

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Long Term Care Survey and Complaint Investigation conducted at Life Care Center of Kirkland on 03/27/19, 03/28/19, 03/29/19, 04/01/19, 04/08/19, 04/09/19, 04/10/19 and 04/11/19. A sample of 39 residents was selected from a census of 116. The sample included 36 current residents and the records of 3 discharged residents.</p> <p>The following complaints were investigated as part of this survey: #3633073, #3633540</p> <p>The survey was conducted by: Jomar Balgos, RN, BSN Susan Harris, RN, BSN Ann Lee-Hunter, BA Robin Windhausen, RD, MS</p> <p>The survey team is from: The survey team is from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, Region 2, Unit H 20816 44th Ave. W. #240 Lynnwood, WA 98036</p> <p>Telephone: (425)-670-6040 Fax: (425)-672-2216</p>	F 000			
F 550 SS=E	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and</p>	F 550		5/25/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/05/2019

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 1 outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility</p>	F 550	Preparation and execution of this		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 2</p> <p>failed to provide services in a manner that promoted and maintained residents' dignity. Failure to ensure dining services were provided in a manner which promoted a dignified environment in one of two dining rooms (Baker) could negatively impact the quality of life and appetite of four sample resident's (4, 21, 23, 52) and one non sampled resident (45).</p> <p>In addition, the facility failed to provide care and services in a dignified manner for 2 of 30 sample residents (95, 31), who had thier personal privacy violated. This failure could negatively impact the individual resident's sense of self-worth and quality of life.</p> <p>Failure to maintain a dignified dining experience in the Dining Room:</p> <p>On 04/09/19, the following was observed between 8:45 am - 9:00 AM: At 8:45 am, Resident 52, was seated at a table with a plate of food on the table. Staff Z, a Nursing Assistant, was pulling a bus cart with the dish tubs on it past Resident 52's table. Staff Z stopped momentarily next to Resident 52's table, removed a large square plastic bin (a silverware receptacle) from the cart, and placed it on the table making a loud thud. The bin was placed directly across from Resident 52's place setting while the resident was still engaged in breakfast.</p> <p>Staff Z, who was wearing gloves, continued to pull the cart between the tables, stopping at empty place settings and scraping food scraps from plates into a garage can that was attached to the cart, loudly stacking the dishes in the bins. Three residents who remained in the dining room</p>	F 550	<p>response and Plan of Correction do not constitute an admission or agreement by the provider or signer of the truth or accuracy of the alleged facts or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. This Plan of Correction is not an admission of non-compliance with the cited regulation(s).</p> <p>This Plan of Correction constitutes the provider's written credible allegation of compliance for the deficiencies noted.</p> <p>Identified residents: Residents #4, 21, 23,31,45,52, and 95 were assessed and care plans updated to include preferences of dining and clothing choices. Staff D and C were educated on Residents rights and preferences. Staff Z is no longer at the facility.</p> <p>Identification of others:</p> <p>All residents could be potentially affected by the identified practices. Staff to assist in the dining rooms will be provided training and education on the facilities dining experience and customer service. Staff will be provided training and education on resident rights and preferences.</p> <p>Residents and families will be interviewed regarding clothing and dining experience choices.</p> <p>Managers are to be assigned in the dining rooms to ensure facility dining room experience and customer service.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 3</p> <p>at three different tables were approached by Staff Z, after clearing, scraping and staking the dishes at empty place setting at each separate table.</p> <p>After clearing dishes, scraping food items, stacking the dirty dishes at Resident 23's table. Staff Z began clearing dishes at Resident 23's place setting, while the resident was still seated at the table.</p> <p>Staff Z, then repeated the same actions at the table, where Resident 21 was seated. Staff Z then approached Resident 4's table and repeated the same actions. Resident 4 was the last resident to leave the dining area, at approximately 9:00 AM.</p> <p>Scraping food garbage into a receptacle at the table side, while residents were still seated and engaged in meals, which could negatively impact a resident appetite. In addition, the loud dish noises could disrupt the dining experience.</p> <p>A similar observation occurred during the observation of the noon meal on 04/09/18,</p> <p>On 04/09/19 at 1:00 PM, three sample residents (21, 23, 52) and one non sample resident (45) remained seated at the table eating. Staff Z, was observed to clearing, scraping and stacking dishes, by moving the cart next to the table.</p> <p>After clearing the dishes from empty place settings, Staff Z, then began to take dishes from Resident 23's place setting, A similar pattern of actions, was noted when the staff approached Resident 20's table, Resident 52's table, and Resident 21's table.</p>	F 550	<p>Nurse Managers will conduct daily observation rounds to ensure resident rights for dignity of clothing preferences. Systemic Changes: The facility Resident Care Managers or designee will implement observation rounds and maintain a checklist for resident rights for preferences to be used in the review at daily meetings. Ongoing monitoring The administrator and Resident Care Managers or designee will observe residents in their rooms regarding resident rights for dignity and preferences. Audits conducted weekly x4 and monthly x2. Negative findings of these audits will be presented to QAPI committee monthly x3 months for identification of needed education and training. Responsible for compliance: Administrator or designee</p> <p>May 20, 2019</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 4</p> <p>At 1:10 PM, Staff Z was interviewed as she exited the dining room. When asked if training, was provided on how to clear the dishes from tables, she said, "I ask before taking the dishes."</p> <p>On 04/09/19 at 1:15 pm, Staff T, the Assistant Food Service Manager was asked if training was provided to staff, who bus the dining room tables. He explained the housekeeping staff assist with the task. After sharing information about the observations, Staff T agreed the task could be completed in a different way to maintain more a dignified environment in the dining room. Failure to provide care and service in an environment that promotes privacy and dignity;</p> <p>RESIDENT 95 Resident 95 was admitted to the facility on [REDACTED] 18 for rehabilitation therapy. The resident's diagnoses list included: [REDACTED] [REDACTED] nd [REDACTED].</p> <p>The last quarterly Minimum Data Set (MDS) assessment, dated 03/13/19, showed the resident had severe cognitive impairment and needed extensive assistant from one staff with dressing and grooming.</p> <p>The resident's care plan, dated 09/25/18, showed the resident had an "ADL self-care performance deficit related to Dementia and weakness."</p> <p>During observations on 03/27/19 at 10:15 AM and at 11:48 AM, the resident was observed in bed with the lower body uncovered and exposed.</p>	F 550			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 5</p> <p>The resident's incontinent brief was visible from the hallway and upon entering the resident's room.</p> <p>During a joint observation and interview on 03/28/19 at 8:31 AM with Staff D, Nursing Assistant (NA) and Staff C, Registered Nurse, (RN) the resident was observed in bed with dry skin on (face, arms and legs) with cracked/dried lips. The resident was not wearing any lower body clothing, except for an incontinent brief.</p> <p>During an interview on 04/08/19 at 1:38 PM, the Director of Nursing stated that residents should be fully dressed and should be covered and provided with privacy at all times. The DNS stated she would immediately follow-up with staff to address the observed concern.</p> <p>RESIDENT 31 Similar findings were applicable to Resident 31.</p> <p>Resident 31 was a long term resident of the facility. The resident's diagnoses list included: [REDACTED]</p> <p>The quarterly MDS assessment dated 01/27/19, showed the resident was "rarely/never understood" and needed one person assistance with dressing and personal hygiene needs.</p> <p>The resident's care plan, dated 11/15/18, showed the resident had an "ADL (activities of daily living) self-care performance deficit related to the resident's history of motor-vehicular accident with traumatic brain injury and quadriplegia.</p>	F 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 6 During observations on 03/27/19 at 10:23 AM, 03/28/219 at 9:22 AM, and 04/08/19 at 9:23 AM, the resident was observed in bed with the lower body exposed and uncovered. The resident's incontinent brief and lower body was visible from the hallway and upon entering the resident's room. The facility did not ensure these two residents who could not speak for themselves were provided care and services in a manner that enhanced dignity. Given a reasonable person's point of view, someone a similar situation would likely experience feeling of humiliation, embarrassment and poor sense of well-being.	F 550			
F 561 SS=E	Reference: (WAC) 388-97-0180 (2)(3) Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 10101 NORTHEAST 120TH STREET KIRKLAND, WA 98034		
(X4) ID PREFIX TAG F 561	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 561	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Continued From page 7</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to honor personal bathing frequency choices for 4 of 4 residents (90, 6, 71 and 37) reviewed for important daily life choices. This failed practice had the potential to diminish the resident's psychosocial well-being and overall quality of life.</p> <p>Findings included...</p> <p>Review of the facility's "Resident Admission Agreement," last updated 2018, showed under Section 11, Resident Rights: "25. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care."</p> <p>RESIDENT 90 Resident 90 admitted to the facility on [REDACTED]/18. According to the Quarterly Minimum Data Set (MDS) assessment dated 03/10/19, the resident had mildly impaired cognitive status. The assessment indicated the resident was total</p>		<p>Identified residents: Resident #90 is being given showers per her preferences. Shower schedule updated as indicated Resident # 6 is being given showers per her preferences. Shower schedule updated as indicated Resident # 37 is being given showers per her preferences. Shower schedule updated as indicated Resident # 71 is being given showers per her preferences. Shower schedule updated as indicated</p> <p>Identification of others: An audit was conducted for the past 14 days from April 14 thur the 28th□s documentation in point of care to determine if resident□s preferences for bathing/showering were being followed. Bathing/showers were reoffered if indicated and shower schedule updated. Systemic Changes: " SDC or designee educated Licenses staff on resident rights and preferences</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	<p>Continued From page 8 dependence of one staff for bathing.</p> <p>A review of the resident's current care plan for bathing/showering showed, "The resident requires extensive assist by 1 staff with showering 2 times a week and as necessary. Prefers female only."</p> <p>A review of the shower documentation in the electronic record showed for the dates of March 12, 2019 through April 9, 2019 (30 day look back) the resident received four showers and one documented refusal to shower.</p> <p>In an interview on 04/09/19 at 3:20 PM with Resident 90, stated, she did not receive her two showers per week, and if she refused due to having a male caregiver, the staff do not reschedule her. She further stated "One shower a week is not enough."</p> <p>In an interview and shower documentation review on 04/09/19 at 3:15 PM with Staff Q, Registered Nurse/Resident Care Manager (RN/RCM), Staff Q stated that if the resident refused a shower, it should be documented and rescheduled for a different day, and that reschedule should be documented.</p> <p>RESIDENT 6 Resident 6 was admitted to the facility on [REDACTED] 18 for rehabilitation therapy. The resident's diagnoses list included [REDACTED] and [REDACTED]</p> <p>A review of the resident's quarterly Minimum Data Set (MDS) assessment dated 12/31/18, showed the resident needed one person assistance with personal hygiene and bathing.</p>	F 561	<p>regarding bathing/showering and importance of monitoring that showers are given per preferences. " All new admits will be offered shower/bathing per their preferences. Care plan /Kardex updated as indicated. Ongoing monitoring The RCMs or designee will audit point of care weekly x 4 then monthly to determine residents are given showers per their preferences. Negative findings will be reported to QAPI for review until substantial compliance is determined. Responsible for oversight DON</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	<p>Continued From page 9</p> <p>The MDS also showed it was "very important" for the resident to choose between a shower, bed bath or sponge bath.</p> <p>Review of the resident's care plan and care directives (Kardex) dated 10/10/18, showed the resident's preference was to receive showers at least twice per week.</p> <p>In an interview on 03/27/19 at 9:39 AM, the resident stated she was not getting her showers regularly. The resident also stated that she would like to have two showers per week especially when it gets hot because "you feel dirty."</p> <p>Review of the resident's shower documentation from 02/28/19 to 03/28/19, showed the resident missed showers from the week of 03/03/19 to 03/10/19 and only received one shower per week from 03/14/19 to 03/28/19.</p> <p>RESIDENT 71 Resident 71 was a long term resident of the facility. The resident's diagnoses list included [REDACTED] and [REDACTED]</p> <p>A review of the resident's quarterly MDS assessment dated 03/01/19, showed the resident needed one person assistance with personal hygiene and bathing. The MDS also showed it was "very important" for the resident to choose between a shower, bed bath or sponge bath.</p> <p>Review of the resident's care plan and care directives dated 09/14/18 (revised on 12/07/18) showed the resident's preference was to receive showers at least once a week.</p>	F 561			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	<p>Continued From page 10</p> <p>In an interview on 03/28/19 at 11:01 AM, the resident stated, she would like to get a shower at least once a week but "she's (the shower aide) forgetful." The resident stated that her shower schedule was every Tuesday, but "I am not getting it." The resident further stated sometimes she "feels dirty."</p> <p>Review of the resident's shower record from 03/05/19 to 04/05/19 showed the resident only received two bed baths in the past 30 days, and not a weekly shower as desired.</p> <p>In an interview on 04/08/19 at 1:22 PM, the Director of Nursing stated that the expectation was to honor the resident's preferences and to provide at least one to two showers per week for each resident as requested/desired.</p> <p>RESIDENT 37 Resident 37 was admitted to the facility on [REDACTED] 19 for rehabilitation after a fall and a fracture. The quarterly MDS assessment, dated 01/29/19, indicated the resident needed physical assistance from one staff member for showers.</p> <p>On 03/27/19 at 2:09 PM, during an interview Resident 37 stated the facility provided one shower a week and stated she wanted more than one a week. The resident explained prior to her recent hospitalization, she lived alone in the community and showered daily. The resident stated she did not recall being asked by the facility about bathing preferences.</p> <p>The care plan, initiated 01/11/19, noted the resident preference for showers is morning, required total assistance of 1 staff, and</p>	F 561			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	<p>Continued From page 11 documented the resident received two showers a week or more if needed.</p> <p>During a follow up interview on 04/09/19 at 9:10 AM, Resident 37 reiterated she only received assistance with one shower a week. When asked about assistance provided for showers, she reported staff provided set up assistance, getting the supplies, and escorted her to the shower room.</p> <p>On 04/08/19, the bathing records for the past 30 days were reviewed (between 3/10/19 and 04/07/19). The record found multiple entries which conflicted, such as on 3/20/19, the staff documented a "shower" with a check mark and also noted with a check mark "the activity did not occur, family or non-facility staff assisted." Similar entries were found on 12 occasions, when the staff documented a shower and then noted the activity did not occur/ or the resident received assistance from family or a non staff person. The record did show the resident did get set-up help for two showers on 03/19/19 and 04/02/19 during the 30 day look back period.</p> <p>On 04/09/19 at 12:20 PM Staff O, the MDS Coordinator was interviewed about the care plan and documentation in the task sheet. The provide two showers a week was implemented when the resident resided in the Medicare area, she explained residents in the long-term care area get one shower a week.</p> <p>She then opened up the task sheet (which contains individualized interventions for each resident to the direct care staff) and stated the resident was scheduled for one shower a week</p>	F 561			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 12 on Wednesday. When asked why the care plan was not updated, she explained the resident was not due for a quarterly assessment until April. After reviewing the 30 day look back period documentation, she agreed the documentation was conflicting.	F 561			
F 584 SS=E	Reference: (WAC) 388-97-0900 (1) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	<p>Continued From page 13 resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents environment was homelike and provide the necessary maintenance services in resident rooms and other common areas. These failures placed residents at risk for harm and diminished quality of life.</p> <p>Findings included...</p> <p>RESIDENT 80 During an observation on 03/28/19 at 2:12 PM, the resident's room was observed with the following:</p> <p>A. A broken bedside wall frame and cork board. The frame was hanging with exposed sharp edges at the bottom of the frame. B. The bathroom door had a 4-5 centimeter (cm) length by 4-5cm wide hole/broken center piece. C. Over-bed light and covering was broken. The cover was hanging right on top of the resident's bed. D. Boxes and other personal items were placed in-front of the wall heater. The wall heater</p>	F 584	<p>Identified residents: Resident #80 wall frame and cork board was replaced. Items removed from in front of the heater. The bathroom door and the over the bed light were fixed. Resident rooms #5, 19, 20,23,24,25, 57 and shower room have been fixed regarding scuffed walls, doors and door frames. Resident similar situations: All residents could be affected by the identified practice. Environmental rounds were conducted on resident's rooms to ensure homelike environment. Systemic Changes: The Executive Director or designee will educate all department staff on Homelike environment and reporting maintenance concerns in facility work order system Tels. The staff will be trained and educated to use the facility work order system Tels to place maintenance concerns. Ongoing monitoring</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 14 showed a sign that stated, "No item in front of the heater." E. The resident room was not homelike. The room was not personalized, no decorations, pictures or any indication the room was individualized for the resident. In an interview on the time of the observation, the resident stated those items, such as her cork board, over-bed light and bathroom door has been broken for a while and she doesn't know how to fix it. The resident also stated that she would like to have more decorative items in her room "and some pictures." The resident further stated that she was "worried it may fall over her face" (referring to the broken over-bed light cover). DOORS AND PHYSICAL PLANT Observations were conducted on 03/27/19 to 04/11/19: Observations revealed scuffed walls, scraped door and door frames for the following rooms: Room 5, 19, 20, 23, 24, 25, shower room/long-term hall (across room 27) and room 57. During a joint observation and interview on 04/11/19 at 10:01 AM, Staff H, Maintenance Director acknowledged the above findings and stated he would immediately work and fix the following concerns.	F 584	Resident Care Managers or designee will audit residents rooms regarding Homelike environment and complete environmental rounds to ensure all maintenance concerns are reported timely audits conducted weekly x4 and monthly x2. Negative findings of these audits will be presented to QAPI committee monthly x3 months for identification of needed education and training. Responsible for oversight Director of Nursing or designee		
F 604 SS=D	Reference: WAC 388-97-0880 (1)(2) Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 15</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess and monitor the need of physical restraints for 3 of 4 residents (95, 56 and 31) reviewed for physical restraints. Additionally, the</p>	F 604	<p>Identified residents: Resident # 95 no longer resides in the facility Resident # 56 was reassessed for the need of a physical restraint. Pillows were</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 16</p> <p>facility failed to document ongoing re-evaluation for the need of the restraint. These failures placed residents at risk for harm and diminished quality of life.</p> <p>Findings included...</p> <p>The Centers for Medicare and Medicaid Services (CMS) defined Physical Restraints as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual Appendix PP)."</p> <p>A review of the facility policy titled, "Restraint and Position Change Alarm Use" dated 11/2017, showed "The intent is for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical restraints for discipline or convenience, prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity, and limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints."</p> <p>The policy defined convenience: "The result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest" and Freedom of movement "any change in place or position for the body or any part of the body that the person is physically able to control."</p>	F 604	<p>removed from being tucked and layered under the right side of the bed creating a barrier. A comprehensive assessment was completed to determine appropriateness of bed against the wall, bilateral bed bolsters and bed being in the lowest position to the ground. physician order and consent obtained and resident's care plan and Kardex were update as indicated. A clinical progress note was written in resident's medical record to convey a reduction or continuance of device and appropriateness of use.</p> <p>Resident # 31 was reassessed for the need of physical restraints. Therapies reevaluated resident for the appropriateness of tilt and space wheelchair, seat belt in wheelchair and bilateral side rails to determine justification of use. Residents care plan and Kardex was updated as indicated. A progress note was written in resident's clinical medical record to convey justification of a reduction or continuance of device and appropriateness of use.</p> <p>Identifications of other residents: All residents currently in the facility that use a device, material or equipment attached or adjacent to the body that they cannot move easily or restricts their freedom of movement will have a comprehensive assessment to determine reduction, alternative method or if continual use is necessary. A physician order and assessment will be placed in the medical record if indicated. The Care Plan and Kardex will be updated with</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	Continued From page 17 The policy directed the facility staff to: 1. A physician order was required for the use of the specific type of restraint. The order should include the specific type of restraint, the condition and/or medical symptom that warrants restraint use, where and how the restraint is to be applied and used, and the time and frequency the restraint should be released. "The physician's order alone, without supporting clinical documentation, is not sufficient to warrant the use of a restraint." 2. The use of restraint must be individualized and must be based upon the resident's condition and medical symptoms that must be treated. "The care plan is revised as needed and must include: A. The specific type of restraint; B. The resident's condition and medical symptom(s) that warrant restraint use; C. The length of time the restraint is anticipated to be used to treat the medical symptoms; D. The identification of who may apply and release the restraint; E. Where and how the restraint is to be applied and used, F. The time and frequency the restraint should be release; G. The type of specific direct monitoring and supervision provided during the use of restraint; H. Identification of how the resident may request staff assistance and how needs will be met during use of the restraints, such as for re-positioning, hydration, meals, using the bathroom and hygiene; I. Measures to reduce the risk of negative outcomes related to restraint use including, but not limited to: skin breakdown, loss of mobility or range of motion, loss of dignity, confusion, fear, agitation, anxiety, or irritation in response to	F 604	changes. Systemic changes: " SDC or designee will in service Licenses staff on the facility policy regarding restraints. Titled <input type="checkbox"/> restraints and position change/alarm use " LN will be educated on doing comprehensive assessments and monitoring of restraint or potential restraint devices quarterly, change of condition, upon implementation of device and annually. Ongoing monitoring: The RCM/designee will monitor and audit for appropriate comprehensive assessments, care plan and Kardex and use of resident <input type="checkbox"/> s requiring adaptive equipment or restraints on admission, change of condition, quarterly and annually. Finding will be reported to QAPI for review until substantial compliance is determined Responsible for oversight: DON		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 18 restraint use.</p> <p>3. "Documentation must include: An active plan to decrease usage or for the eventual removal of the restraint."</p> <p>RESIDENT 95 Resident 95 was admitted to the facility on [REDACTED]/18 for rehabilitation therapy. The resident's diagnoses list included [REDACTED] and [REDACTED].