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	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kirkland	10101 Northeast 120th Street Kirkland, WA 98034

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food safety when expired food items were not discarded for 1 of 1 dry storage room (Kitchen Dry Storage Room), reviewed for food services. In addition, the facility failed to ensure expired paper tests strips (designed to check the level of chlorine [a chemical that kills germs] in the water used to sanitize the dishware during the dishwasher rinsing phase) were discarded. These failures placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages).Findings included .Review of the facility's policy titled, Food Safety, reviewed on 05/01/2025, showed that food was stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Further review of the policy showed that food that was not safe for consumption or the safety of the food was in question would be removed from storage.Review of the facility's policy titled, Ware Washing-Dish Machine/Manual Process, revised on 04/30/2025, showed that food and nutrition services staff were trained in the proper use, cleaning and sanitation of ware washing equipment and sinks. Further review of the policy showed that low temperature dish machines would be used in accordance with the manufacturer specification and that the temperature and parts per million (PPM - unit of measurement for concentration) of the sanitizers (50-100 ppm for chlorine) will be recorded on the Low Temperature Machine Log a minimum of three times per day.EXPIRED FOOD ITEMIn a joint observation and interview on 09/28/2025 at 8:58 AM with Staff I, Cook, showed a bottle of cooking wine with an expiration date of 11/24/2024. Staff I stated that the bottle of cooking wine was expired and that it should have been discarded.In an interview on 11/24/2025 at 11:09 AM, Staff H, Food Services Director, stated that they expected food items to be discarded by their expiration date. Staff H further stated that the expired bottle of cooking wine should have been discarded.EXPIRED TEST STRIPSIn a joint observation and interview on 11/24/2025 at 1:09 PM with Staff H and Staff J, Dietary Aide, showed Staff J was using Precision Chlorine Test Paper to test the low temperature dishwasher machine rinsing phase. Further joint observation showed the chlorine test paper strips container had an expiration date of 05/01/2025. Staff H and Staff J looked for other chlorine test strips and found three more chlorine test strips containers that had an expiration date of 05/01/2025. Staff H stated that all the four chlorine test strips were expired.In a joint record review and interview on 11/24/2025 at 2:53 PM with Staff H, showed the May 2025 to November 2025 low temperature dishwashing machine log were conducted three times a day for breakfast, lunch, and dinner. Staff H stated that staff were using the expired test strips from May 2025 through November 2025 to test the low temperature dishwasher rinsing phase three times daily. Staff H further stated that the facility should not have used expired chlorine test strips.In an interview on 11/26/2025 at 1:00 PM, Staff A, Executive Director, stated that their expectation was for staff to monitor food expiration dates according to facility policies and to discard expired food items. Staff A further stated that expired chlorine test strips should not have been used to check the low temperature machine rinsing phase.Reference: (WAC) 388-97-1100 (3).

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing information included the actual hours worked by registered and licensed nursing staff directly responsible for resident care per shift for 4 of 7 days, reviewed for posted nurse staffing information. The failure to post a complete and accurate form daily prevented the residents, family members, and visitors from exercising their rights to know the actual nursing staff hours worked in the facility.Findings included .Review of the facility's policy titled, Staff Posting and PBJ [Payroll Based Journal- is the system nursing homes use to electronically report their staff hours to the government] Submission, revised on 09/09/2025, showed that the facility must post the actual hours worked by registered nurses, licensed practical nurses and certified nurse aides on a daily basis at the beginning of each shift. Observations on 11/21/2025 at 9:05 AM and at 2:52 PM, on 11/24/2025 at 11:01 AM and at 3:17 PM, on 11/25/2025 at 9:59 AM and at 3:13 PM, and on 11/26/2025 at 9:43 AM, showed the facility's document titled, Posting of Licensed and Unlicensed Direct Care Staff did not include the actual nursing staff hours worked for the shift. In an interview on 11/26/2025 at 9:58 AM with Staff Q, Staffing Coordinator, stated that their process for filling out the Posting of Licensed and Unlicensed Direct Care Staff posting was to put the actual worked hours on the posting at the end of each shift. In an interview on 11/26/2025 at 10:56 AM, Staff B, Director of Nursing, stated that their process was to update the daily nurse staffing posting at the beginning of each shift. Staff B further stated that the actual hours worked had not been completed at the beginning of each shift and that they should have been.In an interview on 11/26/2025 at 12:46 PM, Staff A, Executive Director, stated that the daily nurse staffing posting must be updated every morning, and the actual hours worked must be completed at the end of each shift. No associated WAC.