abuse/neglect reporting. This failure placed the resident at risk for potential unidentified and ongoing abuse/neglect and lack of protection from abuse/neglect.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse- Reporting and Response- No Crime Suspected, reviewed on 06/17/2024, showed an individual (e.g., a resident, visitor, facility associate) who reports an alleged violation to facility staff does not have to explicitly characterize the situation as abuse or neglect to trigger the facility to investigate. The policy further showed alleged violations of neglect that do not result in serious bodily injury, must be reported by the facility no later than 24 hours.</p> <p>Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 10/15/2024, showed Resident 1 admitted to the facility on [DATE] with intact cognition.</p> <p>Review of the facility's October 2024 Reporting Log showed an allegation of neglect was logged on 10/20/2024, with a date and time of incident on 10/15/2024 at 1616 (4:16 PM).</p> <p>Review of Resident 1's investigation showed that on 10/12/2024 during day shift, the facility staff including the resident's nurse were notified of an allegation that the resident was not changed for a long period of time. The investigation further showed that Resident 1 stated that staff came in at 8:30 AM to change them, and did not come back until 2:30 PM, and that they felt neglected when the incident had occurred.</p> <p>On 10/23/204 at 1:30 PM, Resident 1 stated that they could not remember how it got that bad, and that nobody came in their room. Resident 1 stated that CC1 came in to see how they were doing and found them that way. Resident 1 stated that they were not used to wearing briefs. Resident 1 stated that it was dripping on the floor when [CC1] came in. Resident 1 further stated that they typically use their call light but sometimes the staff forget to give them the call button.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/2024 at 3:46 PM, Collateral Contact (CC1), stated that they came into the facility on [DATE] to visit Resident 1 around 2:30 PM, and that Resident 1 was found crying, and stated that Resident 1 stated they were scared and that they had gone to the bathroom and had not been changed since around 8:30 AM that day. CC1 stated that there was urine and feces everywhere. CC1 further stated that they reported this immediately to Staff C, Registered Nurse (RN) and questioned why the resident had not been changed. CC1 stated that two shower aides came in to help the resident get cleaned up and get into the shower, and that another staff member assisted with wiping down Resident 1's soiled mattress.</p> <p>On 10/30/2024 at 1:15 PM, Staff C stated everyone was a mandatory reporter. Staff C stated that an example of neglect was if a resident was left incontinent or not providing the care services that were needed for that resident. Staff C stated that on 10/12/2024, CC1 had approached them and stated that the resident was soiled and had a lot of bowel movement (BM). Staff C further stated that they did not report this because it did not sound like an allegation.</p> <p>On 10/30/2024 at 2:52 PM, Staff D, Certified Nursing Assistant (CNA), stated that on 10/12/2024, in company with another staff member, had gone in to get Resident 1 ready for a shower. Staff D stated that Resident 1 stated that they had not been changed since the morning, and that they were crying and looked visibly upset about the situation. Staff D stated that they reported this to Staff C. Staff D further stated that the mattress had been soaked through in urine, including the resident's brief with BM in it. Staff D further stated that this would be considered an allegation of neglect, and stated that everyone was a mandatory reporter and that they should have probably reported it, but thought it would have been dealt with when they told Staff C.</p> <p>On 11/06/2024 at 12:25 PM, Staff E, CNA, stated that any staff member at the facility was a mandatory reporter. Staff E stated that an allegation of neglect could be when a resident was not changed timely or was left soaked for a long period of time. Staff E stated that allegations of neglect should be reported to the State Agency immediately. Staff E stated that Staff C reported to them that Resident 1 had reported that they had not been changed and were soaked/wet for a long period of time. Staff E further stated that they were not sure if they should call the state.</p> <p>Joint record review of Resident 1's investigation on 11/06/2024 at 4:13 PM with Staff B, RN Unit Care Coordinator, showed two Suspension Pending Investigation Reports, one for Staff C and one for Staff E. Staff B stated that according to these forms both staff involved were notified of the allegation on 10/12/2024. Staff B stated that the staff should have reported this within two hours on 10/12/2024.</p> <p>On 11/07/2024 at 2:40 PM, Staff A, Executive Director, stated everyone was a mandatory reporter and that they had two hours to report an allegation of neglect into the State Agency. Staff A stated that the facility staff did not notify them on 10/12/2024 of the allegation and thought that no other staff member reported it into the state until they did on 10/15/2024, and that it could have been reported on 10/12/2024 if they had been notified by their staff.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49619</p> <p>Based on interview and record review, the facility failed to ensure allegation of neglect was thoroughly investigated for 1 of 3 resident (Resident 1), reviewed for abuse/neglect investigations. This failure placed the resident at risk for unidentified abuse and/or neglect, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse- Conducting an Investigation, reviewed on 06/17/2024, showed allegations of neglect would be promptly and thoroughly investigated by the facility. The policy showed that when an incident or suspected incident of resident neglect occurred the administrator/designee would investigate the occurrence and provide protection to the alleged victim and other residents, such as changing staff to protect the residents from the alleged perpetrator. The policy showed that the facility must thoroughly collect evidence to determine what actions are necessary (if any) for protection of the residents. It showed that it would be expected, but not limited to include interviews with the alleged victim and representative, alleged perpetrator, witnesses, and other staff. The policy further stated that if the accused individual was an employee, the alleged perpetrator would be removed from resident care areas immediately and placed on suspension pending the results of the investigation.