</p> <p>A review of the resident's quarterly MDS assessment, dated 03/13/19, showed the resident had severe cognitive impairment and needed one person assistance with bed mobility and two person physical assistance with transfers. The MDS also showed the resident was not currently using any form of physical restraints.</p> <p>During several observations on 03/27/19 at 10:15 AM and 03/27/19 at 11:48 AM, the resident was observed in bed. The resident's bed was against the wall (left side of the resident), was positioned in the lowest position, close to the ground, and with bilateral bed bolsters. Additionally, there were three pillows tucked and layered under the right side of the mattress causing a large barrier bump. The resident was observed attempting to move to the right side of the bed, but was not able to move, turn, or reposition in bed because of the large bump in the mattress due to pillows underneath the mattress.</p> <p>During a joint interview and observations on 03/28/19 at 8:31 AM with Staff D, Nursing</p>	F 604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 19</p> <p>Assistant (NA) and Staff C, Registered Nurse, (RN), the resident was observed on the same position as above. The resident's bed was against the wall (left side of the resident), was positioned in the lowest position/close to the ground with bilateral bed bolsters and there were three pillows tucked and layered under the right side of the mattress causing a large barrier bump. Both the staff members stated that they used the pillows and tucked it in under the mattress because the resident constantly tried to get up and get out of bed. Both Staff D and Staff C stated that the resident was "a frequent faller" and the pillows would help to "avoid her from getting up" and "it would make it harder for her (Resident 95) to get up."</p> <p>Review of the resident's clinical records (Physician order sheets, Assessments and Evaluations, care plan and clinical progress notes (both electronic and hard chart), showed no evidence that the facility had comprehensively and accurately assessed the resident's condition that would warrant use of restraints for the purpose of convenience. The resident's clinical records showed the resident had at fallen 16 times (2 times for the month of March 2019) and the resident was either found "on the floor next to the bed" and/or had "rolled out bed." (Refer to F689 - Free of Accident Hazards/Supervision/Devices for more information.)</p> <p>RESIDENT 56 Resident 56 was a long term resident of the facility. The resident's diagnoses list included [REDACTED] and [REDACTED]</p>	F 604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 20</p> <p>A review of the resident's quarterly MDS assessment dated 02/13/19, showed the resident had impaired cognition and needed one person assistance with bed mobility and transfers. The MDS also showed, the resident was not currently using any form of physical restraints.</p> <p>During several observations on 03/27/19 at 9:46 AM and 03/28/19 at 8:23 AM, the resident was observed in bed alone. The resident's bed was against the wall (left side of the resident), was positioned in the lowest position/close to the ground and with bilateral bed bolsters. Additionally, there were three pillows tucked and layered under the right side of the bed causing a large barrier bump. The resident was observed attempting to stand up but was not able to move, turn and/or reposition in bed because of the pillows underneath the bed.</p> <p>In an interview at the time of observation on 03/28/19 at 8:23 AM, the resident stated "it was difficult for her to move even turn in bed when they do that (referring to the pillows under the right side of the bed.)"</p> <p>During a joint observation and interview on 03/28/19 at 8:25 AM with Staff E, NA, the resident was observed on the same position above. Staff E stated, the pillows were used to help "prevent the resident from getting out of bed."</p> <p>Review of the resident's clinical records (Physician order sheets, Assessments and Evaluations, care plan and clinical progress notes (both electronic and hard chart), showed no evidence that the facility had comprehensively</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 21 and accurately assessed the resident's condition that would warrant use of restraints for the purpose of convenience.</p> <p>In an interview on 04/08/19 at 1:38 PM, the Director of Nursing (DNS) stated that putting pillows to prevent the resident from getting out of bed was not acceptable practice and could be considered restraints. The DNS stated she would immediately follow-up with the staff to address this concerns.</p> <p>RESIDENT 31 Resident 31 was a long term resident of the facility. The resident's diagnoses list included: [REDACTED] and [REDACTED].</p> <p>A review of the resident's quarterly MDS assessment dated 01/27/19, showed the resident was "rarely/never understood" and needed two person assistance with bed mobility and transfers. The MDS also showed the resident was not currently using any form of physical restraints.</p> <p>Review of the resident's care plan dated 11/15/18, showed the resident had deficit in performing activities of daily living (ADL's) related to TBI, Quadriplegia, Spastic Extremity and Trunk movements ..." The care plan interventions included use of: "Tilt and space wheelchair with self-release seatbelt for supportive device to keep patient upright and positioned safely" and "Unable to use call bell, provide frequent visual checks." The care plan also showed the resident needed bilateral grab bars "when in bed for</p>	F 604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 22</p> <p>Resident 31 to grab during care. This helps prevent him from hitting staff and assists with turning."</p> <p>Review of the "Restraint - Physical (Quarterly/Annual Evaluation)" dated 02/12/19, showed the reason for restraint use were "agitated behaviors, sliding out of chair/wheelchair and unbuckles seatbelt." The evaluation also documented, "3. Describe attempts to reduce restrain use over the past quarter: none attempted" and "D. Recommendations: Resident to continue restraint/safety belt in wheelchair." The resident's use of Tilt and Space Wheelchair and bilateral side rails/mobility bards were not discussed and/or reviewed on this evaluation. The assessment and evaluation form were missing key information to justify continued use of the restraints as directed by the facility policy.</p> <p>Review of the resident's current Physician order sheet for March 2019 showed no specific orders for the resident's continued use of Tilt and Space wheelchair, seat belt, and bilateral side rails/mobility bars and were missing key information to justify continued use of the restraints as directed by the facility policy. (Refer to F700 - Bed Rails for more information.)</p> <p>During several observations on 03/28/19 at approximately 10:00 AM, 03/28/19 at approximately 12 noon, and on 04/08/19 at 11:20 AM, the resident was observed sitting in his tilt and space wheelchair, alone in his room. The wheelchair was tilted back at 20 degrees measured using a protractor (a measuring device/instrument). The resident was observed</p>	F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	<p>Continued From page 23</p> <p>with his seatbelt on. The resident was non-verbal, not able to follow simple commands from the surveyor, and had a soft splint placed on his [REDACTED]. The resident was not able to touch, hold or release his seatbelt during these observations (when asked by the surveyor). The resident was not able to physically call for help and assistance, and no call light was in place during these observations.</p> <p>During several staff interviews on 03/28/19 at approximately 10:00 AM with Staff D, NA and Staff I, Licensed Practical Nurse (LPN), and on 03/28/19 at approximately 12 noon with Staff A, RN/Resident Care Manager, each stated the resident "sometimes" removed the seatbelt "but not all the time." Each staff members stated that the resident will continue to slide in the wheelchair, even with the use of the seatbelt.</p> <p>During a joint observation and interview on 04/08/19 at 11:25 AM with Staff O, RN/MDS Coordinator and Staff P, LPN/MDS Coordinator, both staff had attempted to talk to the resident and asked the resident to either touch, press and release the seatbelt, but was not successful (in terms of the resident following their request). The resident was not able to follow the simple commands given by each staff members.</p> <p>Further review of the resident's clinical records (Physician order sheet from both the current (Point Click Care) and previous (Soft-Care) electronic medical records, Assessments and Evaluations (both electronic and hard chart), care plan and clinical progress notes showed no evidence that the facility had comprehensively and accurately assessed the resident's condition</p>	F 604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 604	Continued From page 24 for the continued use of the seatbelt. The clinical records showed no evidence of documentation an individualized approach that showed detailed assessment, specific plan to reduce and when to remove the restraint, and other supporting documentations for continued use and monitoring of the physical restraint as directed by the facility's own policy.	F 604			
F 641 SS=E	Reference: (WAC) 388-97-0620 1(a)(b) 2(d) 4(a)(b)(c) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for three of 30 residents (115, 4, 31). This failure placed residents at risk for unidentified and/or unmet needs. Findings included... RESIDENT 115 Resident 115 discharged from the facility [REDACTED] 19. Per a progress note, dated [REDACTED]/19, the resident discharged to home. The Discharge Return Not Anticipated MDS assessment Section A2100, dated 03/02/19,	F 641	Identified residents: Resident # 115 no longer resides in the facility Resident # 4's MDS was modified for accuracy of oral/denture status Resident # 3's MDS was modified related to the resident's use of seat belt and physical restraints Identification of other residents: The last 30 day OBRA MDS assessment sections for section P, L and Q where reviewed for accuracy and modified as indicated. Systemic Changes: The MDS nurses were educated on MDS assessment and accuracy Ongoing monitoring: The DON/designee will review random	5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 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 641	<p>Continued From page 25 identified Resident 115 as being discharged to an [REDACTED].</p> <p>In an interview and joint record review on [REDACTED]/19 at 1:04 PM, Staff J, Registered Nurse (RN)/MDS Coordinator, stated the MDS entry was an error, as Resident 115 discharged to home.</p> <p>RESIDENT 4 Resident 4 was a long term care resident of the facility. The resident's diagnoses list included: [REDACTED] and [REDACTED].</p> <p>During an observation and interview on 02/27/19 at 11:02 AM, the resident stated he had a denture that did not fit and it kept "falling off." The resident stated that both his upper and lower dentures were ill-fitting, and the facility was aware, but "they told me it's hard to fix." The resident further stated that he could not recall when the last time he saw a dentist and "It does affect my ability to chew or eat my food."</p> <p>A review of the resident's annual MDS assessment, dated 12/28/18, showed the resident had mild-moderate cognitive impairment and needed one person assistance with personal hygiene.</p> <p>The MDS assessment also showed discrepancies related to the resident's dentition and inaccurately coded the resident's ill-fitting dentures.</p> <p>During an interview and record review on 04/09/19 at 11:51 PM, staff O, RN/MDS coordinator stated she was not aware of the resident's loose, ill-fitting dentures, and she would follow-up to ensure that Resident 4 will</p>	F 641	<p>OBRA MDS assessments sections P, L, and Q weekly for 4 weeks and then monthly for 2 months and reported results to QAPI for review until substantial compliance is determined</p> <p>Responsible for compliance DON</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 641	<p>Continued From page 26 have an accurate MDS coding. (Refer to F791 - Routine/Emergency Dental Services for more information.)</p> <p>RESIDENT 31 Resident 31 was a long term resident of the facility. The resident's diagnoses list included [REDACTED] and [REDACTED].</p> <p>During several observations on 03/28/19 at approximately 10:00 AM, 03/28/19 at approximately 12 noon, and 04/08/19 at 11:20 AM, the resident was observed on his tilt and space wheelchair alone in his room. The resident wheelchair was tilted back at 20 degrees measured using a protractor (a measuring device/instrument). The resident was observed with his seatbelt on. The resident was non-verbal, not able to follow simple commands from the surveyor, and had a soft splint placed on his [REDACTED]. The resident was not able to touch, hold and/or release his seatbelt during these observations when asked by the surveyor. The resident was not able to physically call for help and assistance and no call light was in place during these observations.</p> <p>A review of the resident's quarterly MDS assessment dated 01/27/19, showed the resident was "rarely/never understood" and needed two staff person assistance with bed mobility and transfers. The MDS assessment also showed discrepancies related to the resident's use of seat-belt and physical restraints as it was not coded/identified.</p>	F 641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 641	Continued From page 27 During a joint observation and interview on 04/08/19 at 11:25 AM with Staff O, RN/MDS Coordinator and Staff P, LPN/MDS Coordinator, both the staff members had attempted to talk to the resident and asked the resident to either touch, press and release the seatbelt but was not successful. The resident was not able to follow the simple commands given by each staff members. (Refer to F604 - Physical Restraints for more information.)	F 641			
F 646 SS=D	Reference WAC 388-97-1000 (1)(b) MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 4 of 5 residents (74, 55, 90, 37) Preadmission Screening and Resident Review (PASRR) assessments were completed for residents with newly evident or possible serious mental disorders. This failure potentially resulted in a delay of access to additional mental health services. Findings included... RESIDENT 74 Resident 74 admitted to the facility [REDACTED]/18.	F 646	Identified residents: Resident #90 PASARR was reassessed and updated then sent for review Residents #74, 55, and 37 no longer resides in the facility Identification of others: All residents could be affected by identified practice. Audits completed for residents with new mental illness and changes in medication to ensure new or updated PASARR was completed and sent for review. Systemic Changes:	5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 646	<p>Continued From page 28</p> <p>Diagnoses on the medical record face sheet identified major [REDACTED] and [REDACTED]. Both diagnoses' onset date were listed as 05/03/18.</p> <p>The Admission PASRR, dated 05/03/18, Section 1 A, Serious Mental Illness (SMI), did not identify Resident 74 with an SMI, and there were no behaviors exhibiting serious functional limitations.</p> <p>Physician notes dated 11/23/18 identified Resident 74 with depression. The physician ordered an antidepressant medication to treat the depression, beginning 11/23/18.</p> <p>Physician notes dated 12/17/18 identified Resident 74 with agitation and depressed affect. The physician ordered an antipsychotic medication to treat the agitation, beginning 12/17/18.</p> <p>Review of the current physician orders, dated 04/01/19, found Resident 74 continued to be administered the antipsychotic and antidepressant medications.</p> <p>In an interview and joint record review on 04/09/19 at 1:43 PM, Staff K, Social Services Director (SSD), said the PASRR should have been updated because it did not accurately reflect the resident's status. RESIDENT 55 Resident 55 admitted to the facility on [REDACTED] 18, for skilled rehabilitation following a stroke.</p> <p>The Admission PASRR, dated 10/16/18, Section</p>	F 646	<p>Social Services will audit medication orders to ensure changes in mental illness is updated on the PASRR timely</p> <p>Ongoing monitoring</p> <p>Social Services or designee will audit residents with new mental illness diagnosis or changes in medications in antipsychotic for new / updated PASRR. Audits will be conducted weekly x4 and monthly x2. Negative findings of these audits will be presented to QAPI committee monthly x3 months for identification of needed education and training.</p> <p>Responsible for oversight Social Services or designee</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 646	<p>Continued From page 29</p> <p>1 A, did not identify Resident 55 with any SMI, and there were no behaviors exhibiting serious functional limitations.</p> <p>A review of the medical record showed, on 02/18/19 during his stay at the facility, the resident received a diagnosis of [REDACTED].</p> <p>A review of the physician orders showed the resident was started on an antidepressant to treat his depression. Further review showed the dosage was increased twice during his stay.</p> <p>In a joint interview and record review on 04/09/19 at 1:46 PM with Staff K, SSD, stated the PASRR needed to be updated due to a new diagnosis of [REDACTED] and [REDACTED].</p> <p>RESIDENT 90 Resident 90 admitted to the facility on [REDACTED]/18 with diagnoses that included [REDACTED] and [REDACTED].</p> <p>A review of the Admission PASRR, dated 12/08/18, completed by the hospital did not identify Resident 90 with any SMI and no behaviors exhibiting serious functional limitations. Further review of the record showed Staff K, SSD, completed a new PASRR dated 12/17/18 to correct the PASRR completed by the hospital, but only added the diagnosis of [REDACTED] and [REDACTED].</p> <p>A review of the resident's current care plan for behaviors showed "behaviors related to</p>	F 646			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 646	<p>Continued From page 30</p> <p>ineffective coping secondary to perceived fears of obtaining UTI [urinary tract infection] by sharing bathroom. Making unsubstantiated allegations against staff due to feelings they are favoring others. Trying to take over the shared room. Unrealistic expectations with staff and who can care for her." The interventions directed staff to "when taking care of [Resident 90] try if able to have two staff members if possible. If appears to upset her have one person tend to roommate while you are interacting with her. [Resident 90] has a tendency to misinterpret peoples intentions. If she gets upset. Excuse yourself if safe, notify nurse and reapproach or change care givers."</p> <p>A review of the facility form "Monthly Behavior Summary" for March showed, the resident was taking an antidepressant for depression. The target behaviors described "A) Inappropriate response/comments. B) Chasing staff to assist her." Interventions/Plan of action for staff stated "Engage in positive interactions, check in/initiate care. Do not argue during interaction, two on one care if needed. Ombudsman involved."</p> <p>In a joint interview and record review on 04/09/19 at 1:46 PM with Staff K, SSD, stated, "I should have updated the PASRR to indicate the resident is having functional limitations and requested a level II evaluation."</p> <p>RESIDENT 37 Resident 37 was admitted to the facility on [REDACTED]/19, after experiencing a fall and sustaining a fractured pelvis. The PASRR screening form found in the clinical record noted the resident had a diagnosis of [REDACTED].</p>	F 646			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 646	Continued From page 31 Review of the clinical record found the Resident also had a diagnosis of [REDACTED] and [REDACTED] [REDACTED] however the diagnosis was not identified on the PASRR. On 03/28/19 at 9:22 AM, Staff K, the Social Services Director, stated the PASRR was completed by hospital staff. Staff K stated that she checks at the time of admission to make sure the form has been completed and is accurate and update it if needed. After reviewing Resident 37's PASRR, she stated it did not accurately identify the resident diagnosis.	F 646			
F 656 SS=E	Reference WAC 388-97-1975 (1)(7) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 32</p> <p>provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to develop and consistently implement resident person-centered care plan for eight of thirty residents (51, 31, 95, 4, 71, 56, 46, and 70) reviewed for care plan comprehensive care plan and care plan implementation. These failures placed resident's at risk for not receiving needed care and services and unmet care needs.</p> <p>Findings included...</p> <p>RESIDENT 51</p>	F 656	<p>Identified residents:</p> <p>Resident # 95 no longer resides in the facility. She was discharged to the hospital on [REDACTED]/19 and planned to discharge from the hospital to her daughters' house with hospice.</p> <p>Resident # 51 and 31's Care plans related to tube feeding was updated to reflect person center approaches with resident specific interventions and methods of monitoring to assure HOB remains elevated during specified times. Licenses staff notified of Care Plan</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 33</p> <p>Resident 51 was re-admitted to the facility on [REDACTED]/19 for rehabilitation therapy. The resident's diagnoses list included: [REDACTED] and [REDACTED]. The resident was admitted with a gastrostomy tube (a feeding tube inserted through the abdomen).</p> <p>A review of the resident's admission Minimum Data Set (MDS) assessment dated 02/04/19, showed the resident had impaired cognition and required one person assistance with eating through a feeding tube.</p> <p>Review of the resident's Tube Feeding care plan dated [REDACTED]/19 (8 days after admission) showed the resident required tube feeding related to dysphagia (difficulty swallowing) and [REDACTED]. The care plan goal was for the resident "will be free if aspiration through the review date."</p> <p>The care plan directed the facility staff to: "The resident needs the Head of Bed (HOB) elevated at 45 degrees during feeding and thirty minutes after the tube feeding."</p> <p>During multiple observations on 03/27/19 at 10:21 AM, 03/27/19 at 2:01 PM, 03/28/19 at 8:39 AM and on 03/28/19 at 8:57 AM, the resident's HOB was observed to be lower than 25 degrees during feeding times.</p> <p>During a joint observation and interview on 03/28/19 at 10:12 AM with Staff G, Licensed Practical Nurse/Trainer (LPN), the resident was observed in bed while receiving TF. Staff G stated, the resident's HOB "was not at least 30 degrees" and the HOB should always be at least</p>	F 656	<p>changes</p> <p>Resident # 4 was assessed for self-medication program and storage. Care Plan and Kardex with resident specific goals and interventions were updated with resident input. Licenses staff notified of Care plan changes</p> <p>Resident #71 was interviewed for shower preferences. Care plan and Kardex updated based on residents own preferred shower preferences and shower schedule updated. Licenses staff notified of Care plan changes</p> <p>Resident # 56 NAR team assessed resident's nutrition care plan for person center approaches resident specific intervention and goals regarding her weight. Residents/responsible party were involved in the care planning process. Care Plan / Kardex updated as indicated. License staff notified of Care Plan changes.</p> <p>Resident #46 skin assessment was completed. Resident's pressure ulcer care plan and Kardex was updated with resident specific goals and interventions to heal existing pressure sore and maintain skin integrity without further breakdown. Residents daughter involved in the Care Planning process. Licenses staff notified of Care Plan changes.</p> <p>Resident # 70's Care plan regarding Dental services was reviewed with the resident and interdisciplinary team (IDT.) Interventions and resident specific goals were implemented. Care Plan and Kardex updated.</p> <p>Identification of other residents.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 34</p> <p>"35-45 degrees to minimize the risk of aspiration." Staff G further stated, she would immediately re-educate and in-service the staff about proper positioning for TF residents.</p> <p>The facility failed to implement Resident 51's care plan and ensure the HOB was at least 45 degrees during tube feeding as directed by the resident's plan of care. The resident was hospitalized on [REDACTED]/19 and was admitted with a diagnosis of [REDACTED] or [REDACTED]. Refer to F693 - Tube Feeding Management/Restore Eating Skills for more information.)</p> <p>RESIDENT 31 Resident 31 was a long term resident of the facility. The resident's diagnoses list included: [REDACTED] and [REDACTED]. The resident had a gastrostomy tube since admission to the facility on [REDACTED] 16.</p> <p>A review of the resident's quarterly MDS assessment dated 01/27/19, showed the resident was "rarely/never understood" and needed one person assistance with eating via Tube Feeding (TF).</p> <p>Review of the resident's TF care plan dated 11/15/18, showed the resident required TF related to Dysphagia and esophagitis (inflammation of the esophagus/ food pipe).</p> <p>The care plan directed the facility staff to: "The resident needs the Head of Bed (HOB) elevated at 45 degrees during feeding and thirty minutes</p>	F 656	<p>Reviewed Incident reports for falls the last 30 days. The care plan interventions, care directives, current medications and safety monitoring in place will be reviewed to ensure adequate supervision and measures are in place to prevent further falls.</p> <p>Residents who are currently in the facility with wounds, dental issues, nutritional problems, specific shower preferences, falls, tube feeding or who are on a self-medication program Care plans were reviewed in these areas. The Care Plan and Kardex was updated as indicated with resident or responsible parties input.</p> <p>Systemic Changes: The SDC or designee will educate LN□S and MDS staff on development of person center care plan with measureable goals and specific interventions to meet a residents medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Ongoing monitoring: Care plans related to pressure sores, nutrition, dental, self-medication program, shower preferences and tube feeders will be reviewed for accuracy and person centeredness in conjunction with OBRA MDS calendar by the DON or designee. Findings will be brought to the QAPI meeting for review until substantial compliance is met.</p> <p>Responsible for compliance: DON or designee</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 35 after the tube feeding."</p> <p>During multiple observations on 03/27/19 at 10:23 AM, 03/28/19 at 9:22 AM, 03/28/19 at 10:13 AM and 03/29/19 at 8:22 AM, the resident's HOB was observed to be lower than 25 degrees during feeding times.</p> <p>In an interview on 04/08/19 at 1:38 PM, the Director of Nursing, (DNS) stated, she was aware of the concerns related to not having the HOB elevated at 30-45 degrees for Resident 51 and Resident 31.</p> <p>The facility failed to implement Resident 31's care plan and ensure the HOB was at least 45 degrees during tube feeding as directed by the resident's plan of care.