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded for 2 of 3 medication carts (Cascade Medication Cart & Olympic Medication Cart), and for 1 of 2 medication rooms (Central Supply Room), reviewed for medication storage and labeling. This failure placed the residents at risk for receiving compromised and ineffective medications.Findings included .Review of the facility's policy titled, Storage and Expiration Dating of Medications, Biologicals, revised on 06/30/2025, showed, Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacture or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.CASCADE MEDICATION CARTDuring a joint observation and an interview on 11/24/2025 at 10:13 AM with Staff M, Registered Nurse (RN), showed the Cascade medication cart had one opened Mupirocin (used to treat skin infection) ointment tube with an expiration date of 10/2025 (October 2025). Staff M stated that the ointment expired last month, and it should have been discarded.OLYMPIC MEDICATION CART A joint observation and interview on 11/24/2025 at 12:47 PM with Staff L, RN, showed the Olympic medication cart had one opened Fiber (a supplement) powder bottle with an expiration date of July 2025. Staff L stated that the fiber powder was expired, and it would be discarded.CENTRAL SUPPLY MEDICATION ROOM A joint observation and interview on 11/24/2025 at 2:09 PM with Staff F, Nurse Unit Manager, showed the following medications stored in the Central Supply Room:- 18 packages of Bisacodyl (medication that helps with bowel movement) 10 milligrams (mg - unit measurement) suppository (a piece of medicine that inserted into a body opening), expired in June 2025.- Four packages of Bisacodyl 10 mg suppository expired in July 2025.Staff F stated that the medications had expired and should have been discarded. In an interview on 11/25/2025 at 12:35 PM, Staff B, Director of Nursing, stated that their expectation was that expired medication should be discarded.Reference: (WAC) 388-97-1300 (2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper transport of clean linens was followed for 1 of 1 staff (Staff U), reviewed for infection control. In addition, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed during medication administration for 2 of 4 staff (Staff O & Staff N). These failures placed the residents, visitors, and staff at risk for infection and related complications.Findings included. Review of the facility's policy titled, Laundry Folding and Distribution, reviewed on 05/27/2025, showed, All linen will be handled, folded, and distributed in a neat and orderly fashion. Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during loading, transport, and unloading. TRANSPORT OF CLEAN LINENSSTAFF U Observation on 11/25/2025 at 8:27 AM, showed Staff U, Laundry Aide, was inside the laundry room putting clean folded towels into a rolling wired laundry basket up to its brim. Staff U then placed an unfolded bath towel over the top of the laundry basket with the sides of the laundry basket not fully covered. Staff U observed pushing the wired laundry basket and stocking up towels in the shower room and the clean utility room both located in the Cascade Hall. In an interview on 11/25/2025 at 8:35 AM, Staff U stated that they placed clean linens in a covered rolling cart and the clean towels in a wired laundry basket covered with a bath towel before transporting it to the unit. When asked if the use of a bath towel to cover the clean towels in a wired laundry basket was their process for transporting clean towels, Staff U stated, yes. In an interview on 11/25/2025 at 8:57 AM, Staff V, Environmental Services Director, stated, Carts should be fully covered, and we used a blanket or a sheet to cover. When we use the basket cart, we use a sheet to fully cover the towels. Staff V further stated that they expected staff to follow the policy and procedure, and they should fully cover the basket cart and not expose cleans towels when transporting them. In an interview on 11/26/2025 at 2:50 PM, Staff B, Director of Nursing, stated, Carts should be clean and fully covered when transporting clean linens [and] towels to the unit. HAND HYGIENE/GLOVE USEReview of the facility's policy titled, Hand Hygiene, revised on 10/28/2025 showed, Associates perform hand hygiene (even if gloves are used) in the following situations:a. Before and after contact with residentb. After contact with blood, body fluids, or visibly contaminated surfacesc. After contact with objects and surfaces in the resident's environment; . STAFF OObservation on 11/24/2025 at 1:03 PM, showed Staff O, Registered Nurse, was preparing to administer medication for Resident 33 via a feeding tube (a flexible tube used to deliver nutrition or medication to the stomach). Staff O put on gloves and gown prior to entering Resident 33's room. Staff O closed Resident 33's room window blinds with their gloved hands. With the same gloved hands, Staff O administered Resident 33's medication via feeding tube. Staff O did not change their gloves after they closed the window blinds and before administering medication to Resident 33. STAFF NObservation on 11/25/2025 at 7:55 AM, showed Staff N, Licensed Practical Nurse, was preparing to administer medication for Resident 24. Staff N entered Resident 24's room, gave Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	24 their medication, and touched and moved the resident's meal tray sitting on their bedside table. After medication administration, Staff