STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505334	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kirkland	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to conduct a thorough investigation for 1 of 3 residents (Resident 3), reviewed for abuse investigations. This failure placed the resident at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions.Findings included.Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, All alleged incidents of abuse, neglect.and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. It further showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences.Review of the facility's policy titled, Abuse-Protection of Residents, reviewed on 05/07/2025, showed, Have evidence that all alleged violations are thoroughly investigated.Review of the quarterly Minimum Data Set (an assessment tool) dated 08/15/2025, showed Resident 3's cognition was moderately impaired.Review of the facility's investigation report dated 07/31/2025 showed Collateral Contact 1 (CC1) reported that the thousand dollars ($1000) they brought in three months ago was missing from Resident 3's wallet. The investigation report showed that CC1 alleged that today [07/31/2025] is the first day that they and Resident 3 had looked in Resident 3's wallet since the money was placed three months ago. Review of the investigation report showed: Immediate Action Taken:-Investigation initiated-Police called-Room was searched for possible misplacement of the money-Belonging list was reviewed with no mention of money-Reported to State Agency.Further review of the investigation report showed that interviews with other residents and staff members were not conducted.In an interview on 08/28/2025 at 12:33 PM, Staff J, Certified Nursing Assistant, stated that they had been assigned to Resident 3 and were not aware of Resident 3's alleged missing money. Staff J stated that they were not interviewed about Resident 3's report of missing money.In an interview on 08/28/2025 at 1:17 PM, Staff K, Registered Nurse (RN), stated that they were assigned to Resident 3 on 07/31/2025 and did not receive a report about Resident 3's alleged missing money. Staff K stated that they were not interviewed about Resident 3's report of missing money.In an interview on 08/28/2025 at 1:22 PM, Staff L, RN, stated that they had been assigned to Resident 3 and did not receive or heard a report about Resident 3's alleged missing money and that they were not interviewed about it.In an interview and joint record review on 08/29/2025 at 10:16 AM, Staff I, Assistant Director of Nursing, stated that they reported and investigated Resident 3's allegation of missing money and that they followed the Purple Book in their investigation process. Staff I stated that they would interview staff members and other residents as part of their investigation process. A joint record review of the investigation report dated 07/31/2025 did not show documentation that other residents and staff were interviewed. Staff I stated that they did not conduct interview of staff and other residents about Resident 3's allegation of missing money.In an interview on 08/29/2025 at 11:01 AM, Staff B, Director of Nursing, stated that they reviewed Resident 3's investigation report and did not see documentation that other residents and staff were interviewed. Staff B stated, I checked [Staff I]'s paper, and I did not see staff interviews or [other] residents' interviews. When asked if the investigation was completed thoroughly Staff B stated, I expected that the investigation should have been thoroughly done and that would include interviews with staff and residents. No, it was not [thoroughly investigated].Reference: (WAC) 388-97-0640 (6)(a).

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess, provide timely treatment, and implement pressure relieving interventions to prevent worsening of skin condition for 1 of 3 residents (Resident 1), reviewed for pressure injury (localized damage to the skin and/or underlying tissue that occurs due to prolonged pressure on the skin). Resident 1, who was at an increased risk of skin breakdown, experienced harm when a wound on their sacrum (triangular-shaped bone in the lower back located between the hip bones) had not been identified on their admission skin assessment, developed into an avoidable unstageable pressure injury (obscured full-thickness skin and tissue loss) that worsened requiring debridement (surgical removal of dead or infected tissue from a wound to promote healing), was diagnosed as a Stage 3 pressure injury (full thickness loss of skin) requiring application of a Wound Vac [vacuum-machine to assist with wound healing). This failure placed the resident at risk for further skin breakdown, pain, infection, and a diminished quality of life. Findings included .Review of the National Pressure Injury Advisory Panel (NPIAP - leading expert in pressure injuries/wounds), dated February 2025, defined pressure injury stages as follows:-Stage 2 Pressure Injury is a partial thickness skin loss with exposed dermis (the top inner layers of skin) and may be present as an open ulcer with a red or pink wound bed or as an intact or ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation (newly formed) tissue, slough (dead tissue) and eschar (dried blood and tissue) are not present. -Stage 3 Pressure Injury is a full thickness loss of skin, in which adipose tissue is visible in the ulcer and granulation tissue and epibole (rolled or curled wound edges) are often present. Slough and/or eschar may be visible.-Stage 4 Pressure Injury is a full-thickness loss of skin and tissue with exposed or directly palpable fascia (layer of tissue covering the muscle), muscle, tendon (a cord or band of dense, tough, inelastic, white, fibrous tissue, serving to connect a muscle with a bone or part), ligament (a tough fibrous band of connective tissue that supports internal organs and holds bones together at the joints. It connects bones to other bones and helps hold organs in place), cartilage (a strong, flexible connective tissue that protects the joints and bones acting as a shock absorber throughout the body) or bone in the ulcer. Slough and/or eschar may be visible. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location.