</p> <p>RESIDENT 95 Resident 95 was admitted to the facility on [REDACTED]/18 for rehabilitation therapy. The resident's diagnoses list included: [REDACTED] and [REDACTED]</p> <p>A review of the resident's quarterly MDS assessment, dated 03/13/19, showed the resident had severe cognitive impairment and needed one person assistance with bed mobility, transfers, and toileting needs.</p> <p>Review of the resident's care plan, dated 09/16/18, showed the resident was at risk for falls related to dementia (memory problem), impaired mobility and history of falls. The care plan</p>	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 36</p> <p>directed the facility staff to:</p> <p>A. Call light within reach. Created and initiated on 09/16/18.</p> <p>B. Frequent checks. Created and initiated on 09/25/18.</p> <p>C. Frequent repositioning when in bed. Created and initiated on 09/25/18.</p> <p>The resident's clinical records showed the resident had fallen 16 times from since admission to the facility (2 times for the month of March 2019) that resulted and contributed to the development of a substantial injury (fracture) of the [REDACTED]</p> <p>The care plan also showed it did not contain specific interventions related to the circumstances of the falls, and was not consistently reviewed and/or revised after each fall occurrence and as directed by the facility policy. The care plan was not person-centered (individualized) and included interventions that was not appropriate for the resident related to her poor cognition and physical/mental limitations.</p> <p>During a joint record review and interview on 04/08/19 at 2:43 PM, the Director of Nursing (DNS) stated the Resident 95's care plan needed to be revised and the interventions listed as "frequent checks" for Resident 95 should have been more specific for staff to effectively implement and evaluate the effectiveness of the intervention.</p> <p>RESIDENT 4 Resident 4 was a long term care resident of the facility. The resident's diagnoses list included: [REDACTED] and [REDACTED].</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 37</p> <p>A review of the resident's annual MDS assessment dated 12/28/18, showed the resident had mild-moderate cognitive impairment and needed one person assistance with Activities of Daily Living (ADL's).</p> <p>During an observation on 03/28/19 at 9:14 AM, the resident was observed to have one bottle of TUMS (an antacid medication), and one small tube of Sport scream (a pain cream) at his bedside table. The resident stated that he had these medications for a long time and he used it on a regular basis. The resident also stated that he took TUMS almost every day for stomach upset and indigestion.</p> <p>Review of the resident's clinical records and care plan showed no information or assessment that showed Resident 4 could independently manage and keep any medications at his bedside.</p> <p>In a follow-up interview on 04/09/19 at 8:35 AM, the resident stated he did not recall being a part of the care planning process and nobody had talked to him or informed him about safe medication storage and administration.</p> <p>RESIDENT 71 Resident 71 was a long term resident of the facility. The resident's diagnoses list included [REDACTED] and [REDACTED]</p> <p>Review of the resident's care plan and care directives dated 09/14/18 (revised on 12/07/18) showed the resident's preference was to receive showers at least once a week.</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 38</p> <p>Review of the resident's shower record from 03/05/19 to 04/05/19 showed the resident only received two bed baths in the past 30 days, and not a weekly shower as desired.</p> <p>In an interview on 03/28/19 at 11:01 AM, the resident stated that her shower schedule was every Tuesday but "I am not getting it." The resident also stated sometimes "she feels dirty".</p> <p>In an interview on 04/08/19 at 1:22 PM, the Director of Nursing stated that the expectation was to honor the resident's preferences and the resident's plan of care wasn't followed and implemented as required. (Refer to F561 - Self-Determination for more information.)</p> <p>RESIDENT 56 Resident 56 was a long term resident of the facility. The resident's diagnoses list included [REDACTED], and [REDACTED]</p> <p>Review of the resident's care plan dated 12/03/18, showed the resident "has nutritional problem or potential nutritional problem" related to "intake appears less then optimal on average, however progressive weight gains."</p> <p>The care plan directed facility staff to: "Observe and report to the Medical Doctor as needed signs and symptoms of malnutrition and significant weight loss (3 lbs. in one week, greater than 5% in 1 month, greater than 7.5% in 3 months and greater than 10% in 6 months.)"</p> <p>A review of the resident's Weight Summary</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 39</p> <p>showed the facility failed to obtain and monitor the resident's weight as directed by the resident's plan of care. The resident's last documented weight in the clinical record taken and documented on 11/26/18.</p> <p>During a meeting on 04/09/19 at 2:08 PM with the DNS, Administrator and Regional Nurse Consultant 1, the resident's weight should have been taken and monitored at least monthly and/or weekly as needed related to the resident's increased risk for weight loss and poor intake. (Refer to F692 - Nutrition/Hydration Status Maintenance for more information.)</p> <p>RESIDENT 46 Resident 46 was originally admitted to the facility in in 2011. The last annual MDS assessment, dated 05/26/18, indicated the resident needed extensive assistance from one staff member to complete most activities of daily living (ADL's = bed mobility, transfers, dressing, toileting and hygiene) except eating.</p> <p>On 12/27/18, the progress notes identified open area on the [REDACTED]. The facility obtained a physician order for a wound consultant to assess and treat the wound on 12/27/18.</p> <p>On 01/08/19, the consultant from United Wound Healing completed an assessment and identified a stage III pressure ulcer. (Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible undermining and tunneling may occur.) The consultant also recommendations included frequent repositioning while in the wheelchair (every 2 to 3 hours) and encourage off-loading (of pressure) of the [REDACTED]</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	<p>Continued From page 40 and bony prominences.</p> <p>A section on the Care Plan (CP), initiated 11/22/18, showed that the resident was at risk for skin breakdown. The interventions included; "minimize pressure over boney prominences"; "off-load pressure throughout day as appropriate."</p> <p>The CP was updated on 12/27/18 to identify an open ulcer on the [REDACTED]. The only intervention was for staff to provide wound care treatment per order(s). Refer to United Wound Healing for wound care assessment and treatment.</p> <p>On 03/29/19, review of the directives for direct care staff on "Bedside Kardex Report," found it did not identify interventions "to off load pressure on the [REDACTED] or boney prominences" or how frequently position changes should occur while seated in the wheelchair.</p> <p>The care plan was not updated to identify individualized interventions in place for Resident 46. This increased the risk for additional skin breakdown.</p> <p>RESIDENT 70 Resident 70 was admitted to the facility on [REDACTED]/18, with multiple diagnoses including [REDACTED], and [REDACTED]. The initial MDS assessment, dated 09/07/18, indicated the resident was alert and oriented, required supervision assistance from one staff for personal hygiene and oral care and documented the resident had "obvious cavities and/or broken teeth."</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 41 The current CP to address dental issues, dated 12/04, the interventions noted the facility would "Coordinate arrangements for dental care and transportation as needed (or) / ordered." On 03/28/19 at 2:29 PM, during an interview Resident 70 stated the facility staff had not talked to him about coordinating dental services. On 04/09/19 at 2:46 PM, Staff K, the Social Services Director, was interviewed. Staff K stated dental services were coordinated, by the Social Service Staff or Resident Care Manager. When asked if Resident 70 had been evaluated by a dentist, she stated if a consult had occurred it would be in the clinical record. On 04/11/19 at 9:30 am, Staff A, the Resident Care Manager was asked if Resident 70 had ever been evaluated by Dentist. Staff A said she was unable to find a consult to verify the facility had coordinated any dental services for Resident 70. The CP to assist with the coordination was not followed. This placed the resident at risk for infection and pain related to cavities and broken teeth.	F 656			
F 686 SS=G	Reference WAC 388-97-1020 (3) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	<p>Continued From page 42</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to comprehensively assess a resident's increased risk for skin breakdown and failed to implement timely interventions necessary to prevent the development of a facility-acquired pressure ulcer for one of two residents (46), reviewed for pressure ulcers. These failures caused harm to Resident 46 who developed an avoidable pressure ulcer with full thickness skin loss and pain.</p> <p>Findings included...</p> <p>The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury (Ulcer) definition and stages included:</p> <p>A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged</p>	F 686	<p>Identified residents:</p> <p>Resident #46 <input type="checkbox"/> Comprehensive skin re-assessment completed Braden Scale completed Care plan and care directives reviewed and updated Repeat CT scan revealed no fracture positive for gout flare up</p> <p>Identification of other residents:</p> <p>" A comprehensive skin assessments was completed on current residents to identify any other possible pressure injury issues</p> <p>" Braden Scale completed for all current residents and care plans updated to reflect prevention interventions placed based on the results</p> <p>" Audit of current residents with wounds will be completed for treatment orders, measurement documentation, weekly licensed skin assessment and up-to-date care directives for the CNAs</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	<p>Continued From page 43</p> <p>pressure or pressure in combination with shear.</p> <p>Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable redness.</p> <p>Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.</p> <p>Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible undermining and tunneling may occur.</p> <p>Unstageable Pressure Injury: 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.</p> <p>The facility policy, dated 07/05/18, entitled "Pressure Ulcer/Injury Prevention and Management" indicated all resident were assessed for existing skin issues at the time of admission and readmission. It indicated a common risk assessment, the "Braden Scale" was used to determine a resident's risk for developing a pressure ulcer and noted that weekly skin assessments were completed by the Licensed Nurses. It also listed measures that could be implemented to maintain and improve tissue tolerance, and protect the patient against external mechanical forces, described as pressure, friction, and shear, were implemented in the plan of care. The policy noted that when skin breakdown occurred, it required attention and a change in the care plan to appropriately treat the patient.</p>	F 686	<p>Systemic Changes</p> <p>" Licensed nurses will be re-educated on accurate wound assessments, wound documentation and wound policy per ABC of Wound Care HCA Module. To be completed by DON/designee</p> <p>" CNAs (Certified Nursing Assistants) will be educated on prevention per HCA Module Skin Basics. To be completed by DON/designee</p> <p>" Licensed nurses will be reeducated on Braden Scale and implementation of aggressive prevention interventions as applicable</p> <p>Ongoing monitoring</p> <p>" Random residents of the weekly skin assessment will be reviewed for completion, identification of any new pressure injury, completion of treatment plan, notifications and care planning. To be completed by DON/designee for weekly x 4 and monthly x 2 months until compliance by Quality Assurance committee</p> <p>" 10 weekly audits of Residents with pressure ulcers will be reviewed weekly for effectiveness of treatment plan, improvement or worsening of the wound, Nutritional supplements, appropriate supports, IDT involvement and updated care plan/care directives. To be completed by the RCMs and submitted to the DON</p> <p>" 10 random Braden Scale for appropriate interventions</p> <p>" All audit results will be presented and reviewed at the monthly QAPI meetings</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	<p>Continued From page 44</p> <p>RESIDENT 46</p> <p>Resident 46 was admitted to the facility in 2011. The last annual Minimum Data Set (MDS) assessment, dated 05/26/18, showed the resident had memory problems, sometimes understood others, and spoke a language other than English. The resident needed extensive assistance from one staff member to complete most activities of daily living (ADL's) such as bed mobility and transfers. The MDS also showed Resident 46 was at risk for pressure ulcers, but had no pressure ulcers.</p> <p>The quarterly MDS assessment, dated 11/13/18, showed the resident needed the extensive assistance of two staff members for bed mobility and transfers, and did not have any pressure ulcers.</p> <p>The next quarterly MDS assessment, dated 02/06/19, indicated the resident had developed a Stage III pressure ulcer (on the [REDACTED]).</p> <p>During observations on 03/27/19 and 03/28/19, Resident 46 was observed seated in her wheelchair in her room throughout the day, and sleeping intermittently. A blue padded boot covered the right foot and a slip-on shoe was on the left foot. Both feet rested on the floor. There was no black bolster cushion observed on the bed.</p> <p>Observation by a nurse surveyor on 04/10/19 at 1:45 PM of Staff C, a Registered Nurse, who completed wound care to Resident 46's [REDACTED]. The wound was observed to display a full thickness skin loss, approximately 3 centimeters(cm) Length x 3 cm Width x 0.3 cm</p>	F 686	<p>x3 months</p> <p>Responsible for compliance Director of Nursing or designee " 05/20/2019</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	<p>Continued From page 45</p> <p>Depth. The wound bed was 80% dark red and 20% covered with slough(dead tissue), had a foul odor, and yellowish discharge. The wound edge was tender and the surrounding skin was macerated (skin change related to prolonged exposure to moisture). The resident was observed groaning and was guarding the area during the wound care treatment. (See citation under F 679 for concerns about lack of implementing adequate pain management plan)</p> <p>On 04/10/19 at 2:00 PM, the family member who also observed the wound treatment stated that she was surprised to see the condition of the wound and was concerned about infection because of the odor and yellowish discharge. The family member stated that she believed the wound developed due to the resident remaining seated in her wheelchair too long, causing pressure to the [REDACTED]</p> <p>The Braden Scale assessments (to identify the risk for skin breakdown) were documented at least monthly between 11/27/18 and 04/01/19 and showed that the resident had a "mild risk" of skin breakdown.</p> <p>The Care Plan (CP) dated 11/22/18 was updated on 12/27/18 to identify an open ulcer on the [REDACTED]. The only intervention was for staff to provide wound care treatment per order(s).</p> <p>A separate section on the CP, initiated 11/22/18, showed that the resident was at risk for skin breakdown. The goal, initiated 11/22/18, was to maintain intact skin through 05/14/19. The interventions included: "minimize pressure over boney prominence's" and "off-load pressure</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	<p>Continued From page 46</p> <p>throughout day as appropriate." The CP did not specify how staff were to off-load pressure or identify other specific interventions to ensure pressure relief for the resident's [REDACTED]</p> <p>Review of the record showed a weekly skin check dated 11/24/18 that documented no open areas were found.</p> <p>A progress note, dated 11/28/18, also showed the resident was on alert charting for a toe abrasion and that the resident was encouraged to float her [REDACTED] with pillows.</p> <p>A second progress note on 11/28/18, noted the resident's [REDACTED] slightly red, but blanch slowly." An order to treat the [REDACTED] with Povidone-iodine swabs was obtained. It also noted "a wedge cushion was refused" and "padded boots" were not appropriate due to self-transfers and risk of falls.</p> <p>A wound observation tool, dated 12/11/18, documented the resident had a Stage 1 pressure ulcer was on the left [REDACTED] and noted the Stage 1 ulcer on the left [REDACTED] was first observed on 11/28/18.</p> <p>The progress notes between 11/28/18 and 12/24/18 showed no further mention of redness on the resident's [REDACTED]</p> <p>On 12/24/18, a progress note showed the resident had a non-blanchable area measuring 3 cm x 3.5 cm on right outer foot near the [REDACTED] and, [REDACTED] covered with "Alevyn heel cup." It showed that Tylenol was helpful with pain and the [REDACTED] was floated with black bolster cushion."</p>	F 686		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	<p>Continued From page 47</p> <p>The entry noted the physician was notified of the pressure ulcer.</p> <p>A 12/26/18 progress note showed there was a cream-colored hard skin area on the [REDACTED] outer foot near the [REDACTED] "that is intact except for a small 0.2 area."</p> <p>Then on 12/27/18, an order for an outside wound consultant assessment and treatment was obtained.</p> <p>The progress notes after 12/24/18 showed intermittent use of positioning devices, referred to as a black bolster pillow or [REDACTED] protectors. There was no evidence the resident refused the positioning devices.</p> <p>The wound consultant's initial visit occurred on 01/08/19. The consultant report indicated the resident had a Stage 3 pressure ulcer on the [REDACTED]. The recommendation was for frequent repositioning while in the wheelchair, every 2-3 hours, to ensure the [REDACTED] remained free from pressure. However the Care Plan, dated 11/22/18, was not revised to reflect this recommendation, there were no specific directives provide position changes while in the wheelchair, or pressure relieving devices. The care guide directives for the Nursing Assistants, found no directives to indicate position changes should occur while in the wheelchair, nor did it identify the pressure relieving devices that were implemented.</p> <p>The March 2019 Treatment Administration Record (TAR) showed a directive to float the [REDACTED] when in bed that was initiated on 12/27/18.</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 686	Continued From page 48 According to the TAR, an order to reduce pressure to the [REDACTED] while seated in the wheelchair was not implemented until 03/08/19, more than 60 days after the [REDACTED] ulcer was first observed. On 04/11/19 at 09:10 AM, Staff A, the Resident Care Manager, a Registered Nurse, was interviewed. When asked about the [REDACTED] pressure ulcer and how it developed, she stated the resident refused a wedge cushion on her bed and that padded boots would have increased the resident's risk for falls. When asked if the resident was still able to transfer, Staff A stated the resident had declined in the ability to use the transfer pole. The facility failed to accurately assess the risk of pressure ulcers and implement timely interventions to off load [REDACTED] pressure which resulted in the development a Stage 3 pressure ulcer on the [REDACTED]	F 686			
F 689 SS=G	Reference WAC 388-97-1060(3)(b) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 689	Identified residents	5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 49</p> <p>review, the facility failed to comprehensively assess, initiate appropriate and timely fall interventions, provide adequate supervision, or follow the plan of care for 3 of 5 residents (95, 56 and 17) reviewed for accidents, hazards, and falls. The facility's failure to provide adequate supervision, failure to initiate timely and appropriate fall interventions and the failure to follow written policy and plan of care caused harm to Resident 95 who suffered multiple falls with injuries and contributed to the development of a substantial injury (fracture) of the [REDACTED] and placed the other residents at risk for fall recurrence and injury.</p> <p>Findings included....</p> <p>[REDACTED] "is a partial or complete break in the [REDACTED] due to external force ..." and "Are usually a result of injury or trauma." Sub-Acute Fracture; "the term sub-acute refers to the pain following the fracture of a bone rather than the actual fracture itself. It is the pain that occurs in the first few weeks as the bone and soft tissue begin to heal ..."</p> <p>A review of the facility policy titled, "Fall Management," dated 12/13/18, defined avoidable accidents "means that an accident occurred because the facility failed to:</p> <ol style="list-style-type: none"> Identify environmental hazards and/or assess individual resident risk of an accident, including need for supervision and/or assistive devices. Evaluate/analyze the hazards and risks and eliminate them, if possible, or if not possible, identify and implement measures to reduce the hazard/risks as much as possible. Implement interventions, including adequate 	F 689	<p>" Resident # 95 no longer resides in the facility. She was discharged to the hospital on [REDACTED] 19 and planned to discharge from the hospital to her daughters' house with hospice.</p> <p>" Resident #56 □ resident's fall history, care plan and care directives was reviewed and updated to reflect measurable goals and interventions generated after each post-fall huddle by the IDT</p> <p>" Resident #17 □ resident's fall history, care plan, care directives and current medication reviewed. Care plan and directives updated and use of antianxiety medication reviewed for necessity</p> <p>Identification of other residents</p> <p>" Incident reports were reviewed last 90 days and resident who had repeat falls were identified. The care plan interventions, care directives, current medications and safety monitoring in place will be reviewed to ensure adequate supervision and measures are in place to prevent further falls</p> <p>" Identify fall risk residents by completing Fall Assessment on admission, readmission, change of condition and any fall event</p> <p>" A post-fall huddle will be done for any fall incidents and interventions will be implemented to provide adequate supervision and measures to prevent further fall</p> <p>Systemic changes</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 50</p> <p>supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident.</p> <p>d. Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.</p> <p>The policy directed the facility staff as follows:</p> <ol style="list-style-type: none"> Residents will be assessed for fall indicators upon admission, readmission, quarterly, change in condition and with any fall event utilizing Fall Risk Evaluation form. The interdisciplinary team will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change and quarterly MDS (Minimum Data Set assessment), upon a fall event and as needed thereafter. Accurate and thorough assessment of the patient is fundamental in determining indicators for potential falls ... Patient conditions may vary throughout the day, week, month or other time period and the identification of patient fall indicators is an ongoing, interdisciplinary assessment process. <p>RESIDENT 95 Resident 95 was admitted to the facility on [REDACTED] /18 for rehabilitation therapy. The resident's diagnoses list included: [REDACTED] and [REDACTED]</p>	F 689	<p>" Licensed nurses education on accident and incident investigation and providing appropriate interventions based on the root cause of any incident including but not limited to adequate supervision, safety monitoring, and Bowel & Bladder assessment and as necessary have appropriate toileting plan, oversight, therapy involvement and restorative plan as needed. To be completed by the DON/designee</p> <p>" Nursing staff will be re-educated on purpose and process of a fall huddle. To be completed by the DON/designee</p> <p>" A weekly Incident Review (IR) meeting will be conducted with the Interdisciplinary Team and review all incidents including falls for the past week to ensure that interventions that were implemented To be completed by the DON/designee</p> <p>" Medications will be reviewed with falls for possible complications and changes made as ordered the by physicians</p> <p>Ongoing monitoring</p> <p>" 10 weekly audits of the IR meetings for effectiveness of intervention implemented x4 weeks and x2 months</p> <p>" 10 weekly audits of the post-fall huddles for timely implementation of preventive measures x4 weeks and x2 months</p> <p>" Results of the audit will be presented and discuss in the monthly QAPI meeting x 3 months</p> <p>Responsible for oversight</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 51</p> <p>A review of the resident's quarterly MDS assessment, dated 03/13/19, showed the resident had severe cognitive impairment and needed one person assistance with bed mobility, transfers, and toileting needs.</p> <p>Review of the resident's care plan, dated 09/16/18, showed the resident was at risk for falls related to dementia (memory problem), impaired mobility and history of falls. The care plan included the following interventions:</p> <p>A. Call light within reach. Created and initiated on 09/16/18.</p> <p>B. Frequent checks. Created and initiated on 09/25/18.</p> <p>C. Frequent repositioning when in bed. Created and initiated on 09/25/18.</p> <p>The care plan also showed the following documented falls for Resident 95:</p> <ol style="list-style-type: none"> 09/24/18 at 7:30 PM. "Rolled out of bed." 10/02/18 at 5:15 PM. "Found on floor next to w/c (wheelchair)." 10/06/18 at 3:50 PM. "Fall with ([REDACTED] swelling and bruise." 10/10/18 at 3:10 AM. "Per roommate she rolled out of bed." 10/15/18 at 4:50 PM. "Tipped wheelchair backwards resulting in hematoma (collection of blood caused by an injury/trauma to the wall of a blood vessel) to back of head." 10/19/18 at 11:00 AM. "Found sitting on the floor in doorway of another resident's room." 10/29/18 at 10:00 AM. "Found on the floor next to bed." 11/06/18 at 2:35 PM. "Found on the floor next to bed." 11/13/18 at 11:15 PM. "Found near bathroom 	F 689	Director of Nursing or designee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 52</p> <p>door on the floor." 10. 11/18/18 at 8:20 AM. "Found sitting on comforter on the floor next to bed." 11. 11/26/18 at 10:30 AM. "Found sitting on the floor next to bed." 12. 12/05/18 at 11:00 AM. "Found on the floor next to bed." 13. 01/31/19 at 9:25 PM. "Found on the floor next to her bed." 14. 03/07/19 at 11:30 AM. "Found next to bed, sustained abrasion to inner [REDACTED] and redness to tip of [REDACTED]" 15. 03/13/19 at 9:15 PM. "Resident 95 was found on the floor next to her bed ..."