</p> <p>Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 10/15/2024, showed Resident 1 admitted to the facility on [DATE] and was cognitively intact.</p> <p>Review of the facility's October 2024 Reporting Log showed an allegation of neglect was logged on 10/20/2024, with a date and time of incident on 10/15/2024 at 1616 (4:16 PM).</p> <p>Review of Resident 1's investigation showed that on 10/12/2024 during day shift, the facility staff including the resident's nurse were notified of an allegation that the resident was not changed for a long period of time. The investigation showed that Resident 1 stated that staff came in at 8:30 AM to change them, and did not come back until 2:30 PM, and that they felt neglected when the incident had occurred. Further review of the investigation showed no statements from staff [Staff D, Certified Nursing Assistant (CNA) who changed and showered Resident 1 after it was reported that they were not changed for a long period of time and no documentation how the resident was found after the allegation was reported.</p> <p>Review of the facility's October 2024 nursing schedule showed Staff C, Registered Nurse (RN), continued to work with Resident one after the allegation was reported on 10/12/2024, and continued working with them on 10/13/2024, 10/14/2024 and 10/15/2024.</p> <p>Review of the Grievance Form dated 10/19/2024, showed a CC1 reported to Staff A [Executive Director] that they no longer wanted Staff C to work with Resident 1.</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>On 10/23/2024 at 1:30 PM, Resident 1 stated that they could not remember how it got that bad, and that nobody came in their room. Resident 1 stated that Collateral Contact 1 (CC1) came in to see how they were doing and found them that way [soaked in urine and had a BM]. Resident 1 stated that they were not used to wearing briefs. Resident 1 stated that it was dripping on the floor when [CC1] came in. Resident 1 further stated that they typically use their call light but sometimes the staff forget to give them the call button.</p> <p>On 10/30/2024 at 1:15 PM, Staff C stated that on 10/12/2024, CC1 had approached them and stated that the resident was soiled and had a lot of BM. Staff C stated they did not see if the resident had a BM because two shower aides came in to take Resident 1 for a shower. Staff C further stated they asked staff to ensure Resident 1's linen was changed.</p> <p>On 10/30/2024 at 2:52 PM, Staff D stated that on 10/12/2024, in company with another staff member, had gone in to get Resident 1 ready for a shower. Staff D stated that Resident 1 stated that they had not been changed since the morning that day, and that they were crying and looked visibly upset about the situation. Staff D stated they notified Staff C that the resident was soaked in urine. Staff D stated that everything was soaked through, and that they got their pants wet from leaning against Resident 1's mattress while moving them in bed. Staff D stated that they found Resident 1's mattress wet and that their brief was heavily wet with BM and once they rolled the resident over the brief was sopping wet, almost disintegrating. Staff D further stated that they could not find Staff E [CNA], at first, so another staff member took Resident 1 to initiate their shower and they stayed behind to wipe down the mattress with bleach wipes and then Staff E took over the cleaning of the mattress.</p> <p>On 11/06/2024 at 12:25 PM, Staff E stated that Resident 1 was changed in the morning, and they had been checking on them several times and the resident did not mention that they were wet. Staff E stated that Resident 1 had a BM around 2:00 PM, and that two of their colleagues had changed and showered Resident 1. Staff E further stated they assisted with cleaning the bed because there was BM on it, and they had to disinfect it and change the linen.</p> <p>On 11/06/2024 at 4:13 PM, Staff B, RN/Unit Care Coordinator, stated that while investigating an allegation of neglect, the staff directly working with the resident should be interviewed. Staff B stated that the alleged staff should be suspended while the investigation was pending for the safety of the residents. Staff B further stated that it was the staff responsibility to check on the residents to ensure their care needs were met.</p> <p>Joint record review and interview on 11/06/2024 at 5:00 PM with Staff B, showed Resident 1's investigation included that the resident was changed and showered after the allegation was reported, but did not include a statement of the staff who had arrived first on scene to change or give the resident a shower. Staff B further stated that it should have been included.</p> <p>Joint record review and interview on 11/06/2024 at 5:12 PM with Staff B, showed the shower documentation revealed Resident 1 received a shower on 10/12/2024 with a two person assist. Staff B stated they did not know who the other staff involved was and that it would have been vital to get a statement from the staff that assisted the resident with a shower.</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>On 11/07/2024 at 2:40 PM, Staff A stated that there was no history of allegations from the resident prior to 10/12/2024 as the investigation stated. Staff A stated that they interviewed the two alleged perpetrators, and they denied the allegations as well as other residents and did not have any concerns, and that aided in ruling out neglect. Staff A stated that they did not have documentation that the resident was being checked on every two hours other than Staff E's statement. When Staff A was notified of Staff D and Staff E's additional interviews, they stated those details would have been important to include in the investigation.</p> <p>Reference: (WAC) 388-97-0640 (6)(a)</p>