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	06/16/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete timely and comprehensive vital-sign assessments (measurements of the body's most basic functions), specifically blood-glucose (sugar) level and temperature, for 2 of 3 residents (Residents 1 & 2) during changes in condition, reviewed for quality of care. This failure placed the residents at risk for unrecognized medical complications, unmet care needs and a diminished quality of life.Findings included.Review of the facility's policy titled, Changes in Resident's Condition or Status, reviewed on 08/29/2025, showed that the facility must immediately inform the resident; consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) and if there was a decision to transfer or discharge the resident from the facility.Review of the facility's procedure document titled, eINTERACT Change in Condition Process, reviewed 12/01/2025, showed that This process is utilized to identify and assess any resident change of condition. Further review showed a process for nursing staff to complete an eINTERACT Change in Condition Evaluation (SBAR - Situation, Background, Appearance, & Review - a communication form used to inform medical providers) when a change in condition was identified. It further showed that identification of a resident change in condition may be identified by a Report of change of condition from family or visitor and/or Licensed staff observe change in condition.RESIDENT 1Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnosis that included diabetes (a condition where a person's body has trouble handling glucose in the blood) and after care following an orthopedic surgery (type of surgery to repair broken bones). Review of Resident 1's care plan for diabetes, dated 05/29/2026, showed nursing interventions included observation and reporting of signs and symptoms of hypoglycemia (low blood sugar) to include confusion and slurred speech.Review of a nursing progress note dated 06/02/2025 at 3:45 PM, showed [Resident 1's Collateral Contact] arrived and stated that [Resident 1's] orthopedic surgeon requested to send [Resident 1] to ER right now, [Resident 1] is in bed at this time, with no acute distress noted of [Resident 1]. It did not show documentation that Resident 1's vital signs, including blood-sugar level, were assessed to identify a change in condition. It further showed that the progress note was completed by Staff C, Resident Care Manager.Review of a nursing progress note dated 06/02/2026 at 3:59 PM, showed [Resident 1's Collateral Contact] requested that [Resident 1] be sent to [Name of Hospital] d/t [due to] change of condition. Stated that [Resident 1] has stopped talking. [Name of Medical Transport Service] was called to take [Resident 1] to hospital. It did not show documentation that Resident 1's vital signs, including blood-sugar level, were assessed to identify a change in condition.Review of a nursing progress note dated 06/02/2026 at 6:06 PM, showed that medical transport arrived at the facility around 5:30 PM to take [Resident 1] to the ER [Emergency Room] and that Resident 1 left at 5:40 PM.Review of Resident 1's Electronic Health Records (EHR) of the Blood Sugar Summary showed blood-glucose level readings documented at 7:47 AM and at 12:47 PM on 06/02/2026. It showed that Resident 1's blood glucose was recorded as 120.0 mg/dL (milligrams per deciliter - a unit of measurement used to show how much sugar was in a small amount of blood). It did not show (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	additional blood sugar level readings were documented after 12:47 PM on that date.Review of Resident 1's SBAR Communication Form, dated 06/02/2026, showed that the instructions on the form directed staff to check vital signs before calling a healthcare provider. It also showed that vital signs to be checked by staff included finger stick glucose for diabetics. It showed that Resident 1 was marked to have decreased level of consciousness (sleepy, lethargic [drowsy and/or not alert]). Further review showed that Resident 1's recorded blood sugar level was 120.0 (mg/dL).Review of Resident 1's ER records dated 06/02/2026, showed that Resident 1 presented with altered mental status [not alert] and hypoglycemia and that the resident Started to have slurred speech, now they were struggling to communicate and altered. The resident was found to have blood glucose [readings] in the 50's in the field which did not improve with 2 doses of 45 g [grams - unit of measurement] of carbs [carbohydrates - administered for hypoglycemia]. It further showed that on medic evaluation [Medical transport staff that assessed Resident 1 at the facility] the resident apparently had blood glucose in the 50's which was persistent despite sipping juice.Labs (blood tests done at the hospital) were primarily notable for initial blood glucose 50.In an interview and joint record review on 06/16/2026 at 1:28 PM, Staff C stated that nursing assessments used to identify a resident's change in condition include checking vital signs and obtaining blood-glucose levels for residents with diabetes. Staff C stated that nursing staff would complete a SBAR Communication Form when residents were assessed for a change in condition. A joint review of Resident 1's nursing progress notes dated 06/02/2026 showed that Resident 1 was reported to have a change in condition and he stopped talking. When asked when Resident 1's change in condition occurred on 06/02/2026, Staff C stated, Around 3;00 PM through 3:45 PM A joint record review of Resident 1's SBAR Communication Form dated 06/02/2026 and his EHR Blood Sugar Summary showed that his blood-glucose was documented as 120.0 mg/dL on 06/02/2026 at 12:47 PM. Joint record reviews did not show documentation that Resident 1's blood-glucose level was obtained during his change in condition between 3:00 PM and 3:45 PM, prior to medics arriving at the facility. Staff C