</p> <p>The care plan showed it did not contain specific interventions related to the circumstances of the falls, and was not consistently reviewed and/or revised after each fall occurrence and as directed by the facility policy. The care plan was not person-centered with individualized interventions related to the resident's poor cognition, and physical and mental limitations.</p> <p>Review of the nursing progress notes from admission to [REDACTED] 19 showed the resident also had a fall on 12/11/18 at 8:00 PM.</p> <p>During several observations on 03/27/19 at 10:15 AM and 03/27/19 at 11:48 AM, the resident was alone in her room, lying in bed.</p> <p>During a joint interview and observations on 03/28/19 at 8:31 AM with Staff D, Nursing Assistant (NA) and Staff C, Registered Nurse, (RN), the resident was observed in the same position as above. Both the staff members stated that they tucked pillows under the right side of</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 53</p> <p>the mattress because the resident constantly tried to get up and get out of bed. Both Staff D and Staff C stated that the resident was a frequent faller and the pillows helped to prevent her from getting up and it made it harder for her (Resident 95) to get up. (Refer to F604 - Right to Be Free from Physical Restraints for more information.)</p> <p>The incident investigations showed the following information about supervision of the resident: 11/26/18-The fall investigation showed the resident was found sitting on the floor at 10:30 AM. The resident was last seen and cared for by staff at 10:10 AM. Interventions included: "Cont. (continue) freq. (frequent) monitoring, toilet her when she is restless, when resident or roommate calls out, go to room immediately."</p> <p>12/05/18-The fall investigation showed the resident was found on the floor by her bed at 11:05 AM. The resident was last seen and cared for by staff at 10:30 AM. Interventions included: "Has had constant monitoring. She does call for help ... continue to monitor and follow care directives ... Continue to monitor frequently ..."</p> <p>12/11/18- The fall investigation showed the resident was last seen and cared for by staff at 7:00 PM. and was found on the floor at 8:00 PM. Interventions included: "Continue frequent visual check for safety to prevent fall."</p> <p>01/31/19- The fall investigation showed the resident was last seen and cared for by staff at 9:15 PM. The resident was lying on the floor at 9:25 PM. Interventions included: "Frequent visual checks when in bed ..."</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 54</p> <p>03/07/19- The fall investigation showed the resident was last seen and care for by staff at 11:30 AM. The resident was found on the floor, at 11:25 AM. Incident description: "get out of bed on her own, attempted to walk, fell on the floor." Interventions included: "continue with frequent checks, if restless get up and place at nurse's station or hallway in room."</p> <p>03/13/19- The fall investigation showed the resident was last seen and cared for at 8:30 PM. The resident was found on the floor at 9:15 PM. Interventions included: "Continue frequent visual checks for safety."</p> <p>All the above incident investigations reviewed above were missing specific and objective, measurable interventions in order for the facility staff to implement, analyze and evaluate the effectiveness of each specific intervention attempted (frequent checks and supervision needed by Resident 95). There was no evidence or documentation that showed the facility followed and completed post-fall evaluations for each occurrences, as directed by the facility policy and fall incident report procedures.</p> <p>During a joint interview on 03/28/19 at 8:31 AM with Staff D, NA and Staff C, RN, the staff members stated that frequent checks could be different depending upon the situation. The staff stated that frequent checks could be every two hour checks, every hour or every thirty minutes. Both indicated that in general for residents identified as being at risk for falls, frequent checks could mean that staff will look in the resident's room every time they walk past or</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 55</p> <p>perhaps every fifteen minutes. Both staff members stated that a frequent checks intervention should be specific. The staff stated they were not sure on how frequently they should check Resident 95.</p> <p>During an interviews on 03/28/19 at 9:02 AM with Staff A, RN/Resident Care Manager, Staff A stated that frequently checking of a resident who at risk of fall could be every 15 to 30 minutes.</p> <p>On 03/28/19 at 9:25 AM with Staff I, Licensed Practical Nurse, (LPN), Staff I stated that frequent checks of a resident at risk for falls could perhaps be every 1-2 hours and as needed.</p> <p>Review of the resident's clinical records showed the resident was hospitalized on [REDACTED]/19 for several diagnoses including [REDACTED]. The hospital notes noted the resident had a fall out of bed several weeks ago and indicated this was a new fracture</p> <p>During a joint record review and interview on 04/08/19 at 2:43 PM, the Director of Nursing (DNS) reviewed the resident's clinical records and fall investigations with the surveyor. The DNS stated that the intervention listed as "frequent checks" should have been more specific for staff to effectively implement and evaluate the effectiveness of the intervention. The DNS also stated that the resident's orthostatic blood pressure (a vital sign gathered from a patient who has potential blood pressure problems when transitioning positions, going from lying down to sitting up, sitting to standing, etc.) was not obtained and evaluated from each</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 56</p> <p>incident of falls for Resident 95. The DNS further stated that Resident 95's care plan should have been reviewed and revised for every fall incident to minimize the risk of re-occurrence of fall incidents.</p> <p>RESIDENT 56 Resident 56 was a long term resident of the facility. The resident's diagnoses list included [REDACTED] and [REDACTED].</p> <p>A review of the resident's quarterly MDS assessment, dated 02/13/19, showed the resident had impaired cognition and needed one person assistance with bed mobility and transfers.</p> <p>During several observations on 03/27/19 at 9:46 AM and 03/28/19 at 8:23 AM, the resident was alone in the room, lying in bed.</p> <p>Review of the resident's clinical records, showed the resident had 3 documented falls on 12/28/18, 12/12/18, and 01/03/19.</p> <p>Review of the resident's care plan dated 11/30/18, showed the resident was at high risk for falls related to current use of psychoactive medications (medications that can alter brain functions) and was unaware of her safety needs. The care plan was not revised at the time of each incident and as directed by the facility policy.</p> <p>Review of the fall incident investigations dated 12/28/18, 12/12/18, and 01/03/19 were missing specific and objective, measurable interventions in order for the facility staff to implement, analyze and evaluate the effectiveness of each specific</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 57</p> <p>intervention attempted (frequent checks and supervision needed by Resident 56). There was no evidence or documentation that showed the facility followed and completed post-fall evaluations for each occurrences, as directed by the facility policy and fall incident report procedures.</p> <p>RESIDENT 17 Resident 17 was admitted on [REDACTED]/18 with a [REDACTED] diagnosis and hospice services in place. The initial MDS assessment, dated 10/17/18, indicated the resident could ambulate independently, did not identify any behavioral issues and received no psychotropic medications, or Anti-Anxiety (AA) medication was administered.</p> <p>The last quarterly MDS, dated 04/05/19, showed the resident was administered an AA medication (Lorazepam) every day during the assessment period. It also documented Resident 17, had three falls since the previous quarterly assessment, dated 01/10/19, was completed.</p> <p>The care plan, initiated 10/10/18, identified the risk of falls. The interventions included: assist with Activities of Daily Living as needed, keep the call light in reach, complete fall risk assessment and orient the resident to the room and encourage non-skid socks when not wearing shoes. The interventions were all initiated on 10/10/18.</p> <p>The accident incident log documented Resident 17 experienced three falls, which occurred on 02/13/19 at 10:00 PM, 02/25/19 at 2230 (10:30 PM), and 03/17/19 at 0015 (12:15 am). The</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 58</p> <p>investigations completed by the facility, found a fall risk assessment was completed after each fall. It was also noted the resident was administered the anti-anxiety medication prior to each of the fall incidents.</p> <p>The Medication and Treatment Administration record for March 2019 directed staff to monitor the resident for adverse side effects related to the administration of the AA medication. The MAR/TAR noted the staff were monitoring the resident for "Ataxia (drunk walk), dizziness, confusion.."</p> <p>The care plan for the use of the AA medication included additional side effects, including "loss of balance, cognitive impairment that looks like dementia and an increase risk of falls, broken hips and legs." It also listed "clumsiness, slow reflexes, ... disorientation, ... memory loss and forgetfulness.."</p> <p>The adverse side effects related to the use of the AA medication, clearly identified increased risk of falls. However, there was no evidence the facility considered the falls could be a adverse side effect of the AA medication and effectively addressed this issue.</p> <p>On 04/11/19 at 11:20 AM, the Director of Nursing Services was interviewed about the AA medication administered to Resident 17. The DNS explained the medication order was implemented by hospice, and was in place as a PRN (or as needed) at the time of admission. She stated she did not know if the staff had considered the medication as a possible factor contributing to the falls during the facility</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 59 investigations of the incidents.	F 689			
F 692 SS=G	Reference: (WAC) 388-97-1060 (3)(g) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess residents' nutrition and hydration status, failed to implement written policies and procedures related to weight loss, and failed to initiate timely interventions as needed to prevent significant weight loss and dehydration for 4 of 5 residents (95, 21, 52 and 56) reviewed for nutrition and hydration status and weight loss.	F 692	Identified residents: Resident # 95 is no longer in facility Resident #21 was weighed. Physician, Registered Dietician(RD) and Resident Representative were notified of resident's current weight. Resident #21's fluid intake and food consumption was monitored and the physician, RD and	5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 60</p> <p>These failures caused harm to Resident 95, Resident 21 and Resident 52 who developed severe and unplanned weight loss, and placed Resident 56 at risk for further weight loss and decline in nutritional status.</p> <p>Findings included...</p> <p>The Minimum Data Set (MDS) assessment defined a clinically significant weight loss episode for nursing home residents as a loss equal to or greater than 5% within a 30-day period or 10% within a 180-day period.</p> <p>Review of the facility's policy titled, "Weight monitoring," dated 03/01/13, identified a process to obtain, record, and track resident's weights and ensure accuracy.</p> <p>The policy directed facility staff to:</p> <ol style="list-style-type: none"> 1. For the development of a successful height and weight program/process, the facility involves Nursing, Food and Nutrition Services, Rehab and Maintenance. 2. The criteria for reweighs are as follows: <ol style="list-style-type: none"> A. A reweigh is obtained when a resident's weight varies by 5 pounds (lbs.) in a month or 3 lbs. in a weekly or bimonthly weight. Reweighs should occur in the same shift but no more than 24 hours after the first weighing. B. Weekly weights would be obtained for "New admissions weekly for 4 weeks" and "Any resident receiving an enteral(gastric) feeding. C. For any resident who experiences an unplanned weight loss, significant weight change, or undesirable weight change, notification will be made to the physician and responsible party. D. Planned/expected weight loss is weight loss 	F 692	<p>Resident Representative were notified of the amount of food and fluids consumed. Resident was assessed by RD for resident's goal weight, required calorie, nutrient and fluid intake and whether the resident's documented intake was adequate to meet those needs. RD spoke with resident and/or resident representative and discussed resident food and fluid preferences. Resident was evaluated for eating assistance by Speech Therapist(ST). Facility Inter Disciplinary team(IDT) met with resident and/or resident representative and discussed resident's current weight, plan of care for resident and physician orders. Resident's care plan was updated with all new interventions.</p> <p>Resident #52 was weighed. Physician, Registered Dietician(RD) and Resident Representative were notified of resident's current weight. Resident #52's fluid intake and food consumption was monitored and the physician, RD and Resident Representative were notified of the amount of food and fluids consumed. RD spoke with resident and/or resident representative and discussed resident food and fluid preferences. Resident was evaluated for eating assistance by Speech Therapist(ST). Facility Inter Disciplinary team(IDT) met with resident and/or resident representative and discussed resident's current weight, plan of care for resident and physician orders. Resident's care plan was updated with all new interventions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	Continued From page 61 that is intended or expected, documented, and included in the resident's care plan before it occurs. E. Each identified resident with a weight change has a current nutrition assessment/progress note. F. The Interdisciplinary Care Plan team addresses the issue of the weight loss/poor intake or weight gain, assesses dining needs if indicated, provides realistic and measurable goals, indicates specific and individualized interventions, and more as needed. The resident's interdisciplinary care plan reflects the current interventions, evaluations, and revisions. The nutrition progress notes describe the changes, plan of action, and progress or lack of progress. G. Interventions for weight loss/declining intake may include but not limited to: Food is tried first, snacks/supplements are intended to increase the number of calories consumed daily. H. Once it is determined that a resident has unplanned weight loss and/or declining intake, the interdisciplinary team does the following: a. Interview the resident, CNA's (Certified Nursing Assistants), family and/or responsible party for any new or alternative food preferences, b. After reviewing nutritional intake a determination is made if large/double portions can be provided, c. Try whole milk at meals if the resident consumes milk, d. Try other fortified foods if the resident will consume them, e. If increase food at meals is not an option due to intake, try a high calorie snack between meals such as half sandwich with milk, pudding, milk and cookies ... I. If the above interventions have been implemented and the goal is not met, the RD (Registered Dietitian) assesses for more	F 692	Resident #56 was weighed. Physician, Registered Dietician(RD) and Resident Representative were notified of resident's current weight. Resident #56's fluid intake and food consumption was monitored and the physician, RD and Resident Representative were notified of the amount of food and fluids consumed. Resident was assessed by RD for resident's goal weight, required calorie, nutrient and fluid intake and whether the resident's documented intake was adequate to meet those needs. RD spoke with resident and/or resident representative and discussed resident food and fluid preferences. Facility Inter Disciplinary team(IDT) met with resident and/or resident representative and discussed resident's current weight, plan of care for resident and physician orders. Resident's care plan was updated with all new interventions. Identification of Others: Facility residents were weighed. Any residents with 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days were assessed for signs and symptoms of dehydration the Director of Nurses(DON)/designee and most recent resident labs. If identified at risk for poor hydration a hydration care plan was implemented. Residents with 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days had a complete nutritional		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 62</p> <p>aggressive interventions, such as a fortified supplement ...</p> <p>J. If weight monitoring is not indicated, such as for a terminally ill resident, obtain a physician's order to discontinue weights due to the diagnosis, notify resident family and responsible party, and update the resident's care plan.</p> <p>RESIDENT 95 Resident 95 was admitted to the facility on [REDACTED] 18 for rehabilitation therapy. The resident's diagnoses list included: [REDACTED] and [REDACTED]</p> <p>A review of the resident's quarterly MDS assessment, dated 03/13/19, showed the resident had severe cognitive impairment and needed one person assistance with eating. The MDS also showed the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months and was not Hospice care (end of life care). The resident had lost more than 10% of her weight in the last 6 months and was not on a physician-prescribed weight loss regimen.</p> <p>Review of the resident's nutrition care plan, created and initiated on 09/21/18, showed the resident "has nutritional problem r/t (related to) medical dx (diagnosis): [REDACTED] Weight loss since admission. Intake <50% (less than 50 percent)."</p> <p>The care plan directed the facility staff to: A. Observe and report resident's refusals to eat.</p>	F 692	<p>assessment by the RD completed and documented. Physician and resident representative were notified of at risk residents for poor hydration and residents with 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days. The weights of residents with 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days, and the residents identified as at risk for poor hydration were reviewed by the RD and the IDT team to ensure appropriate interventions and assistance for food and fluid intake were being offered and encouraged. Care plans were updated with new interventions.</p> <p>Systemic Changes: " Facility will have a nutritional committee that will meet weekly that will review residents with a 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days to ensure appropriate food and fluid interventions. Residents identified from their monthly weight with 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days will be weighed weekly for four weeks and/or until their weight change has become stable with new interventions implemented. Nurses, CNA's, the RD and dietary staff were educated by the DON/Designee on the following: " Residents will be weighed on admission and monthly unless ordered</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 63</p> <p>B. Observe and report to the Medical Doctor, as needed, signs and symptoms of malnutrition and significant weight loss. (3 lbs. in one week, greater than 5% in 1 month, greater than 7.5% in 3 months and greater than 10% in 6 months.)</p> <p>C. Monitor intake and record every meal.</p> <p>A review of the resident's Weight Summary showed the following weights: 09/16/18 = [REDACTED] lbs. (admission) 10/15/18 = [REDACTED] lbs. 11/15/18 = [REDACTED] lbs. 12/03/18 = [REDACTED] lbs. 01/31/19 = [REDACTED] lbs. 02/13/19 = [REDACTED] lbs. 02/20/19 = [REDACTED] lbs. 02/27/19 = [REDACTED] lbs. 03/06/19 [REDACTED] lbs.</p> <p>The resident's weight on admission was [REDACTED] lbs. The resident's weight on 10/15/18 was [REDACTED] lbs. which was a loss of 8.6 lbs. in 30 days, and a 6.41% loss of body weight. Resident 95's weight continued to decline. Her weight on 03/06/19 was [REDACTED] lbs. which totaled a significant weight loss of 36.8 lbs. and a 27.42% loss of body weight in approximately 6 months.</p> <p>A review of the resident's meal intakes from 02/27/19 to 03/27/19 showed the resident was consuming less than 50% of her meals. The meal intakes also showed the resident was only offered snacks six times during that time frame, and consumed 50 percent or less on average. The resident's meal intakes did not consistently document information related to the amount of fluid the resident was consuming during each meal, and whether staff had offered any other</p>	F 692	<p>differently by the physician or different recommendations by the nutritional committee</p> <p>" Residents with 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days will be weighed weekly for four weeks and/or until their weight change has become stable with new interventions implemented</p> <p>" Physician and resident representative will be notified by nursing of all residents with a 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days and this will be documented in the resident's medical record.</p> <p>" The RD will perform a complete nutritional assessment on all new admissions, and residents with a 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days to ensure appropriate food and fluid interventions.</p> <p>" The RD and DON/Designee will review weight of residents obtained monthly and residents with a 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days will be reviewed by the nutritional committee for four weeks and/or until their weight change has become stable to ensure appropriate interventions for food and fluid intake are implemented and updated on resident's care plan.</p> <p>Ongoing Monitoring: " DON/Designee will audit weight weekly for thirty days then monthly for 60</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 64</p> <p>source of food or fluid to the resident related to the resident's poor oral intake.</p> <p>Review of the quarterly MDS note, dated 03/19/19, showed the resident "eats 25% to 50% of her meals, her daughter brings food from home and she has a diagnoses for [REDACTED]. Care plan reviewed. Proceed with care plan."</p> <p>Review of the quarterly Nutrition Assessment, dated 03/21/19, completed by Staff B, Registered Dietitian (RD), showed the resident's intake was "variable (and stable) per usual with averaged 36% (ranging 24-48%)." The assessment also showed the resident had a significant weight loss and the plan was to "continue with current nutritional plans, honor food and fluid wishes, monitor monthly weights."</p> <p>Review of the previous Nutrition Assessment and weight change notes, dated 02/04/19 and 01/02/19, showed the resident's average intake was 33% to 39% per day. However, the facility did not comprehensively assess the resident's hydration status and fluid intake to determine if this low intake could be a contributing factor for the resident's continued weight loss.</p> <p>The resident's clinical records, Nutrition care plan, quarterly MDS notes, quarterly Nutrition Assessments/weigh change notes, Physician's notes, and nursing progress notes, showed no evidence the facility had comprehensively assessed the resident's hydration status/fluid intake. The assessments were missing key information, such as the resident's target weight range, required calorie, nutrient, and fluid intake</p>	F 692	<p>days to ensure all weights have been obtained as recommended and that residents with a 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days are reviewed by the RD and by the nutritional committed for further interventions for adequate food and fluid intake.</p> <p>" DON/Designee will audit weekly for thirty days then monthly for 60 days to ensure that the physician and the resident representative were notified of residents with a 5% weight change in 30 days, 7.5% weight change in 90 days and 10% weight change in 180 days and this was documented in the medical record</p> <p>" DON/Designee will track and trend the audits monthly and present the results to QAPI for review and recommendations as needed until substantial compliance has been met.</p> <p>Responsible for compliance: DON or designee</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 65</p> <p>needs, and whether the resident's documented intake was adequate to meet those needs. Additionally, the resident's nutrition care plan interventions were never updated or revised as needed related to the resident's poor intake and continued weight loss. All of Resident 95's care plan interventions were created and initiated upon admission dated 09/21/18.</p> <p>During an observation on 03/27/19 at 10:15 AM, the resident was observed in bed asleep. The resident's breakfast tray was at the bedside and appeared untouched. The resident was observed with dry skin on her face, arms and legs with dry, cracked lips.</p> <p>During a joint observation and interview on 03/28/19 at 8:31 AM with Staff D, Nursing Assistant (NA) and Staff C, Registered Nurse, (RN) Resident 95 was observed in bed with dry skin and cracked lips. Staff D stated that the resident had poor intake and does not eat or drink much almost every meal. According to Staff D, the resident's daughter comes daily, at least twice a day, and helps feed the resident. Staff D further stated, "She (Resident 95) will not eat or drink with us, only with her daughter" and stated the resident was not on any supplement or snacks for meals which the resident "refuses all the time."</p> <p>In an interview on 03/29/19 at 8:07 AM with Staff E, NA, Staff E stated that the resident had poor intake and did not eat or drink much at most meals.</p> <p>During a record review and interview on 03/29/19 at 2:34 PM with Staff A, Registered</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 66</p> <p>Nurse/Resident Care Manager (RN/RCM), stated Resident 95 was not on input and output monitoring. Staff A stated that no fluid intake was being documented and monitored for the resident during meals and/or every other time. Staff A reviewed both the resident's electronic medical records and hard copy charts and stated that there was no evidence of any fluid monitoring and/or hydration evaluation for the resident. Staff A also stated that the resident was recently started on Intravenous (IV) fluid therapy due to severe dehydration, and stated that the resident's weight should have been monitored weekly (more frequently) due to her increase risk of dehydration, poor intake, and continued weight loss.</p> <p>In an interview on 03/29/19 at 2:51 PM with Staff C, RN, stated the resident "only takes fluids from her daughter and not with staff" which could have contributed to the resident's dehydration. According to Staff C, there was a discussion about hospice and palliative care in the past for Resident 95, but the resident and her daughter were not ready yet so the resident was never put on hospice and/or palliative care. Staff C further stated that the resident was not on any fluid monitoring and there were no other supplements such as health shakes or med pass currently being offered or provided to the resident. Staff C also stated that she was not sure why the resident was not on weekly weights "because the resident was losing a lot of weight and had a very poor intake."