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	03/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an allegation of neglect was reported to the State Agency within the required timeframe for 1 of 4 residents (Resident 1), reviewed for abuse reporting. This failure placed the resident at risk for potential unidentified neglect and lack of protection from neglect.Findings included . Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, Neglect means: a) a pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. Review of the facility's policy titled Abuse, Neglect and Exploitation, Chapter 3: Abuse - Reporting and Response -No Crime Suspected, revised on 05/07/2025, showed, The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property, and will report the results of all investigations to the proper authorities within prescribed timeframes. The policy further 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. Review of the grievance form completed on 02/01/2026 showed that Resident 1 reported that She was in a wet brief from morning till 5:00 PM that day. Review of the February 2026 incident log showed that Resident 1 had a concern documented on 02/01/2026, with the nature of the occurrence recorded as alleged neglect. Review of the incident investigation report dated 02/03/2026 showed, RCM [Residents Care Manager] received a grievance that [Resident 1] reported that on Sunday [02/01/2026] her brief was not changed all day until approximately 1700 [5:00 PM]. Patient [resident] states she was in a wet brief and when activities came to get her, she let them know as well. During that time the CNA [Certified Nursing Assistance] entered the room and when asked why patient hadn't [had not] been changed the aide replied that she was busy and needed to take her break. The report further showed, Investigation initiated, employee suspended pending investigation, [Resident 1] placed on alert for psychosocial/emotional distress, patient interviews in same area initiated, employee interviews initiated. MD [Medical Director], DON [Director of Nursing], family notification completed. In an interview on 03/12/2025 at 10:38 AM, Resident 1 stated, I know that on the weekends there are fewer staff members. I needed to be changed, but she [CNA] did not come the whole day. I asked her a couple of times during that time if she could change me, but she wasn't [was not] able to get to me right away. She should have changed me, and she apologized for that. In an interview on 03/23/2026 at 11:04 AM, Staff C, Assistant DON, stated that they received the grievance form and went to speak with Resident 1. Staff C stated that Resident 1 clarified that their brief was not changed during the evening shift until 5:00 PM. Staff C stated that a round was conducted every day at 2:30 PM and I believe she was seen during that round. However, we do not have documentation for this. Staff C stated they completed an investigation and did not report the (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation to the State Agency because there was inconsistency between what was written on the grievance form and what Resident 1 stated during the follow^up interview. Staff C stated that Resident 1 was placed on alert, the staff member involved was suspended, and the investigation was completed. Staff C further stated the incident was entered into the incident log as alleged neglect. In an interview on 03/23/2026 at 12:03 PM, Staff B, DON, stated that they followed the Purple Book guidelines and that allegations of neglect should be reported to the State Agency. Staff B further stated that Resident 1's allegation of neglect should have been reported to the State Agency. In an interview on 03/23/2026 at 12:17 PM, Staff A, Executive Director, stated that Resident 1's allegation of neglect was not reported to the State Agency and that it should have been. Reference: (WAC) 388-97-0640 (5)(a).