N left Resident 24's room without performing hand hygiene. Further observation showed Staff N continued working on their medication cart without performing hand hygiene. Observation on 11/25/2025 at 8:01 AM, showed Staff N was preparing Resident 23's medication and did not perform hand hygiene prior to preparing Resident 23's medication. Staff N entered Resident 23's room and administered their medication without performing hand hygiene prior to entering the room. In an interview on 11/25/2025 at 8:12 AM, Staff N stated that hand hygiene would be performed between medication administration. Staff N stated that they did not perform hand hygiene after they administered medication for Resident 24 and before they prepared medication for resident 23. In an interview on 11/25/2025 at 12:27 PM, Staff D, Infection Preventionist, stated that they expected staff to perform hand hygiene using hand sanitizer before and after medication administration. Staff D further stated that gloves should be changed after contact with objects and surfaces in the resident's environment. In an interview on 11/25/2025 at 12:41 PM, Staff B stated that they expected staff to use hand sanitizer before and after medication administration. Staff B further stated they expected staff to change gloves between dirty and clean tasks. Reference: (WAC) 388-97-1320 (1)(a)(c)(3) .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement an Antibiotic Stewardship Program (a coordinated effort to optimize the use of antibiotics [medicine that prevents or treats infection] to ensure their appropriate and necessary use) for 1 of 2 residents (Resident 51), reviewed for antibiotic stewardship. The failure to conduct assessment to confirm presence of an infection prior to initiation of antibiotic placed the resident at risk for receiving unnecessary medication and a diminished quality of life.Findings included. Review of the facility's policy titled, Antibiotic Stewardship, revised on 07/22/2025, showed, The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident. It further showed a procedure that included assessment of residents suspected of having an infection.Review of the physician order dated 11/02/2025 showed Resident 51 had an order for Augmentin [an antibiotic] to give one tablet by mouth two times a day for right toe infection for 10 days.Review of the November 2025 Medication Administration Record showed Resident 51 had been administered Augmentin from 11/02/2025 to 11/12/2025.Review of Resident 51's Electronic Health Record (EHR) did not show Resident 51 had been assessed or evaluated for right toe infection prior to initiation of antibiotic.In an interview and joint record review on 11/26/2025 at 1:52 PM, Staff D, Infection Preventionist, stated that they assessed residents for symptoms of infection prior to initiation of antibiotic and that they would inform the physician and document their findings in the residents' progress notes. Staff D further stated that they used order listing report to document and monitor residents' use of antibiotic. A joint record review of a document titled, Order Listing Report, dated 11/03/2025, showed Resident 51 started on Augmentin for right toe infection on 11/02/2025 until 11/12/2025. When asked if Resident 51 had been assessed or evaluated for their right toe infection prior to initiation of the antibiotic, Staff D proceeded to browse over Resident 51's EHR and stated that they did not see documentation related to Resident 51's right toe infection. Staff D further stated that there was no documentation to show that Resident 51 was assessed or evaluated prior to initiation of the antibiotic. In an interview on 11/26/2025 at 2:25 PM, Staff B, Director of Nursing, stated that they expect staff to follow their infection control policies. Staff B further stated that residents should have had an assessment for presence of infection prior to initiation of antibiotic.Reference: (WAC) 388-97-1620(2)(b)(i)(ii) .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure a copy of the advance directive (a written document describing a resident's wishes for care if they became incapacitated such as a living will or Durable Power of Attorney [DPOA- a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) for health care was obtained for 1 of 1 resident (Resident 21), reviewed for advance directive. This failure placed the resident at risk for losing their right to have their preferences honored regarding care. Findings included.Review of the facility's policy titled, Advanced Directives, revised on 11/19/2024, showed staff were required to ask the resident about advance directives and document any wishes the resident may have regarding the care they want or do not want. The policy stated that a written description of the facility's policies regarding advance directives and applicable state law is to be provided to the resident or resident representative. The policy further stated the document should be reviewed during admission, quarterly, and with any change in condition. The Social Services Director (SSD) or designee should document this conversation in the medical record and assist the resident with updating the document if needed.Review of Resident 21's admission packet under the advance directive section showed, Prior to admission, I have executed an Advance Directive and will provide the facility with a copy. A further review of the Electronic Health Record (EHR) miscellaneous tab showed no copy of an advance directive and no