</p> <p>During an interview and record review on 03/29/19 at 3:10 PM with Staff B, RD, stated the expectation and the facility policy was to weigh</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 67</p> <p>the residents with documented weight loss weekly until their weight stabilized. Staff B stated that she was not sure why Resident 95's weight was not being monitored weekly due her increased risk for dehydration and weight loss. Staff B stated that she had "no valuable information to evaluate the resident's hydration status" because there was no documentation of fluid intake for the resident. Staff B further stated that the resident was not on any high calorie/high protein drinks to address the resident's weight loss. Staff B stated that she was not sure whether she had offered these interventions to the resident's representative/daughter recently because there was no documentation that showed such a conversation.</p> <p>Staff B stated that the resident's recommended fluid intake was 1500 milliliters (mL), but she had no information if the resident was consuming any fluids. Staff B also stated that the resident's meal intake documentation of less than 50% per day should also include the amount of fluid intake the resident had consumed, and stated that she had no supporting documents to show the facility staff were monitoring the resident's fluid intake and hydration.</p> <p>Review of the resident's blood chemistry report dated 03/28/19 showed the resident's blood sodium level of 164 (normal value = 135 to 145), a blood urea nitrogen of 55 (normal value = 8 to 25) and a creatinine level of 1.2 (normal value = 0.5 to 1.0). These results were indicators of fluid deficit and dehydration.</p> <p>During an interview and record review on 04/08/19 at 1:16 PM, the Director of Nursing</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 68</p> <p>(DNS) stated that the facility monitored and evaluated the resident's nutrition and hydration status through the meal monitor and meal consumption documentations in Point Click Care (PCC is an electronic medical record). According to the DNS, the meal percentage documentation included any water or fluid consumed by the resident during meals. However, when asked whether the resident was receiving adequate hydration and adequate nutrition, when the documented intake was only 50% or less on the daily meal monitors, the DNS was not able to provide an answer.</p> <p>The DNS reviewed Resident 95's clinical records and stated that the resident had significant weight loss, and there was no documentation to identify how much fluid was being offered and/or consumed by the resident.</p> <p>During a phone interview on 04/11/19 at 9:21 AM with the resident's attending physician and Medical Director (MD), stated he was notified of the resident's weight loss recently on/or before 03/27/19. The MD was not aware that the facility was not monitoring the resident's fluid intake. The MD stated that the resident's fluid intake should have been monitored closely, and the resident's weight should have been monitored weekly, as required and directed by the facility policy.</p> <p>Further review of the resident's clinical records showed the resident was hospitalized on [REDACTED] /19 with the diagnoses of [REDACTED] and [REDACTED]</p> <p>RESIDENT 21</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 69</p> <p>Resident 21 was a long term resident of the facility. The resident's diagnoses list included: <div style="background-color: black; width: 300px; height: 20px; margin: 5px 0;"></div></p> <p>A review of the resident's quarterly MDS assessment, dated 01/13/19, showed the resident had intact cognition and needed one person assistance with eating. The MDS also showed the resident did not have a condition or chronic disease that may result in a life expectancy of less than six months and was not Hospice care.</p> <p>Review of the resident's nutrition care plan dated 10/23/18, showed the resident had a nutritional problem or potential nutritional problem related to Parkinson's disease, difficulty swallowing, and history of brain injury.</p> <p>The care plan directed the facility staff to: A. Observe and report resident's refusals to eat. B. Observe and report to the Medical Doctor as needed signs and symptoms of malnutrition and significant weight loss. (3 lbs. in one week, greater than 5% in 1 month, greater than 7.5% in 3 months and greater than 10% in 6 months.) C. Provide and serve supplement as ordered: shakes three times a day with meals and fortified cereal at breakfast. D. Provide adaptive equipment for feeding as needed: sippy cups or straws.</p> <p>A review of the resident's Weight Summary showed the following weights: 09/03/18 = <div style="background-color: black; width: 40px; height: 15px; display: inline-block;"></div> lbs. 10/01/18 = <div style="background-color: black; width: 40px; height: 15px; display: inline-block;"></div> lbs. 10/30/18 = <div style="background-color: black; width: 40px; height: 15px; display: inline-block;"></div> lbs.</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 70</p> <p>11/30/18 = [REDACTED] lbs. 12/13/18 = [REDACTED] lbs. 01/09/19 = [REDACTED] lbs. 02/13/19 = [REDACTED] lbs. 02/19/19 = [REDACTED] lbs. 02/26/19 = [REDACTED] lbs. 03/04/19 = [REDACTED] lbs. 03/25/19 = [REDACTED] lbs.</p> <p>The resident's weight on 09/03/18 was [REDACTED] lbs. The resident's weight on 03/04/19 was [REDACTED] lbs. which was a loss of 12.6 lbs. in 6 months and a 12.48 % loss of body weight. The resident's weight continued to decline. The resident's weight on 03/25/19 was [REDACTED] lbs. which totaled to a significant weight loss of 14.8 lbs. and a 14.65% loss of body weight in approximately 6 months.</p> <p>A review of the resident's meal intakes from 02/27/19 to 03/27/19 showed the resident was consuming less than or equal to 50% of her meals per day. The meal intakes also showed the resident was offered a snack only 3 times in that timeframe, and consumed 50 percent or less on average . The resident's meal intake documentation did not contain information related to the amount of fluid the resident was consuming during each meal, or whether staff had offered any other source of food or fluid to the resident related to the resident's poor oral intake.</p> <p>During an observation and interview on 03/27/19 at 2:04 PM, the resident was observed eating alone in her room. The resident was struggling to put food in her mouth using a fork and had difficulty drinking from a regular cup. The</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 71</p> <p>resident's tray did not have sippy cups or straws as directed by the resident's plan of care. The resident was observed with dry skin on her face, arms and legs and had cracked lips. The resident stated that sometimes she needed help with eating, and she does not get snacks or fluids in between meals. The resident also stated that she was thirsty and hungry.</p> <p>During a joint observation and interview on 03/28/19 at 2:03 PM with Staff C, RN and Staff F, NA, Resident 21 was observed in her room eating lunch. The resident appeared to be struggling to eat her food and drink from a regular cup. The resident attempted to scoop her food and take bites, but the food kept dropping off the utensil onto her chest area. Staff F stated that the resident needed a sippy cup, but it was not on the resident's tray. According to Staff F, the resident also needed cueing and limited hands on assistance with meals, and stated, "she was not sure why there was no staff to feed her." Staff F further stated that the resident's tray showed the resident only consumed 15% of her meal and "mostly were dropped on the floor."</p> <p>During a record review and interview on 03/29/19 at 2:34 PM with Staff A, RN/RCM, stated that Resident 21 was not on input and output monitoring. Staff A stated that fluid intake was not being monitored and documented during meals or any other time. Staff A reviewed the electronic medical record and hard copy chart and stated that there was no evidence of any fluid monitoring and/or fluid evaluation for the resident. Staff A also stated that there was no evidence that staff had provided supplements or shakes to the resident as directed by the</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 72</p> <p>resident's plan of care. Staff A further stated that the resident's weight had not been obtained weekly for the month of March 2019, and stated that the resident should have been monitored weekly due to her significant weight loss.</p> <p>During an interview and record review on 03/29/19 at 3:10 PM with Staff B, RD, Staff B stated that the expectation and facility policy was to weigh the residents who had documented weight loss weekly until their weight stabilized. Staff B stated that she was not sure why Resident 21's weight was not being monitored weekly, despite her increased risk for dehydration and weight loss. Staff B stated that she had "no valuable information with which to evaluate the resident's hydration status" because there was no documentation of fluid intake for the resident.</p> <p>According to Staff B, she was not aware of Resident 21's significant weight loss and stated that, "I haven't reviewed her yet." Staff B stated that Resident 21's recommended fluid intake should be 1200 mL per day. Staff B stated that she was not able to show any documentation that the resident's hydration was comprehensively assessed and monitored by the facility. Staff B further stated that Resident 21 was not on hospice or palliative care, and not on a planned physician weight loss program.</p> <p>Review of the resident's clinical records from 09/01/18 to 03/28/19, showed no evidence that the facility staff had comprehensively assessed the resident's hydration status and fluid intake. The documentation showed that facility staff did not consistently implement written policies and</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 73</p> <p>procedures related to weight loss. The assessments did not contain key information, such as the resident's required calorie, nutrient, and fluid intake needs and whether the resident's documented intake was adequate to meet those needs. Additionally, the resident's nutrition care plan, created on 10/23/18, showed that interventions were never updated and/or revised as needed related to the resident's poor intake and continued weight loss prior to 03/28/19.</p> <p>During an interview and record review on 04/08/19 at 1:16 PM, the DNS confirmed and stated that Resident 21 had a significant weight loss and she was not sure why the resident was not reviewed by the interdisciplinary team. The DNS reviewed Resident 21's records and stated that the facility had no documentation to support how much fluids were being offered and consumed by the resident. The DNS also stated that there was no documentation as to whether the resident's physician was aware of her continued weight loss (prior to 03/28/19).</p> <p>During a phone interview on 04/11/19 at 9:21 AM, the resident's attending physician (who was also the facility Medical Director (MD) stated he could not recall when and if he was notified of Resident 21's weight loss prior to the survey inspection on 03/27/19.</p> <p>RESIDENT 52 Resident 52 was admitted to the facility on [REDACTED]/18 with multiple diagnosis including [REDACTED] and [REDACTED]. The last annual MDS assessment, dated 02/13/19, documented the resident needed extensive assistance from one staff to complete the Activities of Daily Living</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 74</p> <p>such as mobility, dressing, grooming, toileting, and hygiene, and needed supervision and cueing from one staff with eating. The assessment showed the resident experienced weight loss and that the resident was on a therapeutic diet.</p> <p>The care plan directive concerning dining assistance, dated 11/30/18, stated Resident 52 "is able to eat on her own with set up. Occasionally requires physical assistance with eating." The section addressing "nutritional problems" included the following directives: -Monitor and report significant weight loss including weight loss of greater than 5 % in 1 month. -Glucerna (a drinkable nutrition supplement) daily. -The resident needs a calm, quiet setting during meal times with adequate eating time.</p> <p>Observations on 03/29/19 during breakfast and lunch showed Resident 52 received a tray for each meal while in her room. Staff placed the tray on the overbed table and then left the room. The resident only ate a couple of bites of food at each meal.</p> <p>Observations on 04/09/19 during breakfast and lunch showed Resident 52 was seated in the dining room. The resident did not eat. Although staff were present in the dining room during both meals, staff did not provide Resident 52 with any cueing or encouragement. During the breakfast meal, an activities staff stop by the table momentarily, and offered to hold the resident's "baby doll" which the resident agreed to. The staff took the item from the resident but did not provide any verbal cueing or encouragement. The only verbal cueing was observed during the</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 75</p> <p>noon meal when a staff person approached Resident 52 and offered a cup of cocoa. (See F 676 for more detailed information about lack of providing assistance with dining for Resident 52)</p> <p>Resident 52's weight record documented a 5.8 % weight loss between February and March 2019. On 02/19/19, the resident's weight was [REDACTED] lbs. Then on 03/20/19, the resident's weight had dropped to [REDACTED] lbs. The resident had lost 9 pounds in 30 days which according to the guidelines established by Centers for Medicare Services (CMS) is characterized as severe weight loss.</p> <p>Review of nutritional assessments, dated 12/14/18 and 02/15/19, were completed by the Registered Dietitian. Both showed the resident was on a therapeutic diet and received a regular texture diet with no added salt. The RD assessments also indicated the diet was tolerated well, even though the resident had no bottom denture and had missing teeth.</p> <p>On 03/30/19, a nutrition/dietary progress note by Staff A, RCM/RN showed the resident was offered assist at meals but [the resident] frequently stated, "that is enough, no more." The note also showed "Unavoidable weight loss form in process." The entry also showed that the drinkable nutritional supplement Glucerna was increased to twice a day. Staff A documented the family was informed of the resident's weight loss and that the family did not want lab tests done and to just keep the resident comfortable.</p> <p>Record review showed a document "Unavoidable</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 76</p> <p>Weight loss" that was initiated by Staff A on 03/21/19, and signed by the Physician on 03/21/19. The form noted weight loss prevention measures were in place and listed the following interventions: supplements, offering meal replacements, providing one to one feeding assistance, and ensure the resident received the appropriate diet texture. Further review of the record showed the resident's care plan did not include those interventions.</p> <p>During the meal observations on 03/29/19 and on 04/09/19, Resident 52 was not staff did not ask or offer a meal substitution, any supplements and Resident 52 with one to one feeding assistance. The observations were noted as follows:</p> <p>On 03/29/19 08:18 AM, Resident 52 was observed sleeping in bed, a breakfast tray on the over bed table, the tray meal included pancakes, a round sausage patty and scrambled eggs. The resident was easily aroused by verbal stimulation. When asked if staff ever help her with the meals, she stated "no," and said they just bring it in and leave it here." On 03/29/19 at 08:58 AM, during another observation, although the food had been cut into pieces the food and fluids remained untouched.</p> <p>On 03/29/19 at 12:30 PM Resident 52 was observed seated in the wheelchair in the hallway, outside her room. An unnamed staff member was observed to assist the resident to her room and set up the resident with a lunch tray. At 12:49 PM, Staff W, a NA who was observed passing trays in the hallway where Resident 52 resided. Stated only one Resident in the hallway needed assistance with dining and identified then</p>	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 77</p> <p>by name, it was not Resident 52. At 1:16 PM, Resident 52 was seated in the wheelchair, with a tray on the over bed table before her. The plate of food appeared untouched. At 1:38 PM the resident was observed sleeping, with the tray before her. A different NA, Staff D entered the room, but did not provide any cueing or encouragement for Resident 52. At 1:43 PM, Staff W, entered the room and removed Resident 52's tray. A visual check, of the tray, when the staff exited the room, found only taken a couple of bites of the food served on the plate and part of the desert item were consumed. Staff W, commented Resident 52 said "she was full."</p> <p>On 04/08/19 at 8:45 AM, Resident 52, was heard calling out softly "help, help." After entering the room, it was discovered the meal had been spilled, the food was scatted in her lap and in the bed sheets. The resident's call light was turned on, Staff W, responded to the call light and entered the room to assist. Within, approximately 15 minutes Staff W, exited the room. With the soiled linens, and when asked about the meal she reported, the Resident 52 said "she was finished."</p> <p>On 04/09/19, at 8:45 AM, Resident 52, was seated in the Baker Dining Room, with a plate of food at the place setting before her, but it remained untouched. Resident 52, was observed holding a baby doll, and would occasionally sip on a cup of coco before her, the plate of food remained untouched. At 8:50 AM, Staff X, a Restorative Nursing Assistant, approached Resident 52 who removed the lid from the bowl and verbally cued Resident 52 to</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 78</p> <p>eat, Resident 52 responded "we will wait a bit," and continued to sit at the table with the food items untouched. At 8:49 AM, an unnamed activities staff, approached the table, she offered "I can hold the baby while you drink your Coco." The resident agreed, however the food remained untouched. At 8:50 AM, the resident plate was removed from the table. Although Resident received cueing once and had another verbal exchange, no one asked her why she was not eating or offered a substitute replacement.</p> <p>On 04/09/19, at 12:35 PM, during observation in the Baker dining room, Resident 52 had a full plate of food, a piece of chocolate cake, and glass of water. The resident was readily engaged in eating the dessert and had not touched the plate of food. At 12:55 pm, an Unnamed Activities Staff approached Resident 52, and asked if she wanted a cup of hot chocolate, the resident responded "yes." The staff member returned to the table with in a few minutes and provided the item. At 12:58 PM, the plate of food that remained untouched at her place setting. When asked about the meal, the resident stated she could not eat it, and stated it was "dry. The resident then self-propelled the wheelchair out of the dining room.</p> <p>The facility failed to failed to ensure the nutrition services provided were consistent with the facility policy. In addition, there was no evidence the interventions listed on the form "Unavoidable Weight Loss" had been implemented or attempted. These failures contributed to the resident experiencing a pattern of weight loss.</p> <p>RESIDENT 56</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 79</p> <p>Resident 56 was a long term resident of the facility. The resident's diagnoses list included [REDACTED], and [REDACTED].</p> <p>A review of the resident's quarterly MDS assessment, dated 02/13/19, showed the resident had impaired cognition and needed one person assistance with eating.</p> <p>Review of the resident's care plan, dated 12/03/18, showed the resident had "a nutritional problem or potential nutritional problem related to intake appears less then optimal on average, however progressive weight gains."</p> <p>The care plan directed facility staff to:</p> <p>A. Observe and report resident's refusals to eat. B. Observe and report to the Medical Doctor as needed signs and symptoms of malnutrition and significant weight loss (3 lbs. in one week, greater than 5% in 1 month, greater than 7.5% in 3 months and greater than 10% in 6 months.) C. Monitor intake and record every meal.</p> <p>A review of the resident's Weight Summary showed the following weights: 09/04/18 = [REDACTED] lbs. 11/26/18 = [REDACTED] lbs. 04/02/18 = [REDACTED] lbs.</p> <p>No other weight were documented between 09/04/18 through .</p> <p>During an observation on 03/28/19 at 8:23 AM, the resident was observed in bed. Her meal appeared untouched. The resident was not able to reach her food because of the bed's position.</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	<p>Continued From page 80</p> <p>There was no water pitcher or any fluids at bedside. The resident's skin appeared dry (face, arms and legs) and she had dry, cracked lips.</p> <p>Review of the resident's meal intake documentation from 03/11/19 to 04/08/19 showed the resident was consuming less than 50% of meals per day. The documentation showed the resident had consumed 25% or less of her meals on the following dates: 03/18/19, 03/22/19, 03/23/19, 03/24/19, 03/25/19, 03/26/19, 03/27/19, 03/30/19, 03/31/19, 04/01/19, 04/02/19, 04/03/19, 04/05/19, 04/06/19, 04/07/19 and 04/08/19. The resident's meal intake documentation was missing information related to the amount of fluid the resident was consuming during each meal, and whether the facility staff had offered any other source of food or fluid to the resident related to the resident's poor oral intake.</p> <p>During an observation on 04/09/19 at 1:51 PM, the resident's weight was obtained by the facility staff and documented a weight of [REDACTED] lbs. This was a weight loss of 9.4 lbs., a 5.66% loss of body weight from 11/26/18 through 04/09/19.</p> <p>During a meeting on 04/09/19 at 2:08 PM with the DNS, Administrator, and Regional Nurse Consultant 1, they stated that the resident's weight should have been taken and monitored at least monthly and/or weekly as needed related to the resident's increased risk for weight loss and poor intake.</p> <p>The resident's clinical records, (Nutrition care plan, quarterly MDS notes, Physician's notes, and nursing progress notes) showed no</p>	F 692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 692	Continued From page 81 evidence the facility had comprehensively assessed the resident's hydration status and fluid intake. The assessments were missing key information, such as the resident's goal weight, required calorie, nutrient, and fluid intake needs, and whether the resident's documented intake was adequate to meet those needs. Additionally, the resident's nutrition care plan interventions were never updated or revised as needed related to the resident's poor intake and continued weight loss prior to 03/28/19. All nutrition interventions were created and initiated on 12/03/18.	F 692			