-Unstageable Pressure Injury is an obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. Review of the facility's policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention, last reviewed on 06/11/2025, showed that the facility staff was provided with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP and WONC (Wound, Ostomy [a surgical procedure creating an opening in the body for the discharge of body waste into a collection bag], Continent Nurses Society - the largest and most recognized professional nursing community dedicated to advancing the practice and delivery of expert healthcare to individuals with wound, ostomy, and continence care needs). A comprehensive skin inspection/assessment is completed on admission and readmission to the center. Review of a face sheet showed Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture (break in the bone) to left lower leg, morbid obesity (severe level of obesity that can lead to serious health issues), and moderate protein calorie malnutrition (when not enough protein and calories are consumed and/or metabolized, resulting in muscle loss).Review of Resident 1's admission Minimum Data Set (an assessment tool) dated 08/14/2025 showed Resident 1 had no pressure injury on their sacrum and was cognitively intact. The MDS showed Resident 1 required maximum assistance (helper lifts or holds trunk or limbs) with bed mobility and total assistance (resident does none of the effort to complete the activity) with toileting and transfers. It further showed that Resident 1 was always incontinent of bladder and bowel.Review of Resident 1's BRADEN scale (an assessment tool that measures risk for pressure injury) dated 08/06/2025 showed a score of 15, indicating mild risk for pressure ulcer/injury development. Review of a BRADEN scale dated 08/20/2025 showed Resident 1 scored 12, indicating high risk for pressure ulcer/injury development. Review of the most current BRADEN scale dated 08/27/2025 showed Resident 1 scored 13, indicating moderate risk for pressure ulcer/injury development.Review of Resident 1's Admission/readmission Collection Tool, dated 08/06/2025 showed bruises on their right lower leg and a surgical wound on their left leg related to left ankle fracture surgery. Review of the Weekly Skin Integrity Data Collection, dated

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure hand hygiene practices and/or proper use of personal protective equipment (PPE-glove/gown use) were followed for 2 of 3 residents (Residents 1 & 2), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included .Review of the facility's policy titled, Enhanced Barrier Precautions [EBP-precaution to protect residents from multidrug-resistant organism [MDRO - a germ that is resistant to medications that treat infections]), revised on 08/19/2025, showed that the facility would use EBP for MDRO mitigation as a strategy for residents during high contact care activities that included wounds even if the resident was not known to be infected or colonized with a MDRO. It also showed that EBP would be done for chronic wounds such as pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure), diabetic foot ulcers (skin injury with full thickness skin loss on the foot in patients with diabetes [high levels of sugar in the blood]), unhealed surgical wounds, and venous stasis ulcers (skin injury on lower legs due to poor blood circulation). The policy further showed that EBP required the use of gowns and gloves during high-contact resident care activities.Review of the facility's policy titled, Hand Hygiene, reviewed on 07/07/2025, showed that staff would perform hand hygiene even if gloves were used before and after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces.Review of the undated signage/posting titled, Enhanced Barrier Precautions, showed it instructed staff to wear gown and gloves for high-contact resident care activities that included wound care with any skin opening requiring a dressing.GLOVE USE AND HAND HYGIENERESIDENT 1Review of the wound care notes dated 08/19/2025 showed Resident 1 had an unstageable pressure injury (obscured full-thickness skin and tissue loss in which the extent of tissue damage within the pressure injury that cannot be confirmed because it is obscured by slough [soft yellow or white dead tissue] or eschar [hardened, dry, black or brown dead tissue]) on their sacrum (triangular-shaped bone in the lower back located between the hip bones).During an observation and interview on 08/21/2025 at 9:46 AM, Staff C, Registered Nurse, and Staff D, Resident Care Manager (RCM), showed they provided wound care to Resident 1. Staff D had gloves on and touched Resident 1's soiled disposable brief and proceeded to clean Resident 1's sacral (or sacrum) wound with gauze soaked with normal saline (sterile solution composed of water and sodium [salt]). With the same soiled gloves Staff D touched Resident 1's soiled brief, continued to clean Resident 1's pressure injury wound with a gauze, and a red colored fluid oozed from the wound. Staff D stated, there is a little bit of blood coming out of the wound. Staff D was observed holding the resident's hip while Staff C measured Resident 1's sacral pressure injury. Staff D covered Resident 1's pressure injury with a clean silicone dressing to cover the wound. Staff C and Staff D removed Resident 1's soiled brief, replaced it with a clean brief, repositioned Resident 1 in their bed, and covered Resident 1 with their blanket. Staff D touched and moved Resident 1's bedside table closer to them. Staff C touched and handed their bed control and their call light to Resident 1. Staff D removed their soiled gloves and adjusted Resident 1's pillow without doing hand hygiene. When asked about when to change their soiled gloves, Staff C and Staff D stated that they did not touch Resident 1's wound directly when they provided wound care and/or when measuring Resident 1's pressure wound. Staff D further stated they forgot to use the gel [hand sanitizer] after they removed their gloves before adjusting Resident 1's pillow.In an interview on 08/29/2025 at 11:15 AM, Staff B, Director of Nursing, stated they expected staff to follow infection control policies and to do hand hygiene before putting on clean gloves, between glove use, when doing wound care between tasks from dirty to clean. Staff B stated that Staff C and Staff D should have done hand hygiene and changed their gloves between tasks when providing wound care to Resident 1. Staff B further stated that Staff C and Staff D should not have touched Resident 1's environment with their soiled gloves.USE OF GOWNRESIDENT 2Observation on 08/20/2025 at 4:42 PM showed an EBP signage outside Resident 2's room that instructed staff to wear gown and gloves for high-contact resident care activities that included wound care.During an observation and interview on 08/21/2025 at 10:31 AM with Staff G, Licensed Practical Nurse, showed Staff G provided wound care to Resident 2's left lower leg without wearing a gown. A joint record review of the EBP signage outside Resident 2's room showed that staff were required to wear gown and gloves for high-contact care activities that included wound care. Staff G stated, I should have worn a gown prior to the dressing change [wound care].In an interview on 08/29/2025 at 10:09 AM, Staff H, RCM, stated that EBP was done for residents with wounds and that staff were expected to wear gown and gloves. Staff H further stated that Staff G should