documentation that the resident was asked to provide a copy or offered assistance with completing one.In an interview on 09/30/2025 at 12:18 PM, Resident 21 stated that it had been a while and they could not remember if staff asked for a copy of their advance directive. Resident 21 further stated they were given paperwork to fill out upon admission and believed that what they completed was accurate.In a joint record review and interview on 11/24/2025 at 2:06 PM, Staff P, SSD, showed there was no documentation in the EHR showing that an advance directive was requested, offered, or obtained for Resident 21. Staff P stated that a copy of the advance directive should have been requested during admission, and follow-up communication should have been documented in the social work notes. Staff P further stated that if a resident did not have an Advance Directive, they would assist the resident with completing one or provide community resources for support.In an interview and joint record review on 11/25/2025 at 1:17 PM, Staff B, Director of Nursing, stated that it was the responsibility of Social Services to request a copy of the DPOA during admission. Staff B stated that if a resident reported they had an advance directive, a copy should be uploaded to the EHR and the face sheet updated. Staff B further stated that if a resident did not have an advance directive, Social Services would offer guidance to help them formulate one. A joint record review of Resident 21's EHR showed no copy of an advance directive and no documentation that one was requested, offered, or refused. Staff B stated that documentation should have been completed.Reference: WAC 388-97-0280 (1)(3)(a).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN-a written notice that informs a Medicare [government health insurance program] that a service may not be covered and that resident may be responsible for the cost if they remained in the facility after their Medicare Part A skilled nursing and rehabilitation services ended) for 2 of 3 residents (Residents 104 & 105), reviewed for liability notices. This failure placed the residents and/or their representatives at risk of not having adequate information to make financial decisions related to continued stay in the facility.Findings included .Review of the facility's policy titled, Notice of Charges, revised on 05/06/2025, showed, SNF ABN is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services. RESIDENT 104Review of a face sheet printed on 11/26/2025 showed that Resident 104 was admitted to the facility on [DATE].Review of Resident 104's Notice of Medicare Non-Coverage (NOMNC-a written notice that informs a Medicare beneficiary that their covered services are ending and explains their right to request an expedited appeal) document showed that it was issued and signed on 05/02/2025 with the last covered date of 05/05/2025.Review of the Electronic Health Record (EHR-progress note and miscellaneous/documents tab) showed that Resident 104 was discharged on 05/16/2025. Further review of EHR showed no SNF ABN was provided to Resident 104 with information regarding the payment amount for which they were responsible after choosing to continue to stay in the facility. RESIDENT 105Review of a face sheet printed on 11/26/2025 showed that Resident 105 was admitted to the facility on [DATE].Review of Resident 105's NOMNC document showed that it was issued and signed on 07/09/2025 with the last covered date of 07/11/2025. Review of the EHR showed that Resident 105 was discharged on 08/08/2025. Further review of the EHR showed no SNF ABN was provided to Resident 105 with information regarding the payment amount for which they were responsible after choosing to continue to stay in the facility. In an interview and joint record review on 11/25/2025 at 10:15 AM, Staff P, Social Services Director, stated that if the residents were no longer covered by Medicare but wished to remain in the facility, the facility would issue SNF ABN. A joint record review of the EHR did not show that Residents 104 and 105 were provided with SNF ABN after they chose to remain in the facility. Staff P further stated that the SNF ABN should have been issued and placed in the residents' files.In an interview on 11/26/2025 at 12:46 PM, Staff A, Executive Director, stated that they expected staff to issue the SNF ABN forms to Residents 104 and 105.Reference: (WAC) 388-97-0300 (1)(e).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bed hold and transfer notices to the residents and/or their representatives in writing for 2 of 2 residents (Residents 69 & 94), reviewed for hospitalization. In addition, the facility failed to ensure a copy of the transfer notice was sent timely to the State Long Term Care Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations) office describing the reason for the transfer and/or the location. These failures placed the residents at risk of not having an opportunity to make an informed decision about their transfers.Findings included. Review of the facility's policy titled, Bed Hold, revised on 04/22/2025, showed that bed hold notice would be provided upon transfer of a resident to the hospital (if in an emergency within 24 hours). The facility would provide written information to the resident or resident representative of the facility's bed hold policy before and upon transfer to a hospital. Review of the facility's policy titled, Notice of Transfer and Discharges, revised on 04/22/2025, showed that the facility would