stated, I would expect that they [nursing staff] check all the vital signs including the fingerstick [blood-glucose level] at the time of the [nursing] assessments.In an interview and joint record review on 06/16/2026 at 3:07 PM, Staff B, Director of Nursing, stated that a resident change in condition was Anything that was different from baseline.A deviation from the patient's [resident] mentation status or an exacerbation of their illness. When asked what nursing assessments were completed to identify a resident's change in condition, Staff B stated, They would assess the patients, their vital signs, their mental status, listen to heart and lungs, that's just standard nursing practice. A joint record review of Resident 1's nursing progress notes dated 06/02/2026 showed that he was reported to have a change in condition. When asked when Resident 1's change in condition occurred on 06/02/2026, Staff B stated, He was sent to the hospital around 5:30 PM, so I would estimate around 4:00 PM. A joint record review of Resident 1's SBAR Communication Form dated 06/02/2026 and his EHR Blood Sugar Summary showed that his blood-glucose was documented as 120.0 mg/dL on 06/02/2026 at 12:47 PM. Staff B stated that they expected Resident 1's blood-glucose level would have been checked at the time of his change of condition and that Yes, I would expect it because he had stopped talking.RESIDENT 2Review of a face sheet showed Resident 2 admitted to the facility on [DATE].Review of Resident 2's care plan for respiratory illness, dated 03/31/2026, showed the resident was assessed as being At risk for respiratory illness/infection due to the resident being immunocompromised (having a weakened immune system that makes it harder to fight off infections), advanced age and a history of pneumonia (lung infection) during their most recent hospitalization. It further showed nursing interventions included Monitor for change in [Resident 2's] condition and notify practitioner of findings, and Perform respiratory assessment on an ongoing basis as directed.Review of a nursing progress note dated 04/14/2026 at 10:32 AM, showed [Resident 2] complained of SOB (Shortness of Breath), assessment revealed wheezing, SOB and O2 (oxygen saturation - measurement of how much oxygen is being carried in the blood compared to how much it (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could carry, with a normal level between 95-100%) at 86 % with 3L/min (Liters per minute - measurement of how much oxygen is being delivered through a device) on concentrator (medical device). It further showed that a medical provider directed staff to call 911 (Emergency services). Further review did not show documentation that Resident 2's vital signs, including temperature, were assessed to identify a change in condition.Review of a nursing progress note, dated 04/14/2026 at 10:50 AM, showed [Resident 2's Collateral Contact - CC] came to visit and at that moment [Resident 2] developed mild SOB (Shortness of Breath) and signs of congestion [stuffed up and hard to breathe].Wheezing, O2 [saturation] 86%, O2 4LPM [4 Liters per minute] per NC (Nasal canula - small tubes in the nose used to deliver oxygen therapy). Further review did not show documentation that Resident 2's vital signs, including temperature, were assessed to identify a change in condition.Review of Resident 2's EHR of the Temperature Summary showed that Resident 2's last documented temperature reading of 97.5 F (Fahrenheit - unit of measurement) was recorded on 04/14/2026 at 7:43 AM. Further review of Resident 2's EHR of the Blood Pressure (BP) Summary showed that Resident 2's last documented BP reading of 144/78 mmHg (millimeters of mercury - unit used to measure blood pressure) was recorded on 04/14/2026 at 7:43 AM. It did not show additional vital readings of temperature and BP were documented after 7:43 AM on that date.Review of Resident 2's SBAR Communication Form, dated 04/14/2026, showed documented vital signs of BP 144/78 and a temperature of 97.5F. The form also indicated that Resident 2 was noted to have labored or rapid breathing and SOB.Review of hospital records for the hospitalization on 04/14/2026, showed that Resident 2 arrived at the Emergency Department (ED) at 11:11 AM. ED triage documentation noted complaints of congestion and SOB beginning the previous day, an oxygen saturation of 84% on room air that improved with 4 L/min nasal-cannula oxygen, and a fever of 100.4F. Further review of hospital records showed that Resident 2 was admitted on [DATE] for acute hypoxemic respiratory failure [a person's lungs suddenly cannot get enough oxygen into their blood and oxygen level drops dangerously low] presenting with shortness of breath.A joint record review on 06/16/2026 at 1:36 PM with Staff C showed that nursing progress notes dated 04/14/2026 indicated Resident 2 experienced a change in condition. When asked when Resident 2's change in condition occurred, Staff C stated Around 10:30 AM. Further review of Resident 2's EHR showed that the vital signs recorded at 7:43 AM were the same values documented on the SBAR Communication Form for that date. When asked whether Resident 2's vital signs including temperature, were assessed at the time of their change in condition, Staff C stated, No, the only thing that was updated was their oxygen saturation level. Staff C further stated that They should have checked all vital signs.A joint record review and interview on 06/16/2026 at 3:07 PM with Staff B showed that nursing progress notes dated 04/14/2026 indicated Resident 2 experienced a change in condition. Further review of Resident 2's EHR showed that the vital signs recorded at 7:43 AM were the same values documented on the SBAR Communication Form for that date. Staff B stated I would expect that they [staff] would check the vital signs, including to check the temperature. I would expect [Resident 2's] temperature to have been communicated by nursing. Reference: (WAC) 388-97-1060 (1).