F 693 SS=D	Reference: (WAC) 388-97-1060 (3)(h)(i) Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	<p>Continued From page 82</p> <p>diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents receiving artificial nutrition by tube feeding received appropriate treatment and services for two of two residents (51 and 31) reviewed for special care needs/tube feeding. Failure to provide appropriate supervision and care as per current professional standards of practice and develop/implement resident-directed plan of care placed Resident 51 and Resident 31 at risk for serious harm and other related complications.</p> <p>Findings included...</p> <p>RESIDENT 51 Resident 51 was re-admitted to the facility on [REDACTED] 19 for rehabilitation therapy. The resident's diagnoses list included [REDACTED] and [REDACTED]. The resident was admitted with a gastrostomy tube (a feeding tube inserted through the abdomen).</p> <p>A review of the resident's admission Minimum Data Set (MDS) assessment, dated 02/04/19, showed the resident had impaired cognition and required one person assistance with eating through a feeding tube.</p> <p>Review of the resident's Tube Feeding care plan dated 02/05/19 (developed 8 days after admission) showed the resident required tube feeding related to dysphagia (difficulty swallowing) and [REDACTED]. The care plan goal was for the resident "will be free of</p>	F 693	<p>Identified residents:</p> <p>Resident # 51 was treat with antibiotics with resolution of s/s of infection around G-tube site. Residents dressing change to tube site and observation for s/s of infection is monitored daily. Resident has been assessed and shows no s/s of aspiration pneumonia. Red tape placed on wall so staff can assess that HOB is elevated at least 30 degrees during tube feeding and 30 minutes after meals; LS to monitor that HOB is elevated every hour and prn during scheduled time. Care plan and Kardex updated as indicated to reflect appropriate supervision and care per current professional standards</p> <p>Resident 31's stoma site was assessed for s/s of infection. Resident's dressing change to site and observation for s/s of infection is monitored daily. Resident has been assessed and shows no s/s of aspiration pneumonia. Red tape was placed on the wall so staff can assess that HOB is elevated at least 30 degrees during tube feeding and 30 minutes after Meals; LS to monitor that HOB is elevated every hour and PRN during scheduled nutritional support time via G-Tube. Care Plan and Kardex updated as indicated to reflect appropriate supervision and care per current professional standards</p> <p>Identification of other residents: The Director of nursing or designee with the maintenance completed an audit of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	<p>Continued From page 83 aspiration through the review date."</p> <p>The care plan identified the following interventions: A. The resident needs the Head of Bed (HOB) elevated at 45 degrees during feeding and thirty minutes after the tube feeding. B. Observe and report as needed any signs and symptoms of aspiration such as: fever, shortness of breath, abdominal pain/distention and abdominal tenderness. C. Provide local care to the gastric tube site as ordered and observe for signs and symptoms of infection.</p> <p>Observation and interview on 03/27/19 at 10:21 AM showed the resident was grimacing and was turning side to side in bed. The resident's tube feeding site was visible and was observed with yellowish discharge from the site. The resident showed his abdomen to the surveyor and started saying "pain, very bad pain." The insertion site of the gastric tube was red with partial skin loss and macerated (changes related to prolonged exposure to moisture) skin.</p> <p>During an observation and interview on 03/27/19 at 2:01 PM, Resident 51 again stated that he had abdominal pain. The resident was actively receiving tube feeding (TF) via a TF pump, and the HOB was measured at 23 degrees elevation using a protractor (a measuring device/instrument).</p> <p>During an observation and interview on 03/28/19 at 8:39 AM, the resident was in bed receiving TF via a TF pump. The resident's HOB was measured at 23 degrees elevation using a</p>	F 693	<p>each resident who is receiving tube feeding in the facility to ensure red tape is placed on the wall so staff can assess HOB is elevated per physician orders All resident receiving tube feedings <input type="checkbox"/> either bolus or continuous were identified and a complete respiratory assessment including vital signs, pulse oximetry reading and breath sounds on each of identified resident to ensure the resident is not experiencing any respiratory issues. Assessments were documented in medical records 100 percent audit was completed on all residents receiving tube feeding to ensure that there is a specific degree setting for the head of the bed and that there are orders in place to clean and assess the stoma site each shift and PRN. Tube feeders care Plan will be assessed and updated as indicated to reflect appropriate supervision and care that meet professional standards. Systemic changes The SDC will educate licenses staff on caring for a resident receiving tube feeding, care of the tube site which included monitoring site for s/s of infection and importance of elevating the HOB. Ongoing Monitoring; All residents receiving tube feedings will be monitored to ensure the HOB is elevated per MD orders and that feeding tube site is monitored, cleaned and dressed daily and PRN. Audits will be conducted by RCMS or designee weekly x4 then monthly times two to ensure orders are obtained on tube</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	<p>Continued From page 84</p> <p>protractor. The resident complained and reported severe abdominal pain to the surveyor, was grimacing, and was observed massaging his abdominal area. The resident's stoma (surgical opening in abdomen) site had no dressing, and the site was red with signs of maceration.</p> <p>During a joint observation on 03/28/19 at 8:57 AM with another surveyor, the resident was observed at the same position as above. The resident reported and complained of abdominal pain to the surveyor during this encounter.</p> <p>During an interview and record review on 03/28/19 at 9:02 AM with Staff A, Registered Nurse/Resident Care Manager, (RN/RCM), Staff A stated the resident was care planned to keep his HOB at his preference. According to Staff A, the resident also liked taking ice chips, but was supposed to be on a strict nothing by mouth (NPO) status. However, during a joint review of the resident's clinical records showed no evidence that this information and/or preference was documented in the clinical record and no evidence that the facility had reviewed and/or discussed the risk/benefits of such action or preference. Staff A further stated that the resident was recently started on an antibiotic to treat a possible TF site infection on 03/27/19.</p> <p>During several staff interviews on 03/28/19 at 9:31 AM with Staff D, Nursing Assistant (NA), and on 03/28/19 at 9:25 AM with Staff I, LPN, the staff stated that they only estimated the elevation of the HOB for residents on TF. Staff I also stated that TF sites should always have a dressing in place to minimize the risk of friction and/or exposure of the skin to irritants.</p>	F 693	<p>feeders for tube site care, monitoring for infection, HOB elevated per physician orders and Care Plan and Kardex are updated as indicated. Findings will be brought to QAPI till substantial compliance is determined Responsible for Compliance: DON</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	<p>Continued From page 85</p> <p>During a joint observation and interview on 03/28/19 at 10:12 AM with Staff G, Licensed Practical Nurse/Trainer (LPN), the resident was observed in bed while receiving TF. Staff G stated that the resident's HOB "was not at least 30 degrees" and the HOB should always be at least "35-45 degrees to minimize the risk of aspiration." Staff G further stated that she would immediately re-educate and inservice the staff about proper positioning for TF residents.</p> <p>During a joint interview on 03/29/19 at 8:56 AM with Staff G, LPN/Trainer and Staff H, Maintenance Director, both staff members stated that the facility had revised their process and now put a "clear red tape" to serve as a mark for staff to ensure residents on TF would have an accurate HOB elevation during feeding.</p> <p>Review of the records showed Resident 51 was hospitalized on [REDACTED] 19. The hospital record, dated [REDACTED] 19, showed the resident was admitted with Aspiration Pneumonia. The hospital notes documented, "Pt (patient) with SOB (shortness of breath). Noted to have RLL (Right Lower Lobe) opacity consistent with pneumonia."</p> <p>RESIDENT 31 Resident 31 was a long term resident of the facility. The resident's diagnoses list included: [REDACTED] and [REDACTED]. The resident had a gastrostomy tube since admission to the facility on [REDACTED] /16.</p> <p>A review of the resident's quarterly MDS assessment, dated 01/27/19, showed the</p>	F 693			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	<p>Continued From page 86</p> <p>resident was rarely or never understood and needed one person assistance (to set up) eating via Tube Feeding (TF).</p> <p>Review of the resident's TF care plan, dated 11/15/18, showed the resident required TF related to Dysphagia and esophagitis (inflammation of the esophagus/ food pipe).</p> <p>The care plan directed the facility staff to:</p> <p>A. The resident needs the Head of Bed (HOB) elevated at 45 degrees during feeding and thirty minutes after the tube feeding.</p> <p>B. Observe and report as needed any signs and symptoms of aspiration such as: fever, shortness of breath, abdominal pain/distention and abdominal tenderness.</p> <p>C. Provide local care to the gastric tube site as ordered and observe for signs and symptoms of infection.</p> <p>During an observation on 03/27/19 at 10:23 AM, the resident was observed in bed receiving TF via a TF pump. The resident's HOB was measured at 25 degrees using a protractor. The resident's TF site was exposed and uncovered. The stoma site was red with surrounding skin macerated. There was no dressing or gauze observed around the stoma.</p> <p>During a joint observation on 03/28/19 at 9:22 AM with another surveyor, the resident was observed in bed receiving TF via a TF pump. The resident's HOB was measured at 23 degrees using a protractor.</p> <p>During several staff interviews on 03/28/19 at 9:25 AM and 9:31 AM with Staff D, Nursing</p>	F 693			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	<p>Continued From page 87</p> <p>Assistant (NA), Staff I, LPN, the staff stated that they only estimate the elevation of the HOB for resident's on TF. Staff I also stated that TF sites should always have a dressing in place to minimize the risk of friction and/or exposure of the skin to irritants.</p> <p>During a joint observation and interview on 03/28/19 at approximately 10:13 AM with Staff G, Licensed Practical Nurse/Trainer (LPN), the resident was observed in bed while receiving TF. Staff G stated, the resident's HOB "was not at least 30 degrees" and the HOB should always be at least "35-45 degrees to minimize the risk of aspiration." Staff G further stated that she would immediately re-educate and in-service the staff about proper positioning for TF residents.</p> <p>During an observation on 03/29/19 at 8:22 AM with another surveyor, the resident was observed in bed receiving TF via a TF pump. The resident's HOB was flat and not elevated.</p> <p>During an observation on 03/29/19 at 8:24 AM with Staff G, LPN/Trainer, the resident was observed lying in bed with his HOB in flat position. Staff G stated that the resident had history of sliding down and required constant repositioning from staff.</p> <p>In an interview on 04/08/19 at 1:38 PM, the Director of Nursing, (DNS) stated that she was aware of the concerns related to not having the HOB elevated at 30-45 degrees for residents on TF. According to the DNS, the facility had completed the education and training related to these safety concerns to prevent and minimize the risk of TF complications such as aspiration</p>	F 693			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 693	Continued From page 88 pneumonia.	F 693			
F 697 SS=G	Reference: (WAC) 388-97-1060 (3)(f) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate pain treatment and management for two of two residents (46 and 51) reviewed for pain management. Failure to accurately assess and identify sources and expression of pain caused harm to Resident 51 and Resident 46 who experienced uncontrolled pain, severe discomfort, and diminished quality of life. Findings included... Review of the facility policy titled "Pain Management", dated 06/2016 and 11/2016, showed the facility would ensure that pain management was provided to residents who required such services, consistent with standards of practice. The policy showed that staff should recognize when a patient was experiencing pain, identify circumstances when pain can be anticipated, and evaluate the pain, existing causes, and manage pain or prevent pain.	F 697	Identified residents: Pain assessment was completed for Resident #46 and the physician was notified of pain results. New orders were obtained for scheduled pain medication to be given prior to wound dressing being completed. Staff C was educated on by the Staff Development Coordinator (SDC)/Designee on the signs and symptoms of pain, administering pain medication prior to wound dressings if needed and as ordered as well as asking residents and assessing residents for pre medicated pain management prior to wound dressings. Resident #51 was assessed for pain and the physician was notified of the results of the pain assessment and any new orders were followed up on appropriately. Resident and/or resident representative was interviewed on to determine the location of pain, cause of pain, non-pharmacological interventions that	5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 89</p> <p>The policy showed all residents will be assessed for pain indicators at the time of admission, readmission, and quarterly, and with any event. It showed that an individualized pain management care plan would be developed and initiated when pain indicators were identified. In addition, it showed the interdisciplinary team would review and revise(the plan of care) if indicated.</p> <p>RESIDENT 46 Resident 46 was admitted to the facility in 2011. The last annual Minimum Data Set assessment(MDS), dated 05/26/18, showed the resident needed extensive assistance of one staff member to complete most activities of daily living, such as bed mobility, transfers, dressing, toileting and hygiene. The MDS also showed the resident had declined having an interpreter to communicate with medical staff and care providers.</p> <p>Observation on 04/10/19 at 10:25 AM, showed Staff C, a Registered Nurse (RN), attempting to remove a dressing from a [REDACTED] wound. During the observation, the resident was screaming, and repetitively verbalizing unknown words, grimacing, sweating, and was tearful. Staff C stated the resident "makes this noise all the time" and "may just be upset", and continued with unwrapping the resident's [REDACTED] dressing. The resident continued to scream and show non-verbal signs of distress.</p> <p>When Staff C was asked what Resident 46 was trying to communicate, she responded that she wasn't sure and said she would have to call the resident's family member on the phone to</p>	F 697	<p>had been successful in pain management. Resident's Care plan and Kardex updated as indicated.</p> <p>Identification of others: Director of Nurses (DON)/Designee assessed residents with wound care to identify residents that experienced pain with their wounds or wound care. The physician was notified of residents experiencing pain with their wounds or wound care and scheduled pain medication was requested for residents prior to wound care.</p> <p>Residents were assessed by the DON/Designee for verbal or nonverbal expressions of pain. Any residents identified with pain were interviewed to determine the location of the pain, the cause of the pain, non-pharmacological interventions that helped provide pain management, and what makes it worse. The physician was notified of the results, resident care plans were updated with the information acquired from the interviews and any new physician orders were followed up on at that time.</p> <p>Systemic Changes: Nurses were educated by the SDC/Designee to assess residents with wounds for verbal or nonverbal signs and symptoms of pain and identify if pain is experienced during wound care. If assessment identified the wound as the source of discomfort the nurses are to notify the physician of the assessment findings and request orders to pre medicate resident with scheduled pain</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 90</p> <p>interpret for her. The family member then listened on the phone to the resident's response as Staff C began to lift his foot to provide the treatment. The resident continued to scream, call out, and vocalize. The family member confirmed the resident "was screaming of pain" and the resident was trying to communicate severe pain.</p> <p>The family member requested that Staff C stop the procedure, and told Staff C that the resident was not able to tolerate the pain. The family member reported it was "hard to hear" the resident expressing severe pain during the dressing change. Staff C stated that she would contact the doctor, get an order for a pain medication, and then complete the wound dressing.</p> <p>Observation on 04/10/19 at 1:45 PM, showed Staff C approach the resident to continue the dressing change. Staff C explained the physician had been contacted and an new order received to administer a narcotic pain medication prior to providing wound care and treatments. During the observation, Resident 46 tolerated the treatment without yelling or calling out in pain, but still displayed some non-verbal signs of pain, grimacing, and guarding.</p> <p>During a follow up interview on 04/10/19 at 2:00 PM, the resident's family member stated that the resident complained of pain when the wound specialist debrided the wound. (Debridement is a surgical treatment to remove dead tissue). She stated that this had occurred three to four times, and that the resident had complained of how painful the procedure was. The family member</p>	F 697	<p>medication prior to wound care. SDC/Designee educated the nursing assistants on pain management identification of verbal and nonverbal signs of pain and notification of nursing when occurs. The nursing assistants were also educated on non-pharmacological pain interventions and where to locate on the resident's Kardex.</p> <p>Nurses were educated by the SDC/Designee on assessment of residents for verbal or nonverbal signs of pain upon admission, readmission, monthly and with changes of condition. On assessment of resident to identify location or cause of pain, identifying and implementation of non-pharmacological interventions that are resident specific, Notification to physician if pain identified with assessment, Patient specific care plan for pain management, and documentation and assessment of pain management in the medical record.</p> <p>Ongoing Monitoring Audits will be conducted by RCM or Designee weekly x 4 then monthly times two to assess resident for pain management who have wounds/dressing changes and 5 random residents to ensure an accurate assessment and sources of pain was identified and resident appropriately treated with pain RX if appropriate and non-pharmacological interventions. Findings will be brought to QAPI until substantial compliance is determined. Responsible for oversight:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 91</p> <p>stated the only pain medication provided was Tylenol. The family member then said the Tylenol was intended for the resident's osteoarthritis pain, and was not intended for pain associated with treatments for the [REDACTED]. The family member also stated that the pain the resident experienced today and during wound care debridement was severe to the point where the resident was screaming and was in "agony." The family member stated, "I had to hang-up the phone this morning because I cannot take it and it was crushing my heart." The family member stated the resident was raised to not to yell or scream, "but today, she was screaming out in pain."</p> <p>Further review of Resident 46's clinical records, showed the care plan addressing pain was last updated on 11/22/18, prior to the development of the pressure ulcer. The directives included for staff to anticipate the need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of pain management, observe and report any signs and symptoms of nonverbal pain, which included groaning, yelling out, and facial expressions such as grimacing.</p> <p>A summary of the wound consultant's visit showed the consultant had provided treatment to the wound weekly since 01/08/19. A summary of the visits showed the wound was debrided every time the consultant provided treatment.</p> <p>The last quarterly MDS assessment, dated 02/06/19, identified the resident experienced pain, was administered pain medication(Tylenol) three times a day routinely, did use any PRN pain medication (which was available), and documented the resident reported no problems</p>	F 697	DON or designee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 92</p> <p>with pain. In addition, it noted the resident had developed a Stage 3 pressure ulcer (Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible undermining and tunneling may occur.)</p> <p>The facility pain assessments completed between 11/24/18, 11/27/18 and 02/27/19. A quarterly assessment, dated 11/24/18, showed a pain level of zero and documented pain did not impact the resident's quality of life.</p> <p>The most recent pain assessment, dated 02/27/19, was a quarterly assessment. It documented the resident's pain level as zero, identified that pain affected the resident's quality of life, was managed with Tylenol, and noted position change was an effective intervention to relieve pain (non-pharmacological intervention).</p> <p>The Medication and Treatment Administration Record (MAR/TAR) for April 2019 showed the resident was administered Tylenol routinely three times a day at 8:00 AM, 1:00 PM and 5:00 PM, and had an additional dose available which could be administered as needed. The MAR also directed staff to monitor "generalized" pain each shift and noted an acceptable level of pain was 3. The record did show the resident complained of pain at level 4 on 04/07/19, however the additional dose of Tylenol available was not administered.</p> <p>On 04/11/19 at 9:10 AM, Staff A, a Registered Nurse and the Resident Care Manager, was asked how the resident was assessed for pain. She explained if the resident displayed symptoms of pain the staff should respond. When</p>	F 697			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 93</p> <p>asked if there were any communication tools to assist Resident 46, who primary language was [REDACTED]. Staff A explained a sheet of translations had been placed at the bed side by the family members.</p> <p>By not ensuring the staff assessed the resident pain, identified the location, precipitating factors, and anticipated the needed for additional pain interventions to manage the resident's pain associated with the wound treatments and care contributed to Resident 46 experiencing severe, unrelieved pain.</p> <p>RESIDENT 51 Resident 51 was re-admitted to the facility on [REDACTED]/19 for rehabilitation therapy. The resident's diagnoses list included: [REDACTED] and [REDACTED]. The resident was admitted with a gastrostomy tube (a feeding tube inserted though the abdomen).</p> <p>A review of the resident's admission Minimum Data Set (MDS) assessment dated 02/04/19, showed the resident had impaired cognition and required one person assistance with activities of daily living. The MDS also showed the resident had reported moderate level of pain frequently and the pain had limited the resident's day to day activities including the resident's ability to get sleep.</p> <p>Review of the resident's pain care plan, dated 01/28/19, showed the resident "expresses discomfort r/t (related to)" [REDACTED] and impaired mobility. The care plan directed the facility staff to: "Evaluate the effectiveness of pain interventions and Observe for pain characteristic</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 94 every shift and as needed."</p> <p>During an observation and interview on 03/27/19 at 10:21 AM, the resident reported and verbalized pain to the surveyor. The resident was grimacing and was turning side to side in bed. The resident's tube feeding site was visible and was observed with yellowish discharge from the site. The resident showed his abdomen to the surveyor and started saying "pain, very bad pain" and the stoma site (insertion site of the tube feeding) was red with partial skin loss and macerated skin.</p> <p>During multiple observations and interviews on 03/27/19 at 11:00 AM, 03/27/19 at 1:15 PM, 03/27/19 at 2:01 PM, and 03/27/19 at 2:32 PM, the resident continued to verbalize and report severe abdominal pain to the surveyor. The resident was grimacing and was observed rubbing and massaging his abdominal area.</p> <p>During a phone interview on 03/27/19 at 2:03 PM with the resident's family member, the family member stated that the pain that the resident reported today was not new. The family member stated that the resident would constantly complain of pain and it was mostly related to his abdominal area.</p> <p>During an observation and interview on 03/28/19 at 8:35 AM, the resident reported and verbalized severe abdominal pain to the surveyor. "Pain, very bad pain" while grimacing and massaging his abdominal area.</p> <p>In an interview on 03/29/19 at 1:24 PM, Staff L, Nursing Assistant (NA), stated the resident would</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 95 verbalize pain constantly during her shift.</p> <p>In an interview on 03/29/19 at 1:25 PM, Staff N, Licensed Practical Nurse (LPN), stated that the resident had constant pain related to [REDACTED]. Staff N also stated that the resident was on Morphine Sulfate (narcotic pain medication) and she had given it to the resident twice today during her shift.</p> <p>Review of the resident's most recent pain assessment dated 03/17/19 showed the resident had pain to his left hip area description: "Resident unable to provide details, related to [REDACTED] speaking ... Pain rating was "5" The assessment also documented the resident's quality of life (sleep and rest) were affected because of pain. The assessment was missing information related to the resident's [REDACTED] pain and abdominal pain, including the increase risk of pain and discomfort and intolerance related to the new gastrostomy tube. The only other pain assessment on the resident's clinical record was dated 02/01/19, and was also missing information related to the resident's pain and risk factors for pain.</p> <p>Review of the resident's Physician order sheet and Medication Administration Record (MAR) for February 2019 and March 2019 showed the resident was on the following scheduled pain medication: A. Acetaminophen (Tylenol) 500 milligram (mg) every 8 hours as needed for pain. Initiated on 02/05/19. B. Acetaminophen 500mg (give 2 tablets = 1000mg) three times a day for chronic pain. Initiated on 02/05/19.</p>	F 697		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	<p>Continued From page 96</p> <p>C. Morphine Sulfate 10mg at bedtime for SOB (shortness of breath). Initiated on 03/11/19.</p> <p>D. Morphine Sulfate 10mg every 2 hours as needed for pain/SOB. Initiated 03/11/19. (was every 4 hours prior to 03/11/19)</p> <p>The resident was receiving the scheduled pain medications as ordered. However, the record did not reflect evidence of documentations that the facility had consistently evaluated the effectiveness of the regularly scheduled pain medication (routine Acetaminophen and Morphine) on a routine basis.</p> <p>The pain medication orders were not clear and specific on when the staff should be giving the as needed Acetaminophen tablets, rather than the narcotic pain medication Morphine Sulfate.</p> <p>The resident's pain monitoring sheet also showed the resident reported/observed at least 37 times (21 days) with moderate to severe pain from 03/01/19 to 03/29/19 and received as needed pain medication as ordered. However, the MAR showed no evidence that the facility had documented or followed non-drug interventions as directed by the resident's plan of care and facility policy.</p> <p>The MAR also showed the resident was recently started on an antibiotic to treat a possible Tube Feeding (TF) site infection on 03/27/19.</p> <p>During a record review and interview on 03/29/19 at 2:06 PM, Staff A, Registered Nurse/Resident Care Manager (RN/RCM) stated the resident should have specific and comprehensive pain assessment done recently related to the new</p>	F 697			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 697	Continued From page 97 onset of uncontrolled abdominal pain and initiation of Morphine Sulfate. Staff A also stated, the comment "Unable to provide details related to [REDACTED] speaking" documented on the pain assessment was not acceptable and should have a follow-up and/or should have been re-assessed to ensure a comprehensive pain assessment was completed. Review of the resident's clinical records showed the resident was hospitalized on [REDACTED]/19. The hospital record dated [REDACTED]/19 "Emergency Department Course" showed "the patient began to complain of abdominal pain. His son is here at this time and states that he does have chronic abdominal pain although the patient states it feels worse at this time and would like to have this looked into and treated ... He does have chronic pain in the abdomen. He has been on chronic narcotics for this. In addition he has had a recent pain around the gastrostomy site and was started on Keflex for potential cellulitis (a bacterial infection involving the inner layers of the skin.)" See also F693 - Tube Feeding Management/Restore Eating skills for more information.	F 697			