notify the resident and the resident's representative and office of the State Long Term Care Ombudsman of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. prior to transfer or discharge. [NAME] facilities should use the Nursing Home Transfer or Discharge Notice DSHS 10-237 form. The policy showed that the written notice would include the location of discharge. It further showed that when a resident was temporarily transferred on an emergency basis to an acute care facility, a notice of transfer would be provided to the resident and resident representative as soon as practicable before the transfer. Copies of notices for emergency transfers would be sent to the Ombudsman office when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. RESIDENT 69Review of a discharge Minimum Data Set (MDS- an assessment tool) dated 07/22/2025 showed Resident 69 had an unplanned discharge to a Short Term General Hospital. Review of a nursing progress note dated 07/22/2025 showed that Resident 69 discharged to the hospital on [DATE] for further evaluation. Further review of the notes did not show a written bed bold and/or transfer notice was provided to Resident 69. Review of the July 2025 discharged residents list showed it was sent to the Ombudsman office on 11/14/2025, 115 days after Resident 69 discharged to the hospital. Further review of the discharge resident list did not show Resident 69's discharge location and/or the reason for discharge. Review of the Electronic Health Records (EHR-under documents tab from July 2025 to November 2025) did not show the Transfer or Discharge Notice (DSHS 10-237) form was completed for Resident 69. On 09/29/2025 at 11:44 AM, Resident 69 stated they did not receive a copy of a bed hold and/or a transfer notice when they discharged to the hospital in July 2025. In an interview and joint record review on 11/25/2025 at 9:18 AM, Staff G, Registered Nurse, stated that bed hold notices would be provided to residents before they were discharged the hospital. A joint record review of the EHR (progress notes and documents tab from July 2025 to November 2025) did not show documentation that a copy of bed hold and/or transfer notice was provided to Resident 69. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff G stated that they did not see a copy of bed hold and/or transfer notices were provided to Resident 69. In an interview and joint record review on 11/25/2025 at 10:29 AM, Staff P, Social Services Director, stated that transfer and/or discharge notifications were sent to the Ombudsman monthly. A joint record review of the July 2025 discharge list showed Resident 69's discharge notification was sent to the Ombudsman on 11/14/2025, 115 days after their hospital transfer. Staff P stated that Resident 69's discharge notification should have been sent to the Ombudsman the first week of August 2025. In a joint record review and interview on 11/25/2025 at 12:46 PM with Staff P showed the July 2025 discharge list did not include Resident 69's discharge reason or location. Staff P stated Resident 69's discharge reason or location should have been included. Staff P further stated that Resident 69 should have had a transfer notice form completed. In an interview on 11/26/2025 at 12:11 PM, Staff B, Director of Nursing, stated that they expected residents to be provided with a written bed hold and transfer notice before their discharge to the hospital, and in emergency situations within 24 hours. Staff B stated that there was no documentation to show that a copy of bed hold or transfer notice was provided to Resident 69 before their discharge to the hospital on [DATE] and it should have been. In an interview on 11/26/2025 at 12:46 PM, Staff A, Executive Director, stated they expected staff to follow the facility policies for bed hold and transfer or discharge notices. Staff A stated that the transfer discharge notices should have been sent to the Ombudsman office monthly. Staff A further stated that bed hold and transfer notices should have been provided to Resident 69. RESIDENT 94Review of a nursing progress note dated 07/02/2025, showed that Resident 94 transferred to the hospital for further evaluation. Review of a discharge MDS dated [DATE], showed that Resident 94 had an unplanned discharge to a Short-term General Hospital. Review of Resident 94's EHR (progress notes and documents tab from 06/20/2025 to 11/21/2025) showed no documentation that a bed hold notice was provided to Resident 94 and/or their representative. Review of the July 2025 discharged residents list showed it was sent to the Ombudsman office on 11/14/2025, 135 days after Resident 94 transferred to the hospital. Further review of the discharge resident list did not show Resident 94's discharge location and/or the reason for discharge. Review of the EHR (under documents tab from July 2025 to November 2025) did not show the Transfer or Discharge Notice (DSHS 10-237) form was completed for Resident 94. In an interview on 11/24/2025 at 9:16 AM, Staff F, Nurse Unit Manager, stated that to provide and discuss the bed hold notice was the responsibility of the nursing team. Staff F stated that the bed hold notice was not provided to Resident 94 and/or their representative. Staff F further stated that the bed hold notice should have been provided to Resident 94 and/or their representative. In an interview on 11/25/2025 at 12:44 PM, Staff P, stated that social service was responsible for notifying the Ombudsman when there was an unplanned discharge and/or transfer. Staff P stated that they would send the list of residents transferred to the hospital at the beginning of the following (continued on next page)

