STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION· RESIDENTIAL CARE SERVICES
20816 44thAvenue West, Suite 240 · Lynnwood, WA 98036

06/07/2019

Administrator
Life Care Center Of Kirkland
10101 Northeast 120th
Kirkland, WA 98034

Dear Administrator:

On June 6, 2019, the Department of Social and Health Services (DSHS), Residential Care Services conducted a **post survey revisit** to verify that your facility had achieved and maintained compliance. The deficiencies cited on the **Health** survey(s) were found to be corrected on May 25, 2019.

The Washington State Patrol, Office of the State Fire Marshal (OSFM) has verified that the **LSC survey(s)** deficiencies have been corrected on May 31, 2019.

Based on this information, DSHS will notify the Centers for Medicare and Medicaid Services (CMS) Region X that your facility is in substantial compliance with participation requirements effective May 31, 2019 (latest of 2 or more correction dates), and recommend that your facility's certification for Medicare and/or Medicaid participation continue.

If you have any questions please contact me at (425) 670-6060.

Sincerely,

Patricia Rimar
Field Manager - Region 2, Unit H
Residential Care Services

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 _____	R-C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KIRKLAND	**10101 NORTHEAST 120TH STREET KIRKLAND, WA 98034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Revisit Survey conducted on 06/05/19 and 06/06/19. No deficiencies found.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/17/2019

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.