F 700 SS=D	Reference WAC: 388-97-1060 (1) Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F 700		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 700	<p>Continued From page 98</p> <p>correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to comprehensively assess the need for side rails use, failed to assess the risk of entrapment and the need for continue use of these devices for 2 of 5 residents (31 and 71) reviewed for side rails. These failures placed residents at risk for serious harm and injury.</p> <p>Findings included...</p> <p>RESIDENT 31 Resident 31 was a long term resident of the facility. The resident's diagnoses list included: [REDACTED] nd [REDACTED]</p>	F 700	<p>Identified residents:</p> <p>Resident # 31 was comprehensively assessed by nursing staff and therapist to determine need for side rail use, assessed risk for entrapment and if need for continual use. Documentation was placed in the medical record of their findings. Care Plan and Kardex was updated as indicated.</p> <p>Resident 71 was comprehensively assessed by nursing staff and therapist to determine need for side rail use, assessed risk for entrapment and if need for continual use. Documentation of finding placed in medical record. Care Plan and Kardex was updated as indicated</p> <p>Identification of other residents:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 700	<p>Continued From page 99</p> <p>A review of the resident's quarterly MDS assessment, dated 01/27/19, showed the resident was "rarely/never understood" and needed two staff person assistance with bed mobility and transfers.</p> <p>Review of the resident's current Physician order sheet for March 2019 showed no specific orders for the resident's continued use of bilateral side rails and did not have key information to justify continued use of the bed rails.</p> <p>Review of the resident's care plan, dated 11/15/18, showed the resident had deficit in performing activities of daily living (ADL's) related to TBI, Quadriplegia, Spastic Extremity and Trunk movements...The care plan interventions included use of a "Tilt and space wheelchair with self-release seatbelt for supportive device to keep patient upright and positioned safely" and "Unable to use call bell, provide frequent visual checks." The care plan also showed the resident needed bilateral grab bars "when in bed for Resident 31 to grab during care. This helps prevent him from hitting staff and assists with turning."</p> <p>Review of the "Restraint - Physical (Quarterly/Annual Evaluation)," dated 02/12/19, showed the reason for restraint use were "agitated behaviors, sliding out of chair/wheelchair and unbuckles seatbelt." The evaluation also documented, "3. Describe attempts to reduce restrain use over the past quarter: none attempted" and "D. Recommendations: Resident to continue restraint/safety belt in wheelchair." The resident's use of Tilt and Space Wheelchair and bilateral</p>	F 700	<p>All resident currently in facility that have side rails were comprehensively assessed by nursing staff and therapies to determined need for side rail use, assessed risk for entrapment and if need for continual use. Documentation of findings were placed in their medical record. Care Plan and Kardex was updated as indicated.</p> <p>Systemic Changes: The SDC or designee will educate the license staff and therapy department on the facility policy regarding side rail use/restraints. Ongoing monitoring. RCMS or designee will comprehensively evaluate and assess all new admits, and residents who currently have side rails on admission, with change of condition, quarterly and annually for use components: Medical symptoms and or behavioral symptoms being treated, resident's weight and size in conjunction with the use of side rails, sleep habits, current medication use, cognitions, communication mobility in and out of bed and risk of falling. Finding will be discussed at QAPI until substantial compliance is determined. Responsible for oversight: DON or designee</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 700	<p>Continued From page 100</p> <p>side rails/mobility bars were not discussed and/or reviewed on this evaluation. The assessment and evaluation form were missing key information to justify continued use of these devices. (Refer to F604 - Physical restraints for more information.)</p> <p>During multiple observations on 03/27/19 at 10:23 AM, 03/28/19 at 9:22 AM, 03/28/19 at 10:13 AM and 03/29/19 at 8:22 AM, showed the resident was in bed alone. The resident's bed was positioned against the wall (right side of the resident) with bilateral side rails installed (one-eighth length side rails). The resident showed signs of severe contractures on both upper extremities (██████████). The resident was non-verbal, not able to follow simple commands from the surveyor, and had a soft splint placed on his ██████████. The resident was not able to move side to side during these observations, when asked by the surveyor. The resident was not able to physically able to use his ██████████ specifically the ██████████ and ██████████ due to severe contractures, the presence of a splint and weakness.</p> <p>During a joint interview and observation on 04/08/19 at 9:37 AM, Staff L, Nursing Assistant (NA) and Staff M, NA, both the staff members stated the resident does not use or need the right side rail because the resident cannot use it. Staff M stated that the resident only used the left side rail when turning because of the resident's ██████████ weakness and limitation.</p> <p>During a joint interview and record review on 04/08/19 at 9:48 AM, Staff C, Registered Nurse (RN) stated "He (Resident 31) only used the left</p>	F 700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 700	<p>Continued From page 101</p> <p>side rail and not the right side rail. I am not sure why he had both." Staff C also stated that there was no mention or assessment documentation of the side rails on the "Restraint Assessment" dated 02/12/19. According to Staff C, Resident 31 slides himself down "all the time" and that "the assessment was inaccurate and we need to redo it." Staff C further stated that Resident 31 was at high risk for side rails entrapment due to his physical condition and limitations.</p> <p>Further review of the resident's clinical records (both paper and electronic records) showed no evidence that the facility had comprehensively assessed the resident's need for continued use of side rails that included the following components: Medical symptoms and/or behavioral symptoms being treated, the resident's weight and/or size in conjunction with the use of side rails, sleep habits, current medication use, cognition, communication, mobility in and out of bed and risk of falling.</p> <p>RESIDENT 71 Resident 71 was a long term resident of the facility. The resident's diagnoses list included: [REDACTED] and [REDACTED]</p> <p>A review of the resident's quarterly MDS assessment, dated 03/01/19, showed the resident needed one person assistance with bed mobility and transfers.</p> <p>Review of the resident's care plan, dated 09/14/18, showed the resident uses the following for mobility and transfer assistance "bilateral grab bars."</p>	F 700			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 700	<p>Continued From page 102</p> <p>Review of the "Restraint - Physical (Quarterly/Annual Evaluation)" dated 04/06/19 showed the resident was "currently not using restraint." The resident's use of bilateral side rails/mobility bars were not discussed or reviewed on this evaluation. The assessment and evaluation form were missing key information to justify continued use of these devices.</p> <p>During an observation and interview on 03/27/19 at 10:25 AM, the resident stated that since she came in the facility, "the bed already had side rails". The resident also stated that she doesn't care about it (the side rails) and she does not use it at all except "to hang her purse." The resident stated that she could not recall giving any consent or having a conversation about the risk and benefits for the use of side rails.</p> <p>The resident's bed was in a position in which the lower extremities were lower than the body and head, which were elevated on an inclined plane. The resident's head was positioned below the side rails (approximately 6-8 inches below the rails). The bed had bilateral one-eighth lengths side rails installed.</p> <p>During a joint interview and record review on 04/08/19 at 9:48 AM, Staff C, RN, confirmed and stated that there was no mention or assessment of the side rails documented on the "Restraint Assessment" dated 04/06/19.</p> <p>Further review of the resident's clinical records (both paper and electronic records) showed no evidence that the facility had comprehensively assessed the resident's need for continued use of side rails that included the following</p>	F 700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 700	Continued From page 103 components: Medical symptoms and/or behavioral symptoms being treated, the resident's weight and/or size in conjunction with the use of side rails, sleep habits, current medication use, cognition, communication, mobility in and out of bed and risk of falling.	F 700			
F 758 SS=D	Reference WAC 388-97-1060 (3)(g) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 104</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility failed to ensure 3 of 8 residents (17, 52, 37) reviewed for psychotropic medications were free of unnecessary drugs. Failure to ensure the facility identified and monitored target behaviors, potential adverse side effects, and ensure that psychotropic medications ordered as needed (or PRN) were only used for 14 days without a clinical rational documented in the record, placed the residents at risk for unnecessary medications.</p> <p>Findings included...</p> <p>The facility policy, dated 08/23/18 entitled "Psychopharmacological Medication</p>	F 758	<p>Identified residents: Resident # 17's physician was contacted to determine clinical rational for use of PRN Ativan. PRN Ativan was discontinued. The IDT (Interdisciplinary team) reviewed resident's falls, behavior sheets and progress notes for the past 30 days to determine if psychotropic medication was a contributing factor related to his confusion, wandering or falls and implemented appropriate interventions to provide resident with a safe place for wondering. Care plan and Kardex updated. Resident # 37 no longer resides in the facility</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 105</p> <p>Management" identified, an unnecessary drug is any drug used in excessive dose, for excess duration, without adequate indication for its use and in the presence of adverse consequences which indicated the dose should be reduced or discontinued. The policy also indicated the use of PRN psychotropic medications, would be limited to 14 days. If extension is needed, the attending physician or prescribing practitioner would document the clinical rational in the record.</p> <p>RESIDENT 17 Resident 17 was admitted on [REDACTED]/18 with a terminal diagnosis and hospice services in place and was ambulatory. The hospice orders included an order for an Anti-Anxiety (AA) medication which could be administered if need (PRN), to ease anxiety if needed during the dying process.</p> <p>The initial Minimum Data Set (MDS) assessment, dated 10/17/18, showed the resident did not receive any psychotropic medications. The next MDS, dated 01/10/19, noted an AA medication (Lorazepam 0.5 mg) was administered 4 times during the assessment period. The behavior section of the care plan indicated the resident did not display any behaviors.</p> <p>The care plan, dated 10/26/18, identified the AA medication and directed the staff to monitor behaviors described as "pacing, wandering, disrobing, inappropriate response to verbal communication, violence /aggression towards staff."</p> <p>The behavior monitor(s) documented the facility staff monitored "for extreme fear and wandering"</p>	F 758	<p>Resident # 52□s physician was contacted to clarify the use of hydroxyzine, the frequency, dosing, duration and diagnosis due to potential side effect of dry mouth or involuntary movement disorder. A new consent was obtained by the daughter for use of psychotropic medication. Resident was placed on alert charting for monitoring of medication changes/ reduction of hydroxyzine.</p> <p>Identification of others: All residents currently in house on psychotropic medication were assessed by the interdisciplinary team to ensure residents were monitored for target behaviors, potential adverse side effects and to assess if any residents on a PRN psychotropic medication is only used for 14 days until a clinical rational documented record is completed by the physician and placed in the medical record.</p> <p>Systemic Changes: SDC or Designee educated Licenses nurses including Social services on psychotropic medication use in long term/ Skilled facilities. Identification and monitoring of target behaviors, potential adverse side effects and PRN use of psychotropic medication.</p> <p>Ongoing monitoring: The RCM□S/Designee will review all new admits and residents on psychotropic medication for resident specific target behaviors, potential adverse side effects and clinical review of PRN psychotropic medication weekly x 4 then monthly x 2 and during monthly behavior meetings .</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 106 and "continuous calling out, striking out."</p> <p>The March 2019 Medication Administration Record(MAR) directed staff to observe for side effects described as "increased confusion, loss of balance, clumsiness, disorientation, confusion, forgetfulness, cognitive impairment that looks like dementia and an "increased risk of falls, broken hips or legs."</p> <p>A progress noted entry, dated 01/11/19, showed the resident had an order for the AA medication which could be administered, "This appears to control anxiety and he has been responsive to cues/reminders."</p> <p>Record review showed that on 01/26/19, the order for the AA medication was changed to be routinely administered, two doses of the medication, every day.</p> <p>The accident and incident reporting log showed three falls were documented on 02/13/19, 02/25/19, and 03/17/19. The progress notes showed two additional incidents on 02/06/19 and 02/23/19 where the resident was found on the floor. The resident experienced a total of five falls after the AA medication was changed to routine dose.</p> <p>A pharmacy recommendation, dated 02/06/19, showed a request to consider an increase in the AA medication to three times a day, due to the sporadic use of the PRN order. The pharmacist also noted the absence of "confusion or falls" and the physician agreed with the recommendation. The dose was then increased to three times a day.</p>	F 758	<p>Finding of audits will be reported at QAPI meeting until substantial compliances is determined.</p> <p>Responsible for oversight: DON or designee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 107</p> <p>A quarterly Psychotropic Medication Review, dated 02/13/19, documented in the progress notes, showed the resident was receiving 0.5 mg of the AA medication routinely twice a day. The entry also a behavior monitor was in place, that identified "for wandering and calling out, with wandering occurring persistently," and noted the pharmacy recommendation to increase the AA medication to three times a day.</p> <p>On 02/25/19, a progress note documented a family member had requested that the recent increase in the AA medication be discontinued.</p> <p>The current Medication Administration Record (MAR), dated March 2019, documented the resident was being administered two routine doses, of the AA medication and the order a PRN order for the AA medication. The record indicated the PRN order was initiated on 10/26/19, more than 6 months ago.</p> <p>On 04/11/19 at 10:15 AM, Staff U, the Physician Assistant, who followed the resident was interviewed. Staff U, said the resident was receiving the medication due to the resident behavior of wandering in and out of other residents rooms.</p> <p>On 04/11/19 at 11:20 an interview with Director of Nursing Services was completed, the Corporate Nurse Consultant was also present. The DNS said she "did not know" if the medication was considered as a contributing factor during the investigations of falls. When asked about a justification for the use of the anti-anxiety medication, and the continued use of a PRN</p>	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 108</p> <p>administration. The DNS said sometimes an anti-anxiety medication is given for pain. After sharing the verbal justification provided by the PA during an interview, Staff V, a Clinical Nurse Consultant, stated "that is not good." The DNS was asked if other environmental interventions were attempted to allow the resident to wander safely, prior to initiating the routine use of the Psychotropic medication, she responded "I don't know." The DNS was asked to locate and provide any documentation about the clinical rational to maintain the PRN medication ordered, and no further clarification was provided.</p> <p>On 04/11/18, during a confidential interview a family member expressed concern, about the use of the psychotropic medication, and the increase in confusion they had noted since admission. After attempting to interview the Durable Power Of Attorney, a language barrier was discovered.</p> <p>On 04/23/19, an additional confidential interview with a different family member was completed. They also expressed concerns about a noted decline in cognition, increase in confusion and falls observed. The family member stated the facility had never offered an Medical Interpreter, to assist the Durable Power Of Attorney, or other family members who are involved in care, access to a medical interpreter.</p> <p>The facility failed to identify Resident 17 was potentially displaying potential adverse side effects; an increase in confusion and falls. The facility failed to identify and implement alternative interventions to provide a safe space for wandering prior to initiating the psychotropic medication, and failed to ensure the clinical</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 109</p> <p>rational for the use of the psychotropic medication as a PRN was documented in the record as required.</p> <p>RESIDENT 37 Resident 37, was admitted to the facility on [REDACTED] 19, for rehabilitation after a fall and a fracture. The initial MDS assessment, dated 01/10/19 the admission orders identified the resident was prescribed three different psychotropic medications. An Anti-Psychotic (AP), and Anti-Depressant (AD), and an Anti-Anxiety (AA) medication for multiple diagnoses of [REDACTED] and [REDACTED] and documented the resident was alert and oriented.</p> <p>On 03/27/19, at 2:45 PM, during an interview Resident 37 stated she completed skilled therapy, and was waiting for a placement in a community care setting. The resident reported anticipating a discharge to a community care setting, on [REDACTED]/18. During the interview, the resident was observed to display, abnormal lip (or oral facial) movements. (A common symptom associated with a side effect of psychotropic medications, known as Tardive Dyskinesia (TD). Which is defined as slow rhythmical, automatic movement, either generalized or in a single muscle groups, and noted as an undesirable effect of certain psychotropic drugs.)</p> <p>On 04/08/19 at 8:46 AM, Resident 37, was still residing in the facility, when greeted the same oral facial lip movements were observed. Resident 37, stated the discharge from the facility had been delayed, and she anticipated a discharge on [REDACTED] 19).</p>	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 110</p> <p>On 04/08/19, when asked about the medications, Resident 37 was able to identify the medications by name and said those are my medications to treat the [REDACTED] diagnosis, she said, she had been taking them for the past forty years. The abnormal oral movements were again observed.</p> <p>During subsequent interviews and observations, the same abnormal oral facial movements were observed.</p> <p>The care plan, dated 01/04/19, identified the medication and noted the resident was at risk for changes in mood and behavior and identified the facility staff would follow the policy for the use of the medications. The interventions directed staff to complete an Abnormal Involuntary Movement Scale (AIMS test) at the time of admission and quarterly. (The AIMS test, is a standardized questionnaire intended for staff to monitor for signs of abnormal movements which could be a side effect of psychotropic medication.)</p> <p>The AIMS test, dated 01/03/19, intended to identify signs and symptoms did not note the use of any abnormal oral facial movements.</p> <p>On 04/09/19 at 11:00 AM, Staff AA, a Licensed Practical Nurse, was interviewed about the AIMS assessment. Further review of the clinical record found a previous admission. The AIMS test completed on admission did accurately identify the symptoms. Staff AA, then went observe Resident 37. After exiting the resident room, Staff AA acknowledged the AIMS test, dated 01/03/19, was not accurate.</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 111</p> <p>On 04/11/19 at 9:10 AM, Staff A, the Resident Care Manager (a RN) was interviewed about the resident behavior monitor. Staff A explained the behavior monitors were kept in a binder at the nurse's station, but after reviewing the binder, was not able to locate any for Resident 37. Staff A, stated she did not know why the Resident did not have a behavior monitor. Staff A, was advised to provide the documents if located, and no further information was provided.</p> <p>The facility did not complete an accurate assessment, to document the signs and symptoms of potential adverse side effect related to the use of psychotropic medication, that was present on admission. In addition, they failed to ensure behavior monitors were in place. This left the facility and physician, without the necessary information to ensure the resident was not being administered unnecessary drugs.</p> <p>RESIDENT 52 Resident 52 was admitted to the facility on [REDACTED] 18, with multiple medical diagnoses including [REDACTED]. The initial MDS assessment, dated 03/09/18, documented the resident needed extensive assistance to complete the Activities of Daily Living (ADL's including dressing, grooming, toileting, and mobility) and indicated the resident was administered an Anti-Anxiety (AA) medication 7 days a week.</p> <p>The MDS, dated 03/09/18, noted the resident displayed behaviors described as physical symptoms or verbally aggressive directed towards others (occurred 1-3 days), noted the wandering behavior and indicated the behavior had no impact on the Resident or others. The</p>	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 112</p> <p>most recent Annual MDS, dated 02/13/19, documented the resident was administered an AA medication.</p> <p>During multiple observations, the resident was observed to display abnormal oral, facial movements, mouth movements.</p> <p>On 03/28/19 at 9:36, Resident 52 appeared to be sleeping in bed while clutching a baby doll. The resident was easily aroused with verbal cues, and when conversing the resident was noted to display abnormal oral facial movements.</p> <p>On 03/28/19 01:15 PM the resident was lying in bed clutching the doll, and again the abnormal oral, facial movements were noted. The resident was noted to be confused and declined to participate in an interview.</p> <p>Throughout additional on 03/28/19, 03/29/19, 04/08/19, 04/09/19, 04/11/19, Resident 52 was observed to display the same abnormal oral, facial movements during multiple observations, including while meal times.</p> <p>The care plan for the use of AA medication, identified target behaviors the medication as "pacing, wandering, disrobing, inappropriate response to verbal communication, violence /aggression towards staff." The behavior monitors identified the facility monitored "continuous calling out and repetitive demands" and "refusing care, hitting, grabbing, shoving staff."</p> <p>The MAR, for March 2019, noted the AA Medication (0.5 mg of Clonazepam three times a</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	<p>Continued From page 113</p> <p>day) which was initiated, on 09/09/18. A second medication to treat "end of life anxiety, comfort care," was initiated 12/10/18. The order showed Hydroxyzine HCL 50 mg (H HCL) was administered two times a day. (Which, according to the National Institutes of Health medication information, has ASE's described as a dry mouth and could lead to involuntary movement disorders.) On 03/06/19, a new order for the medication was implemented, however only change noted, was the addition of [REDACTED] added to the diagnosis.</p> <p>The only consent form for the use of the AA medication, dated 03/02/18, noted the use of a different medication "Lorazepam PRN" and was signed by Resident 52. (Even though the MDS assessment's identified Resident 52 had severe cognitive impairment's) There was no evidence the consent form was updated when medication changes were made in the psychotropic medications on 09/09/18 when the AA medication changed or on 12/10/18, when the second medication was added for anxiety.</p> <p>On 04/11/19, at 9:10 AM, during an interview Staff A, the RCM, was asked about the behavior monitoring for Resident 52. Staff A, obtained a binder kept at the nurse's station, and displayed the monitoring sheet.</p> <p>When asked about the residents representative, Staff A, explained the family member lived in a different city, but did occasionally visit the resident. Staff A, stated the family member wanted the resident to receive "comfort care." Staff A, did state on admission the resident had an order for Lorezapam, also an AA medication,</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 758	Continued From page 114 but it was changed to a long acting AA medication Clonazepam. When asked a dose reduction had ever been attempted, she stated "no". When asked about the symptom observed; of abnormal mouth movements, Staff A, denied she had ever observed the abnormal oral/ facial/ mouth movements. And negated the concern, that the abnormal movements could be related to the use of any of the AA medications. The facility did not identify, monitor, and assess the resident for ASE, such as a dry mouth and a possible movement disorder. (Which could potentially be related to the use of Hydroxyzine HCL 50 mg, added to the drug regime to treat anxiety on 12/10/18.) In addition, the consent for the use of the medication was signed by Resident 52, who lacked the capacity to understand the risks and benefits associated with the use of the AA medication. These failure placed this resident at risk for unnecessary drugs.	F 758			