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	505334	A. Building B. Wing	11/26/2025

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Life Care Center of Kirkland	10101 Northeast 120th Street Kirkland, WA 98034

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	month. Staff P stated that the list of residents including Resident 94 who were discharged or transferred was sent to the Ombudsman on 11/14/2025. Staff P further stated that the notice of transfer should have been completed for Resident 94 and sent to the Ombudsman office at the beginning of August 2025. In an interview on 11/26/2025 at 10:56 AM, Staff B stated that Resident 94's bed hold notice had not been provided to them and/or their representative, and it should have been. In an interview on 11/26/2025 at 12:46 PM, Staff A stated that it was their expectation that the facility should complete the notice of discharge, provide education on the bed hold policy, issue the bed hold notice and document it. Staff A stated that the facility should have followed its transfer and discharge policy and provided Resident 94 with a bed hold notice. Staff A further stated that the notice of Resident 94's transfer to the hospital should have been sent to the Ombudsman office timely. Reference: (WAC) 388-97-0120 (2) (a-d) (4) (5)(b) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 1 of 21 residents (Resident 5), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure resident assessment was completed accurately on the MDS regarding medications placed the resident at risk for unidentified and/or unmet care needs, and a diminished quality of life.Findings included.According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated in October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period).Resident 5 was admitted to the facility on [DATE].Review of the admission MDS dated [DATE] showed Resident 5's MDS under Section N0415 (High-Risk Drug Classes: Use of Indication) was marked for anticoagulant (a medication that prevents blood from clotting) use during this assessment period.Review of the August 2025 Medication Administration Record (MAR) showed Resident 5 did not receive an anticoagulant medication during the assessment period.During an interview and joint record review on 11/25/2025 at 9:35 AM, Staff K, MDS Coordinator, stated that the facility follows the RAI manual for completion of MDS assessments and they would review residents' MAR to complete section N (Medications) of the MDS. Joint record review of Resident 5's admission MDS dated [DATE] showed that Section N0415 was marked for anticoagulant use. Joint record review of August 2025 MAR showed Resident 5 did not receive anticoagulant medication. Staff K stated that Resident 5 did not receive anticoagulant medication during the assessment period, and that they would modify the MDS.On 11/25/2025 at 12:48 PM, Staff B, Director of Nursing, stated that the facility follows the RAI manual and they expected MDS assessments to be completed accurately.Reference: (WAC) 388-97-1000 (1)(b).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to include the dialysis (a treatment to remove extra fluid and waste when kidneys fail) days, transportation arrangement and contact information of the dialysis center in the comprehensive care plan for 1 of 1 resident (Resident 31), reviewed for dialysis. This failure placed the resident at risk for unmet care needs and a diminished quality of life.Findings included.Review of the facility's policy titled, Area of Focus: Care Planning-Baseline, Comprehensive, and Routine Updates, reviewed on 11/25/2024, showed that after a completion of Minimum Data Set (MDS-an assessment tool), a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs would be developed and implemented for each resident. Review of a face sheet printed on 11/21/2025 showed Resident 31 was admitted to the facility on [DATE].Review of Resident 31's admission MDS dated [DATE] showed it was completed on 09/22/2025.Review of a physician order summary report dated 11/21/2025, showed Resident 31 had scheduled dialysis services at an offsite dialysis center every Mondays and Thursdays from 8:45 AM to 12:45 PM.Review of Resident 31's hemodialysis (a medical procedure used to treat kidney failure by removing waste products and excess fluids from the blood) comprehensive care plan initiated on 09/13/2025 did not include Resident 31's scheduled dialysis days. Further review of the care plan did not show Resident 31's transportation arrangement and/or contact information of the dialysis center.In an interview and joint record review on 11/24/2025 at 11:58 AM, Staff F, Nurse Unit Manager, stated that Resident 31 went to an offsite dialysis center for their hemodialysis and that it was included in their care plan. Staff F stated that dialysis residents that were admitted to the facility had prior transportation arrangement and that they had a binder that contained the dialysis center contact information. A joint record review of Resident 31's comprehensive care plan did not show the scheduled dialysis days, transportation arrangement and the dialysis center contact information. Staff F stated, No, they are not in [Resident 31's] care plan.In an interview on 11/24/2025 at 2:08 PM, Staff B, Director of Nursing, stated that Resident 31's comprehensive care plan should have had information about their scheduled dialysis days, transportation arrangements and contact information of the dialysis center.Reference: (WAC) 388-97-1020(1)(2)(a).