

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  05/09/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</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 provide a written summary of the baseline care plan to the residents and/or their representatives for 4 of 4 residents (Residents 1, 2, 3 &amp; 4), reviewed for baseline care plan. This failure placed the residents at risk for unmet care needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Baseline Care Plan, reviewed on 09/05/2024, showed staff would 4. Review the baseline care plan and physician orders with the resident and/or representative. 5. Provide the resident[s]and/or representative with copies of the baseline care plan and physician orders. 6. Have all care plan conference attendees sign the last page of the Baseline Care Plan form.</p> <p><b>RESIDENT 1</b></p> <p>In a phone interview on 04/24/2025 at 9:51 AM, Collateral Contact 1 (CC1), stated they did not recall receiving a written summary of Resident 1's baseline care plan.</p> <p>Review of Resident 1's assessment titled, Baseline Care Plan 2, dated 03/10/2025, did not show that Resident 1 or their representative received a written summary of their baseline care plan.</p> <p>Review of Resident 1's nursing progress notes did not show that Resident 1 or their representative received a written summary of their baseline care plan.</p> <p><b>RESIDENT 2</b></p> <p>Resident 2 was admitted to the facility on [DATE].</p> <p>On 04/24/2025 at 1:48 PM, Resident 2 stated that they did not remember if they received a written summary of their baseline care plan.</p> <p>Review of Resident 2's assessment titled, Baseline Care Plan 2, dated 03/04/2025, did not show that Resident 2 or their representative received a written summary of their baseline care plan.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 2's nursing progress notes did not show that Resident 2 or their representative received a written summary of their baseline care plan.</p> <p><b>RESIDENT 3</b></p> <p>Resident 3 admitted to the facility on [DATE].</p> <p>Review of Resident 3's assessment titled, Baseline Care Plan 2, dated 04/09/2025, did not show that Resident 3 or their representative received a written summary of their baseline care plan.</p> <p>Review of Resident 3's nursing progress notes did not show that Resident 3 or their representative received a written summary of their baseline care plan.</p> <p><b>RESIDENT 4</b></p> <p>Review of Resident 4's assessment titled, Baseline Care Plan 2, dated 03/21/2025, did not show that Resident 4 or their representative received a written summary of their baseline care plan.</p> <p>Review of Resident 4's nursing progress notes did not show that Resident 4 or their representative received a written summary of their baseline care plan.</p> <p>On 05/09/2025 at 12:29 PM, Staff C, Assistant Director of Nursing, stated they would expect a resident and/or their representative to receive a written summary of their baseline care plan. Staff C stated that they could not find documentation that Resident 1, 2, 3, and 4 and/or their representatives had received a written summary of their baseline care plan. Staff C stated that they would have expected the baseline care plan to be signed and uploaded into their Electronic Health Record (EHR) and that there would be a progress note. Staff C further stated the baseline care plan was important because it let the staff know how to take care of the residents and what their needs were and included the resident and/or representative input.</p> <p>On 05/09/2025 at 1:02 PM, Staff B, Director of Nursing, stated that they would expect there to be documentation that a written summary of the baseline care plan was provided to the resident or representative.</p> <p>On 05/09/2025 at 1:42 PM, Staff A, Interim Executive Director, stated that they had Resident 1, 2, 3, and 4's baseline care plan completed and that it was not signed by the resident and/or representative.</p> <p>On 05/09/2025 at 1:48 PM, Staff D, Social Services Director, stated their expectation was to discuss the baseline care plan with the resident and/or representative during the resident's initial care conference and that they would be provided with a written summary of the baseline care plan. Staff D stated that it would be uploaded into the resident's EHR with the resident and/or representative's signature on the signature page and documented in a progress note. Staff D stated that there was no documentation that Resident 1, 2, 3, and 4 had been provided with a written summary of their baseline care plan. Staff D further stated a baseline care plan was important to provide for the residents or representatives because it informed them of the services that would be provided at the facility.</p> <p>Reference: (WAC) 388-97-1020(3)</p>		