F 760 SS=D	Reference (WAC) 388-97-1060(3)(k)(i) Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that residents were free from significant medication errors for 1 of 1 resident (56) reviewed for medication errors. This	F 760	Identified residents: Resident #56 had a more thorough investigation related to the medication error on 3/24/2019. DON was educated	5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	<p>Continued From page 115</p> <p>failure placed the resident at risk for harm and serious complications such as drug overdose and respiratory arrest or depression.</p> <p>Findings included...</p> <p>According to Lippincott Drug Guide for Nurses 2017, there are 7 rights of medication administration for keeping resident safe. Medication safety can be managed by consistently using the seven rights of drug administration: right drug, right route, right dose, right time, right patient, right response, and right documentation.</p> <p>According to the United States Food and Drug Administration (FDA), Tramadol "is a specific type of narcotic medicine called an opioid that is approved to treat moderate to moderately severe pain in adults. The FDA label for Tramadol showed, "Risk of Over dosage - Patients taking tramadol should be warned not to exceed the dose recommended by their physician. Tramadol products in excessive doses, either alone or in combination with other CNS (central nervous system) depressants, including alcohol, are a cause of drug-related deaths ... Because of its added depressant effects, Tramadol should be prescribed with caution of sedative, tranquilizers, muscle relaxants, antidepressants, or other CNS depressant drugs."</p> <p>Resident 56 was a long term resident of the facility. The resident's diagnoses list included [REDACTED] and [REDACTED]</p> <p>A review of the resident's quarterly MDS</p>	F 760	<p>on investigation of medication errors to determine if an adverse side effect occurred by the Regional Director of Clinical Services.</p> <p>Identification of other residents: Audits of medication error incident reports were reviewed for the past 30 days for a thorough and complete investigation to determine if an adverse side effect occurred related to the incident. Systemic Changes: All Licenses nurses were educated by the SDC/designee on the 7 rights of medication administration for keeping resident safe according to Lippincott Drug Guide for Nurses. Licenses nurses were also educated on investigation of medication errors to determine contributing factors, if adverse side effect occurred and interventions to decrease risk of reoccurrence. Ongoing monitoring: The interdisciplinary team will review medication error incident reports weekly to determine if avoidable or unavoidable, contributing factors, if interventions were placed to prevent reoccurrence and if any adverse side effects occurred due to error. Results of the audits will be presented at QAPI until substantial compliance is determined. Responsible for oversight: DON or designee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	<p>Continued From page 116</p> <p>assessment, dated 02/13/19, showed the resident had impaired cognition and needed one person assistance with activities of daily living (ADL's).</p> <p>Review of the facility incident reporting log from 03/2018 to 03/2019 showed that on 03/24/19, the resident had an incident of medication error. The log also showed the incident did not result in any adverse side effect or reaction to the resident.</p> <p>Review of the incident report investigation summary, dated 03/24/19, showed that on 03/24/19 at 7:56 PM, the resident received an extra dose of Tramadol 50 milligram (mg) from the licensed nurse. The resident received two doses of Tramadol 50mg (total dose received 100mg), instead of just 50mg. The investigation summary documented, "What contributed more this error? Feeling rushed, not taking time to go through MAR (Medication Administration Record) slowly and methodically ... No adverse effect noted."</p> <p>Review of the clinical progress notes from 03/25/19 to 03/26/19 documented the following:</p> <p>A. 03/25/19 at 12:26 PM: "very sleepy." B. 03/25/19 at 1:46 PM: "Sleeping most of the shift ... Routine Tramadol and Clonazepam (an anti-anxiety medication/a CNS depressant) held because too sleepy." C. 03/25/19 at 10:33 PM: The Tramadol was held at bedtime. "Resident was sleeping after dinner through to bedtime." D. 03/25/19 at 10:49 PM: "Resident is sleeping on and off. Was awake at dinner time and got her Seroquel (an anti-psychotic medication/ a CNS depressant), but fell asleep again. Held her</p>	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	Continued From page 117 Tramadol at bedtime so that she can be more awake..." E. 03/26/19 at 4:19 AM: "Too drowsy." F. 03/26/19 at 6:23 AM: "Resident drowsy yet remained responsive to stimuli ..." During an interview and record review on 04/09/19 at 1:34 PM, the Director of Nursing (DNS) stated she was the one who completed the medication error report for Resident 56. The DNS confirmed and stated that the medication error was significant because it involved a narcotic pain medication and that the incident was avoidable. The DNS stated that common side effects for opioids overdoses included over-sedation. When asked with clarifying questions on why the investigation documented that the incident did not result in any adverse side effects, but the nursing progress notes clearly showed the resident was "sleepy" and showed signs of over sedation after the incident, the DNS was not able to provide an answer.	F 760			
F 791 SS=D	Reference: WAC 388-97-1060 (1)(3)(k)(iii) Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	<p>Continued From page 118</p> <p>the needs of each resident:</p> <p>(i) Routine dental services (to the extent covered under the State plan); and</p> <p>(ii) Emergency dental services;</p> <p>§483.55(b)(2) Must, if necessary or if requested, assist the resident-</p> <p>(i) In making appointments; and</p> <p>(ii) By arranging for transportation to and from the dental services locations;</p> <p>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that routine dental services were coordinated for 3 of 3 residents (70, 4, and 46) reviewed for dental services. Failure to ensure dental services were</p>	F 791	<p>Identified Residents:</p> <p>Dental services were offered to resident # 70, #46 and # 4. Appointment made for them to be seen by dentist. Appointment dates added to Appointment log.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	<p>Continued From page 119</p> <p>coordinated placed the residents increased the risk for health complications associated with caries and poor dentition.</p> <p>Findings included...</p> <p>The facility policy, dated 12/11/18, stated the facility must assist with obtaining routine and emergency services. It also stated they must promptly, within 3 days, refer a resident with lost or damaged dentures for dental services. If services do not occur within three days, the facility must provide documentation of what they did to ensure the resident could still eat while awaiting services and the extenuating circumstances that led to delay. The policy also stated they must have a policy to identify circumstances when the loss or damage is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined to be the responsibility of the facility.</p> <p>RESIDENT 70 Resident 70 was admitted to the facility on [REDACTED] 18, with multiple diagnoses including [REDACTED], and [REDACTED]. The initial Minimum Data Set (MDS) assessment, dated 09/07/18, indicated the resident was alert and oriented, required one person supervision assistance from 1 staff for personal hygiene and oral care. The assessment tool indicated the resident had "obvious cavities and/or broken teeth."</p> <p>On 03/28/19 at 2:29 PM, during an interview Resident 70 reported the last time he saw a dentist was before he entered the facility. He denied any mouth, tooth, or oral pain. He said he</p>	F 791	<p>Identification of others: Audits were completed on all Long term care residents on dental and denture needs and a log / Systemic Changes: The facility initiated a denture/dental log to track dental needs and communicate with Social services for scheduling appointment Ongoing Monitoring: Process will be reviewed quarterly along with QAPI meeting until substantial compliance is determined Responsible for oversight: Social services or designee</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	<p>Continued From page 120</p> <p>was aware that dental work was needed. Resident 70 stated the facility staff had not talked to him about coordinating dental services.</p> <p>Review of the Care Area assessment completed with the initial MDS assessment noted the issue would be identified on the care plan, and the section indicating whether any referral was made was blank.</p> <p>The Care Plan, dated 12/04/18, identified the problem and noted the facility would coordinate dental care and transportation as needed. It also directed the staff to monitor for complications, described as "pain, bleeding, ect." and directed staff to "provide mouth care daily as needed and remind resident to brush teeth."</p> <p>On 04/09/19 at 2:46 PM, Staff K, the Social Services Director, was interviewed. She stated appointments were coordinated by herself or the Resident Care Manager. When asked if Resident 70 had been evaluated by a dentist, she stated if a consult occurred it would be in the clinical record.</p> <p>On 04/11/19 at 9:30 am, Staff A, a Registered Nurse and Resident Care Manager was asked if Resident 70 had ever been evaluated by Dentist. After looking through the clinical record she was unable to find any documentation to verify the facility had coordinated any dental services.</p> <p>RESIDENT 46 Resident 46 was admitted to the facility in 2011. The last annual MDS assessment, dated 05/26/18, showed the resident needed extensive assistance from one staff member to complete</p>	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	<p>Continued From page 121</p> <p>most activities of daily living such as bed mobility, transfers, dressing, toileting and hygiene), except eating.</p> <p>The care plan, initiated 11/22/18, showed the resident had upper and lower dentures, and directed staff to assist resident by removing, cleaning and storing the dentures in a cup at night,</p> <p>During an interview on 03/28/19 at 1:30 PM, Resident 46's family member stated the resident had recently lost her bottom denture and it had been reported to the facility, and identified the staff member. When asked if the facility had helped coordinate any dental appointments, she stated no.</p> <p>During a follow up interview and resident observation on 04/09/19 at 12:40 PM, the family member stated the resident's bottom denture was missing. The resident who was awake, then opened her mouth to display the bottom gum line. The family member explained that the facility had given them a letter stating that they would pay for half the replacement cost, and reiterated that no one had approached her to coordinate or facilitate dental services.</p> <p>The grievance log found a missing item report was filed by the staff member who received the report, dated 12/20/18.</p> <p>On 04/09/19 at 3:12 PM, the Administrator was asked for a copy of the grievance and any letters or notifications sent to the family. When asked about the replacement costs for the denture, the Administrator stated the facility was responsible</p>	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	<p>Continued From page 122 for the cost. When asked why there was a delay in obtaining a replacement, she explained she had not heard back from the family after the letter was sent.</p> <p>Review of the grievance form, provided by the administrator, showed the missing denture was reported on 12/20/18. The grievance form indicated the facility was responsible for the replacement cost of the denture. However, review of a letter, dated 01/15/19, attached to the grievance form showed the family was asked to pay for half the cost for the replacement.</p> <p>During another interview on 04/11/19 at 8:45 AM, the Administrator reiterated that the facility would be paying for the denture replacement.</p> <p>During another interview on 04/11/19 at 1:15 PM, the family member stated the facility staff had helped to coordinate dental services, which were scheduled for the near future.</p> <p>RESIDENT 4 Resident 4 was a long term care resident of the facility. The resident's diagnoses list included a [REDACTED] and [REDACTED].</p> <p>A review of the resident's annual MDS assessment, dated 12/28/18, showed the resident had mild-moderate cognitive impairment and needed one person assistance with personal hygiene.</p> <p>Review of the resident's care plan, dated 01/02/19, showed, "Resident 4 has oral /dental health problems no teeth, wears dentures."</p> <p>During an observation and interview on 03/27/19</p>	F 791			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	<p>Continued From page 123</p> <p>at 11:02 AM, the resident stated that he had a denture that did not fit and it kept "falling off." The resident also stated that both his upper and lower dentures were ill-fitting, and the facility was aware, but "they told me it's hard to fix." The resident further stated he could not recall when the last time he saw a dentist and "It does affect my ability to chew or eat my food."</p> <p>Review of the resident's weight records from 10/23/18 to 04/02/19 showed the resident had lost weight from being [REDACTED] pounds (lbs.) to [REDACTED] lbs., a loss of 11.2 lbs. in 6 months. The resident's meal intake in the past 30 days also showed the resident's documented intake had decreased and averaged 50% per meal.</p> <p>Review of the resident's clinical records (both paper and electronic records) showed no evidence the resident was seen and or evaluated by a dentist for the year 2017, 2018 and 2019. The MDS assessment also showed discrepancies related to the resident's dentition and did not identify or inaccurately coded the resident's ill-fitting dentures. (Refer to F641 - Accuracy of Assessments for more information.)</p> <p>In an interview on 04/08/19 at 1:32 PM, Staff K, Social Services Director (SSD) stated she was responsible for routine and emergency dental coordination of the facility. Staff K stated she was not aware of any recent dental services for Resident 4 but she would immediately follow-up and get back to the surveyor.</p> <p>During an interview and record review on 04/08/19 at 1:52 PM, Staff K stated the resident was not seen by any dental provider or dentist</p>	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 124 since 09/13/16. Staff K stated she was just now made aware that the resident's dentures do not fit well, so she scheduled a dental appointment for the resident on 04/18/19 at 2:00 PM. In a followed-up interview on 04/19/19 at 9:23 AM, the resident stated that aside from his ability to chew and eat his food, not wearing his dentures affected his physical appearance and self-confidence.	F 791			
F 812 SS=F	Reference (WAC) 388-97-1060 (3)(vii) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		5/25/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	<p>Continued From page 125</p> <p>Based on observation and interview, the facility failed to ensure foods were stored, and prepared under sanitary conditions. Failure to ensure food temperatures were consistently monitored, refrigerators had thermometers to monitor temperatures, ensure a system was in place to monitor expiration dates of health shakes and ensure the kitchen doors remained closed increased the risk of a food borne illness and could impact all resident receiving foods from the kitchen.</p> <p>Findings included...</p> <p>Monitor food and Refrigerator Temperatures.</p> <p>On 04/10/2019 during observation of meal service in the Olympic dining room at 12:35 PM, it was discovered the food temperatures had not been documented prior to the meal service. According to the meal times provided, meal service started in each dining room at 12:00 PM.</p> <p>Staff T, the Assistant Food Service Director, who was present during the observation, stated the hot foods were transported from the main kitchen in a heated food warmer. The temperatures of three of the food items were tested and found to be at 140 degrees or above. By not checking the temperatures prior to serving food items, left the facility without a system to identify and correct a potential problem with food temperatures (a critical control point) prior to meal service.</p> <p>Observation on 03/27/19 at 9:00 AM showed one of the two reach-in refrigerators near the kitchen door did not have a thermometer inside.</p>	F 812	<p>Identified residents: No individual resident was identified Staff T was educated and trained to ensure thermometers placed in fridge/ freezer, meal temperatures taken at beginning of service, keeping doors closed to kitchen and dating of health shakes.</p> <p>Identification of others: All residents are could be affected by the identified practices. Audits completed to ensure logs completed</p> <p>Systemic Changes: The Executive Director or designee will educate department staff on meal temperatures, dating of items, keeping doors closed in kitchen and thermometers in fridges and freezers. Ongoing monitoring Food Service Manager or designee will do observations for keeping the doors closed, will audit temperature logs of meals and fridges/ freezer, and review health shakes are dated appropriately. Audits conducted weekly x4 and monthly x2. Negative findings of these audits will be presented to QAPI committee monthly x3 months for identification of needed education and training. Responsible for oversite Food Service or designee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	<p>Continued From page 126</p> <p>Observation on 03/29/18 at 1:30 PM showed that the two refrigerators and a freezer, in the Olympic dining room, and one refrigerator in the Baker dining room did not have thermometers with which to check the temperatures.</p> <p>Failure to Implement a System to Monitor Expiration Dates</p> <p>Observations and interview on 03/27/19 at 9:00 during the initial tour of the facilities kitchen showed an undated box of Health Shakes (HS) was found in a reach-in refrigerator. The box contained HS and the individual cartons had no expiration dates on them. Staff B, the Registered Dietitian, stated the product was received frozen and the staff should be dating the outside of the box when placed in the refrigerator. Staff B, the Registered Dietitian, stated the individual HS cartons were not dated when they leave the kitchen, and explained they were intended to be consumed with meals.</p> <p>Also on 03/27/19, observation of the refrigerator in the Rainier dining room showed two Health Shakes stored on the shelf. No date was on the product and there were no lables, therefore it could not be determined how long the HS had been in the refrigerator.</p> <p>Observation on 03/29/19 at 01:26 PM showed the refrigerators located in the Olympic Dining room contained 18 undated or labeled HS. None of the cartons were dated with an expiration date, therefore it could not be determined how long they had been in the refrigerator.</p>	F 812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 127 In a joint observation on 03/29/19 at 3:00 PM, Staff B, the RD, also observed the undated, unlabeled health shakes in the refrigerator in the Olympic Dining room. Failure to maintain doors to the kitchen closed: Observation on 03/27/19 at 9:00 am after entering the service hallway showed both kitchen doors were propped open. Across from the kitchen was the laundry area. The soiled laundry room door was also propped open, as was an exit door to the building exterior which was at the end of the hallway. Observation on 03/29/19 at 11:40 AM showed that both kitchen doors to the service hallway were propped open, and one of the laundry room doors was open. Observation on 04/09/19 at 1:15 PM showed that after entering the service hallway, the one of the kitchen doors was propped open and the soiled laundry room was propped open.	F 812			
F 880 SS=F	Reference WAC 388-97-2980 (3) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		5/25/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 128 program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 129</p> <p>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to consistently implement an effective infection control program and ensure staff perform wound care and treatment based on professional standards of practice for one of one resident (46) observed during wound care. In addition,the facility failed to ensure staff had knowledge and follow transmission-based precautions as required for one of two residents (95) reviewed for infection control and transmission-based precautions. Also, the facility failed to ensure and maintained adequate ventilation in the laundry room as required. Lastly, the facility failed to ensure staff consistently performed hand hygiene and change gloves as needed while washing dishes.</p>	F 880	<p>Identified residents: Resident #46 wound on [REDACTED] was assessed on 4/30/2019 by the United Wound Physician Assistant. Documentation shows resident [REDACTED] has no signs of infection. Staff C and R were educated by the SDC/Designee on infection control standards of practice during wound care. Resident # 95 no longer resides in the facility. Staff C was educated by the SDC/Designee on infection control/ transmission based precautions. Laundry room exhaust fan was immediately fixed on 4/10/2019. Staff S was educated on infection control and hand hygiene to avoid cross contamination in the kitchen.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 130</p> <p>These failures placed resident's at risk for harm and transmitting/acquiring infections.</p> <p>Findings included...</p> <p>WOUND CARE</p> <p>During an observation and interview on 04/10/19 at 9:28 AM, Staff R, Registered Nurse (RN) was observed performing wound care and treatment to Resident 46. Resident 46 was sitting on her wheelchair with both feet directly touching the ground. Resident 46 had a stage III pressure ulcer (localized damage to the skin and/or underlying soft tissue with Full-thickness loss of skin, in which adipose (fat) is visible) on her [REDACTED]. Staff R attempted to perform the wound care treatment to Resident 46 while both feet were on the floor. The surveyors asked Staff R to stop the wound care and if possible, transfer and/or position the resident better to which her feet were off the ground and for easy assessment and visibility of the wound.</p> <p>During a joint observation and interview on 04/10/19 at 1:45 PM with Staff C, RN and the resident's daughter, the resident's [REDACTED] wound was observed with full thickness skin loss, measured at approximately 3 centimeter (cm) in length, 3cm wide and 0.3cm in depth. The wound bed was dark red with 20% covered by slough (dead tissue), had foul odor and yellowish discharge. The wound edges was tender and the surrounding skin was macerated. The resident was observed groaning and was guarding the area during the wound care observation. (Refer to F697 - Pain Management for more information.)</p>	F 880	<p>Identification of other residents: Residents currently in facility with wounds were assessed for potential signs of infection on 4/30/2019 by the RCMS and United Wound Physician Assistant. No similar residents identified.</p> <p>There is one resident in facility currently on standard/ transmission based precautions to prevent spread of infection as of 5/2/2019. The SDC educated staff on precautions and infection control practices for this resident to reduce risk of transmission of organism.</p> <p>Systemic changes: SDC/Designee educated staff on infection control practices, transmission based precautions and hand hygiene. SDC/Designee will educate Licenses nurses on infection control practices with wound care. SDC/Designee will educate staff on hand hygiene.</p> <p>Ongoing monitoring: SDC/Designee will do 2 random wound competency Skill checks on License nurses. 6 random audits on handy hygiene and 6 random audits on staff awareness and implementation of transmission based precautions. Audits conducted weekly x4 and monthly x2. Negative findings of these audits will be presented to QAPI committee monthly x3 months for identification of needed education and training. Responsible for oversight: SDC or designee</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 131</p> <p>Immediately after the wound care observation, the resident's daughter stated she was concerned that the resident's [REDACTED] wound was infected. The resident's daughter also stated her concerns about several wound care observations she witnessed during care when nurses would "clean the wound while her mother was on her wheelchair and her wound will touch the ground ... It was unhygienic and that was not how we as nurses were trained to do wound care."</p> <p>ISOLATION ROOMS/TRANSMISSION BASED PRECAUTIONS</p> <p>During a joint interview and observations on 03/28/19 at 8:31 AM with Staff D, Nursing Assistant (NA) and Staff C, RN several respiratory supplies were observed on top of Resident 95's bed. A breathing oxygen face mask, nebulizer device, and oxygen tubing were all mixed in with the resident's bed cover sheet and socks. Staff C stated she was not sure why these items were left on the resident's bed and those items "should have been bagged for infection control." Staff C also stated that Resident 95 was recently diagnosed (03/27/19) with [REDACTED] and [REDACTED].</p> <p>During an observation and interview on 03/29/19 at 8:15 AM, Staff C was observed inside Resident 95's room. Staff C was not wearing any personal protective equipment (PPE's) during this observation. The room had a sign that shows "contact precaution" with instructions that directed staff and visitors to wear "mask, gown, gloves" when entering the room." Staff C stated that she was not providing direct care to Resident</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 132</p> <p>95, so she was not required to wear any PPE's. When asked with clarifying questions about the needed precautions for a suspected respiratory infection and if a person (staff or visitor) could potentially acquire and inhale a respiratory bacteria/organisms, Staff C stated that she was wrong and she should have worn a mask when she entered the room.</p> <p>In an interview on 03/29/19 at 8:19 AM, the Director of Nursing (DNS) stated the expectation for an isolation room was for staff to follow the "sign before entering the room" and ensure all PPE's are worn as required and directed by the resident's plan of care and or isolation signs.</p> <p>LAUNDRY ROOM During a joint observation of the laundry on 04/10/19 at 11:48 AM with the Administrator and Staff H, Maintenance Director, the laundry room exhaust fan for the "dirty area/dirty utility room" was broken and not functional. Staff H attempted several times to switch the fan on and off but was not successful. There was no other window and/or ventilation system in the laundry except the broken exhaust fan and the "clean area" for laundry was directly across the dirty utility room.</p> <p>The Administrator and Staff H stated they would immediately fix the ventilation system in the laundry to prevent cross-contamination of clean linens from the air blowing from soiled processing area to clean area of the laundry.</p> <p>Review of the facility's Infection control report for March 2019 showed the facility had two outbreaks of Influenza (a respiratory infection transmitted through airborne exposure) that</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KIRKLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 133</p> <p>affected at least 17 residents (8 confirmed cases with 9 residents with respiratory symptoms) and 7 staff members/caregivers.</p> <p>HAND HYGIENE</p> <p>During the initial tour of the kitchen on 3/27/19 at 9:00 AM, a Dietary Aide, Staff S, was observed wearing gloves while loading soiled dishes into racks and then pushing them in to the dishwasher. After loading several racks with soiled dishes, Staff S, then crossed over to the other side of the dishwasher where clean dishes were drying in the racks and started stacking clean dishes without removing the gloves or washing hands.</p> <p>Staff B, the Registered Dietitian (RD) was also present during the observation. Staff B attempted to verbally provide direction to Staff S, who continued to stack the dishes while wearing soiled gloves.</p> <p>Staff B stated she would correct the practice later. The surveyor intervened and asked her to correct the practice now. Staff B, then went back to the dish area and gave further instructions to the staff working in the dishwashing area.</p> <p>Not ensuring staff washed hands, after handling soiled dishes and before touching clean items, increased the risk of cross contamination or a food borne illness outbreak.</p> <p>Reference WAC 388-97-1320(1)(a)(c)</p>	F 880			