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safety hazards such as a lighter and a box cutter were properly stored for 1 of 2 residents (Resident 13), reviewed for accident hazards. This failure placed the resident at risk for injury, and a diminished quality of life.Findings included.Review of the facility's policy titled, Area of Focus: Incident and Reportable Event Management, reviewed on 11/15/2025, showed, The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision . to prevent accidents.Review of a face sheet printed on 11/24/2025 showed Resident 13 was admitted to the facility on [DATE].Review of the quarterly Minimum Data Set (an assessment tool) dated 07/14/2025 showed Resident 13 had intact cognition.Review of the behavior/mood care plan initiated on 05/29/2025 showed Resident 13 keeps items in room that he is aware is against [facility] policy.An observation on 09/28/2025 at 12:43 PM showed a lighter and an object about four to five inches in length with a visible blade that was later described to be a box cutter (a tool with a blade to open and/or cut boxes) on top of Resident 13's bedside table. Resident 13 was not in their room at that time.An observation and interview on 09/28/2025 at 1:31 PM, showed a lighter and a box cutter next to Resident 13's meal tray on their bedside table. Resident 13 stated that they were a smoker until I came here [in a non-smoking facility] and that they used the lighter for burning strings sometimes. Resident 13 stated that their collateral contact brought them a model kit to work on and used the box cutter as their tool. In an interview and joint observation on 09/28/2025 at 2:18 PM, Staff O, Registered Nurse, stated that residents were not allowed to have lighters or any dangerous items in their room. Staff O stated that if they saw these items, they would keep them and would inform the social worker for proper storage. A joint observation of Resident 13's room with Staff O showed a lighter and a box cutter on top of Resident 13's bedside table. Staff O proceeded to take the lighter and the box cutter and stated that they would talk to the social worker.In an interview on 09/28/2025 at 2:26 PM with Staff P, Social Service Director, stated that Resident 13 cannot have lighters or anything sharp with them and that these items should be locked in a storage. Staff P further stated that they have discussed providing a safety box for Resident 13 during their first care conference.In an interview on 11/24/2025 at 1:31 PM, Staff B, Director of Nursing, stated that residents were not allowed to have a lighter or box cutter in their room as these items were considered safety hazards. Staff B stated that staff were expected to observe items in residents' rooms that may pose a safety hazard and remove them when found. Staff B stated that Resident 13 should not have had a lighter and a box cutter in their room.Reference: (WAC) 388-97-1060(3)(g).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate non-pharmacological interventions for pain management prior to administering as needed (PRN) pain medication for 1 of 1 resident (Resident 21), reviewed for pain management. This failure placed the resident at risk for unnecessary medications and incomplete pain control.Findings included.Review of the facility's policy titled, Pain Assessment and Management, revised on 11/11/2025, showed that all residents will be assessed for pain and based on the assessment, the facility in collaboration with the attending physician, other healthcare professionals, and the resident and/or resident representative would develop and implement both pharmacological and non-pharmacological intervention approaches to pain management.Review of the quarterly Minimum Data Set (an assessment tool) dated 09/25/2025 showed Resident 21 was admitted to the facility on [DATE] with diagnosis that included left knee osteoarthritis (a condition in which the protective cushioning at the ends of the bones wears down, causing the bones to rub against each other).Review of Resident 21's physician order dated 07/03/2025, showed an order for Acetaminophen (a medication used to relieve pain) three times a day PRN for pain and/or fever. Further review of the physician order showed instructions for staff to attempt non-pharmacological interventions that included, 1) resting/immobilizing and 2) repositioning prior to administering PRN pain medications.Review of Resident 21's physician order dated 08/25/2025, showed an order for Oxycodone (a narcotic- controlled medication used to relieve pain) every four hours PRN for moderate to severe pain.Review of the September 2025 Medication Administration Record (MAR) showed Resident 21 received PRN Oxycodone without documented evidence that non-pharmacological interventions were attempted on the following dates:09/01/2025, 09/02/2025, 09/03/2025, 09/04/2025, 09/06/2025, 09/07/2025, 09/09/2025, 09/10/2025, 09/11/2025, 09/13/2025, 09/14/2025, 09/15/2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/20/2025, 09/21/2025, 09/22/2025, 09/23/2025, 09/24/2025, 09/25/2025, 09/26/2025, 09/27/2025, 09/28/2025, and on 09/29/2025.In a joint interview and record review on 11/25/2025 at 12:05 PM, Staff E, Nurse Unit Manager, stated that staff should follow the physician's orders and that non-pharmacological interventions should be tried before PRN pain medication administration. Further review of Resident 21's September 2025 MAR showed non-pharmacological interventions were not documented for most dates when PRN pain medications were given.In an interview on 11/26/2025 at 2:05 PM, Staff B, Director of Nursing, stated it was their expectation that staff followed physician orders and that non-pharmacological interventions should have been offered to Resident 21 prior to administering their PRN pain medication.Reference: WAC 388-97-1060 (1).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure controlled medications were accurately reconciled for 1 of 3 medication carts (Olympic Medication Cart), reviewed for controlled medication storage/reconciliation. This failure placed the facility at risk for potential loss and/or drug diversion of the controlled medication.Findings included .Review of the facility's policy titled, Management of Controlled Substances, reviewed on 09/16/2025 showed, The facility will maintain a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation, and the facility conduct a periodic reconciliation.The facility will ensure that the incoming qualified individual and outgoing qualified individual count all controlled substances and other medications with a risk of abuse or diversion at the change of each shift. The policy further showed, .using the Shift Change Controlled Substance Inventory Count Sheet [the facility] reconcile the number of doses remaining in the package to the number of remaining doses record on the Shift Change Controlled Substance Inventory Count Sheet.In a joint observation and interview on 11/24/2025 at 12:47 PM with Staff L, Registered Nurse, showed the controlled medications book for Olympic medication cart, page 114 had one remaining tablet of Oxycodone (a strong prescription painkiller classified as opioid [narcotic]). Further observation of the controlled medication box showed there was no oxycodone medication for page 114 remaining in the box. Staff L stated that they had counted the controlled medications in the locked controlled medication box at the beginning of their shift. Staff L stated the oxycodone was administered by the night shift staff but was not signed out on the controlled medication book. Staff L further stated that the oxycodone should have been signed out on the controlled medication book.In an interview on 11/24/2025 at 2:56 PM, Staff B, Director of Nursing, stated that whenever controlled medications were removed for administration, it should be signed out on the controlled medication book. Staff B stated that if there was any discrepancy in the controlled medication count, they should have been notified immediately. Staff B further stated they expected controlled medications counted and reconciled every shift.Reference: (WAC) 388-97-1300(1)(b)(ii).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure influenza vaccine (used to prevent influenza [an infection of the nose, throat, and lungs]) were offered for 2 of 5 residents (Residents 6 & 10), reviewed for immunizations. This failure placed the residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from influenza disease.Findings included.Review of the facility's policy titled, Influenza Vaccine Policy for Residents, reviewed on 07/08/2025, showed, Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period. It further showed, The resident's medical record included documentation that indicates.that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.RESIDENT 6Review of a face sheet printed on 11/25/2025 showed Resident 6 was admitted to the facility on [DATE] and discharged on 10/23/2025.Review of Resident 6's immunization record dated 03/19/2024 showed that they received an influenza vaccine on 10/22/2019.Review of Resident 6's Electronic Health Record (EHR) under immunization tab, showed Influenza not eligible. Further review of the EHR showed no documentation that Resident 6 was offered the annual influenza vaccine or was informed about the risks and benefits.RESIDENT 10Review of a face sheet printed on 11/25/2025 showed Resident 10 was admitted to the facility on [DATE] and discharged on 11/24/2025.Review of the EHR under immunization tab showed Resident 10 received the influenza vaccine on 10/15/2018. Further review of the EHR showed no documentation that Resident 10 was offered the annual influenza vaccine or was informed about the risks and benefits.In an interview and joint record review on 11/25/2025 at 9:18 AM, Staff D, Infection Preventionist, stated, Influenza vaccine is offered at the start of [the] flu season, October first. A joint record review of Resident 6 and Resident 10's EHR showed no documentation that the influenza vaccine was offered or refused. Staff D stated that Resident 6 and Resident 10 should have been offered the influenza vaccine around first of October but it did not happen.In an interview and joint record review on 11/26/2025 at 2:43 PM, Staff B, Director of Nursing, stated that they offered the influenza vaccine annually on October first to all residents. Staff B stated that if a resident refused when offered the influenza vaccine, they [staff] should document it and provide education to the resident. Joint record review of the EHR for Resident 6 and Resident 10 showed no documentation that they were offered or refused the influenza vaccine. Staff B stated that they expected everybody in the facility should have been offered the influenza vaccine starting October 1.Reference: (WAC) 388-97-1340 (1)(2).